kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

August 2010

State Medicaid Agencies Prepare for Health Care Reform While Continuing to Face Challenges from the Recession

EXECUTIVE SUMMARY

This report is based on discussions with leading state Medicaid directors in May 2010 that focused on the current economic downturn as well as the expanded role for Medicaid and the states included in the recently enacted federal health care reform law.[1] In May 2010, most states were nearing the end of state fiscal year (SFY) 2010 and working to adopt budgets for 2011 with uncertainty as to whether Congress would act to extend the enhanced federal Medicaid matching funds (FMAP) authorized in the American Recovery and Reinvestment Act of 2009 (ARRA) that are set to expire on December 31, 2010. A summary of key issues from the discussion are below:

The recession continues to impact state Medicaid programs. Even as the overall economy begins to recover, Medicaid caseload and spending growth remain high, state revenue growth remains weak and almost all states are likely to continue to face budget gaps and shortfalls heading into SFY 2011 and beyond because it could take several years for revenues to return to pre-recession levels. More than half of the states assume an extension of the ARRA enhanced FMAP through June 30, 2011 (an additional six months) in the SFY 2011 budget. However, the passage of the FMAP increase and timing of that measure by Congress remains uncertain, which could force these states to make additional budget cuts to meet balanced budget requirements if the funds expire mid-way through SFY 2011. Several attempts to extend these funds has been unsuccessful and the level of financing available has declined from about $24 billion to about $16 billion in last proposal considered.

Medicaid agencies are preparing for a key role in health care reform implementation. Governors are beginning to formalize processes to implement health reform with new offices or commissions designed to coordinate new roles and responsibilities across state agencies like Medicaid and the Department of Insurance. Medicaid Directors are assuming leadership roles in many states to implement major provisions of the new law by 2014. Health reform also requires enhanced collaboration with commercial insurance markets which will mean a transformation in organizational culture for Medicaid agencies, a need for new staff expertise, and an evolving public perception of Medicaid.

Across state Medicaid agencies, fiscal, administrative and provider capacity to accomplish health reform is a serious concern. Looking at all that needs to be done, one director pointed to a prevailing state of "cognitive fiscal dissonance" where states are trying to meet Medicaid budget reduction targets while at the same time putting in place new staff and funding to get started on health care reform implementation. Directors also acknowledged that health reform implementation requires expertise in Medicaid, systems development, and insurance market issues. Directors also expressed concern about the availability of providers to handle increases in both Medicaid and overall health care coverage.

Planning for the Medicaid expansion and coordinating eligibility with state insurance exchanges must begin now to be ready for implementation in 2014. These eligibility issues require significant IT system changes which can be expensive and time-consuming to implement. Under current practice states receive a 90% match rate for claims-based IT system upgrades but receive the regular administrative match rate (50%) for other eligibility system changes. State officials believe that enhanced federal support for eligibility system upgrades is essential for states, who are facing severely constrained administrative budgets in the wake of the recession. Some states officials also suggested that CMS develop prototypes or national models for new systems so that states do not need to "reinvent the wheel" creating systems across the country.

Interest in new options, innovation, demonstration programs and pilots included in the health reform law is high. Medicaid directors participating in the discussion were particularly interested in payment and delivery system reform options and in new long term care opportunities included in the health reform legislation.

[1] The Patient Protection and Affordable Care Act hereinafter referred to as the "Affordable Care Act" or "ACA."

1330 G Street NW, Washington, DC 20005
Phone: 202-347-5270, Fax: 202-347-5274
Website: www.kff.org

INTRODUCTION AND BACKGROUND

In May 2010, as state officials were concluding state fiscal year 2010 and preparing for fiscal year 2011, a group of leading state Medicaid directors convened in Washington, DC for the purpose of discussing the challenges, issues and opportunities they are currently facing. This report is based on that discussion, which focused on how state Medicaid programs are dealing with the worst economic downturn since the Great Depression and the recently enacted federal health care reform law – the Affordable Care Act (ACA) – which envisions an expanded role for Medicaid and the states.

Even though economists now point to data that suggest the national recession is ending, state budgets are expected to continue to see the adverse effects of the economic downturn with severely depressed state revenues and higher demand for human services, including Medicaid. States do not expect state revenues to return to pre-recession levels for several years; although many states hope 2011 will at least be a turning point and the beginning of stronger state revenue growth. As difficult as state fiscal situations are today, they clearly would have been much worse without federal fiscal relief through the American Recovery and Reinvestment Act of 2009 (ARRA.) ARRA provided significant funding that allowed states to preserve vital services and avoid many detrimental cuts. The largest single component of ARRA fiscal relief to states was $87 billion that flowed to states through enhanced federal Medicaid matching funds (known as "FMAP.") Upon enactment, the enhanced FMAP was effective retroactively to October 2008 for a total of nine quarters through December 2010. Without question the Medicaid directors viewed the ARRA enhanced FMAP provided a vital lifeline for state Medicaid programs to maintain eligibility levels and to avoid or mitigate reductions in services and reimbursement.

The fact that the economic downturn has lasted so long and continues to impact state revenues has led Congress to consider extending the ARRA enhanced FMAP for an additional two quarters through June 2011. However, efforts to pass this extension have been unsuccessful to date and the latest proposal under consideration reduced the amount of funding available for the extension from $24 billion to $16 billion. State officials believe drastic cuts in Medicaid and other state programs are a virtual certainty unless the ARRA fiscal relief is extended.[2]

Even as states continue to grapple with historically difficult budget conditions, they are also planning for the implementation of the ACA. States are expected to play key roles in implementing both Medicaid and private insurance coverage changes. In fact, Medicaid is the foundation for the ACA coverage expansion, which will achieve major reductions in the number of uninsured. From 2014 to 2019, enrollment in Medicaid is projected by CBO to expand by at least16 million individuals over baseline projections. To implement these coverage expansions, states will face fiscal and administrative challenges associated with the Medicaid expansion and with developing new health insurance exchanges that are to be operational in 2014. States must re-design their Medicaid eligibility systems to incorporate a new income eligibility determination methodology and do so in a way that will interface with new state health insurance exchanges. The ACA also offers states numerous grant opportunities and demonstration programs to test new payment and delivery system methodologies, and new long term care options and incentives intended to increase the availability of home and community-based care options.

[2] At the time of the writing of this report, proposals to extend the ARRA enhanced FMAP through June 30, 2011 were pending in Congress, but passage was uncertain.

METHODOLOGY

This report is based on a structured discussion with the Executive Committee of the National Association of State Medicaid Directors (NASMD), and selected additional Medicaid directors, in late May 2010. The Executive Committee of NASMD is comprised of eleven leading Medicaid directors, including two each from four geographic regions of the country (the Northeast, Midwest, South and West) plus the Chair, Vice-Chair and Immediate Past Chair. Executive Committee members are elected by their peers in each region and the officers are elected by all state Medicaid directors. Nine members of the Executive Committee, plus Medicaid directors from two additional states and the Executive Director of NASMD, were able to participate in the discussion on which this report is based. The views expressed in this report reflect the discussions with these directors, who represented a total of 11 states.

Thanks are extended to Medicaid directors from Illinois, Indiana, Maine, Nevada, New Jersey, New Mexico, Pennsylvania, Tennessee, Washington, West Virginia, and Wisconsin for participating in the discussion of current Medicaid issues; special thanks to the Executive Director and staff of the National Association of State Medicaid Directors for their cooperation and participation. The discussion was facilitated by Health Management Associates.

KEY ISSUES

Despite the enormous fiscal challenges that persist in almost all states, Medicaid Directors are already turning their attention to planning for health care reform implementation even as they also continue to deal with pressures to control Medicaid spending. A discussion of the key issues facing Medicaid programs today follows.

1. The recession continues to impact state Medicaid programs with state revenues remaining depressed, and Medicaid enrollment and spending continuing to grow.

Almost all Medicaid directors reported that their states continue to face substantial budget shortfalls going into SFY 2011 and given Medicaid's large share of state budgets, Medicaid would be expected once again to contribute to the budget cuts needed to close the gaps. Medicaid programs have already taken numerous reductions. One director noted that his state had gone through five cycles of state budget reduction efforts in the past three years, yet the state still needed to close a significant budget shortfall for the next budget cycle. Like more than half of the states, this state budget assumes that Congress would extend the ARRA enhanced Medicaid FMAP through June 30, 2011. Even with ARRA, this Medicaid agency, along with all other agencies in that state, had just been given a 10 percent budget reduction target for SFY 2011. For this state, if Congress does not pass the FMAP extension, cuts in excess of 10 percent will clearly be needed.

Cuts of this magnitude are neither easy to adopt nor to implement, because of the way they impact individuals who need health care. Medicaid directors report that they have already adopted options to generate program efficiencies and made other cuts that try to avoid directly affecting beneficiaries, but additional cuts may have impacts for beneficiaries. Several Medicaid directors reported that certain Medicaid budget reductions proposed by the executive branch of government had not been authorized by the legislature. The difficulty in securing authorization to cut Medicaid illustrates the difficult choices faced by state policymakers and how hard it is to reduce Medicaid spending at a time when increasing numbers of people are turning to the program for assistance. Additionally, state policy makers must balance their budgets in terms of state funds, but states must cut their programs significantly to find small amounts of savings in state dollars because of the federal matching funds. This is particularly true for states with higher FMAP rates (e.g., Mississippi,

West Virginia, Louisiana and Arkansas with regular FMAP rates well above 70 percent). The ARRA enhanced FMAP amplifies this fiscal dynamic with an enhanced FMAP in every states.

After repeated cost containment efforts and with few remaining levers to achieve Medicaid savings, states often turn to provider rate cuts and targeted benefit cuts, Medicaid directors expressed concern about the potential impact these cuts may have on access after making multiple cuts in these areas as the recession has unfolded.

Medicaid directors continue to report high demand for services and strong enrollment growth which together are primary drivers of Medicaid expenditure growth. In most states, enrollment continues to increase faster than projected. As one example, one state Medicaid caseload was 20 percent higher than was assumed when the SFY 2010 Medicaid budget was adopted a year earlier. However, in several states, the pace of enrollment growth has recently begun to moderate. Overall, directors indicated that enrollment growth remained strong (although not increasing as fast), and that they saw no reason not to expect that caseloads would remain at current high levels.

Across the states, possible signs of economic recovery have begun to emerge, such as a "still too high but decreasing" rate of unemployment in one state and state revenue losses that were lower than expected in another. State officials expressed general agreement that overall state fiscal conditions may have hit bottom and concurred with the statement that things were "less worse, but still bad." While encouraged by these signs, directors were well aware that recovery from past recessions was characterized by a significant lag in the revenue recovery for states. In fact, some states anticipate further increases in unemployment as individuals who had stopped looking for jobs try to re-enter the job market. These signs suggest that SFY 2011 could be worse than SFY 2010 for states with ongoing budget shortfalls and the need for further rounds of program cuts.[3] Given the lag in the recovery, states can expect the next few years to be difficult, even beyond 2011.

2. Medicaid agencies are preparing for a key role in health care reform implementation, alongside other state and federal officials.

Even in a period of fiscal austerity and diminished administrative capacity, states are creating the structure to respond to dozens of new roles, responsibilities and opportunities that will come to states with the implementation of health reform. At least 11 governors issued Executive Orders by June 2010 to formalize and initiate the process of planning for health reform, and many more states have organized other specific structures for this purpose.[4] Given the key role for Medicaid in reform, it is important for Medicaid program leadership to participate in those planning efforts. Medicaid Directors expressed a clear expectation that they will play a key role in the policy development and implementation efforts that will be required of states between now and 2014.

Notwithstanding the broader political dynamics, most of the Medicaid directors reported that health reform implementation and policy development conversations were well underway across all affected state agencies. This process is universally expected to include close cooperation between Medicaid directors and state insurance commissioners. Medicaid officials recognized the importance the National Association of Insurance Commissioners (NAIC) and the role insurance commissioners will play in health reform implementation, and the need for Medicaid programs to develop relationships and expertise to understand the implications of the standards that will be set by NAIC during implementation.

---

[3] Elizabeth McNichol and Nicholas Johnson, *"Recession Continues to Batter State Budgets; State Responses Could Slow Recovery,"* Center on Budget and Policy Priorities, Updated July 15, 2010.

[4] State Actions to Implement Federal Health Reform, National Conference of State Legislatures, updated June 22, 2010, accessed at http://www.ncsl.org/?tabid=20231.

In some states, specific agency roles are still under discussion. Roles clearly vary from state to state depending on, for example, where Medicaid is within the state organizational structure, whether the insurance commissioner is appointed by the Governor or is a state-wide elected official, or whether the legislature creates a specific structure for health reform implementation or defines specific oversight and monitoring of state implementation activities. For example:

- In Wisconsin, Governor Doyle issued an Executive Order establishing a health care reform office with the Secretary of HHS and the Insurance Commissioner appointed as co-chairs.
- In Washington, Governor Gregoire issued an Executive Order creating the "Health Care Cabinet" to lead health reform implementation and the separately elected Washington Insurance Commissioner was invited to participate with respect to issues within his jurisdiction. At the same time, the Washington State Legislature established the "Joint Select Committee on Health Reform Implementation" to guide implementation.
- In Pennsylvania, Governor Rendell issued an Executive Order creating an interagency "Commonwealth Health Care Reform Implementation Committee" and the "Commonwealth Health Care Reform Implementation Advisory Committee" to include legislators and external stakeholders.

States have already begun making decisions related to health reform implementation including meeting the April 30, 2010 deadline to decide whether to operate a high-risk pool directly or opt to let the Secretary of the Department of Health and Human Services operate one in their state. Medicaid directors emphasized that the decisions by a number of states to *not* operate the high-risk pool were not indicative of other future health reform decisions including whether those states would choose to operate the insurance exchanges for their states.

Implementation will also be affected by upcoming elections. In November 2010, there are 37 state gubernatorial elections, with at least 24 governors either term-limited or not running for re-election. Election of a new governor means changes in cabinet-level and other executive leadership positions, which will certainly affect Medicaid directors in many states. Medicaid directors stressed the need to developing non-political level leadership that could transition from one administration to the next.

Even though a major share of implementation activity will occur in the states, health reform implementation will be guided and significantly defined by federal directions from CMS. Directors agreed that at this early stage of implementation, CMS is working diligently to be helpful to states. Still, these state officials expressed concern about the immense workload and the aggressive timeline that confronts CMS, and how that might affect states who have so much to do in such a short time.

3. Across state Medicaid agencies, fiscal, administrative and provider capacity to accomplish health reform is a serious concern.

Even with a full implementation more than three years away in 2014, a common concern across Medicaid directors is that state funding and administrative capacity are inadequate to accomplish all of the tasks associated with federal health reform implementation. Looking at all that needs to be done, one director pointed to a prevailing state of "cognitive fiscal dissonance" in his state – that is, trying to meet new Medicaid budget reduction targets while at the same time putting in place new staff and funding to get started on the path to implementing health care reform. Current staff are consumed with implementing the administrative changes necessary to control program spending. In addition to funding concerns, state officials also conveyed concern about the availability of staff with appropriate expertise to manage implementation. States have encountered layoffs and hiring freezes over the past few fiscal years. Incentives for early retirement may make it difficult to retain high

level staff with institutional knowledge and expertise who could transition from one administration to the next.

Even if states could hire additional staff, finding staff with appropriate expertise and experience will be a challenge. Directors acknowledged that health reform implementation requires expertise in Medicaid, systems development, and insurance market issues. That unique combination of required skills and experiences is hard to find, both in terms of individual recruitment and organizational mindset. One Director noted that developing systems entailed more than just writing new software code, but also required states to develop blueprints that map out policy changes, which requires Medicaid policy expertise.

Several ideas were suggested for maximizing administrative resources such as drawing on information learned from the National Governors Association Consortium on Health Reform, creating webinar-style or other training opportunities that would not require out-of-state travel, and encouraging foundations with an interest in health reform implementation to consider funding technical assistance support to states without the need for grant-writing and reporting, which itself can be resource and time-intensive.

Finally, directors expressed concern about the availability of providers to handle increases in both Medicaid and overall health care coverage. Serious workforce shortages may require investments in nurse practitioners and physician assistants, examining and expanding the scope of practice for various levels of caregivers, or employing lower-skilled aides and technology options to help expand access to care. In addition, Medicaid Directors were cognizant of efforts to ramp up program integrity efforts at the federal level. While all Medicaid Directors are strongly in favor of efforts to promote program integrity, they also expressed some concerns that these efforts may increase administrative burdens for physicians and therefore hinder efforts to recruit providers into Medicaid or result in the migration of some providers out of the system.

4. Planning for the Medicaid expansion and coordinating eligibility with state insurance exchanges must begin now to be ready for implementation in 2014.

Two related components of reform under the ACA are major priorities for Medicaid: simplifying Medicaid eligibility up to 133 percent of the federal poverty level (FPL) and integrating Medicaid eligibility determinations with eligibility for federal premium subsidies offered through state Health Insurance Exchanges. Medicaid directors see these eligibility issues as extremely important, both because this aspect of implementation will be high-profile and because these components will require high levels of coordination and significant IT system changes, which means lengthy and expensive work that relies on careful advance planning and high levels of coordination. Current practice is that states receive enhanced federal support for claims-based IT system upgrades (for development, a 90 percent federal match), but receive the regular administrative match rate (50 percent federal match) for other IT work, including Medicaid eligibility system changes. State officials believe that enhanced federal support for eligibility system upgrades is essential for states, who are struggling under significant pressure on administrative budgets in the wake of the recession. Some state officials also suggested that CMS develop prototypes or create national models for new systems from which states can choose so that states do not need to "reinvent the wheel" all across the country.

All states are anxious to learn more details from CMS to determine how the eligibility determination process will be simplified under health care reform. The ACA is structured to provide enhanced federal funding for newly-eligible individuals, while retaining traditional lower federal matching rates for individuals who would have been eligible under state rules before reform. Directors see an essential element of CMS guidance to be how to accomplish the objective of those provisions while avoiding a situation where states are required to operate dual (old and new) eligibility systems.

Directors recognized the tension between wanting standard guidance and also wanting CMS to recognize the unique circumstances of individual states in moving forward. One director noted that there was a "peril in asking for too much guidance" and ultimately getting definitive answers where they may want more flexibility.

Beyond CMS, states will need to coordinate with other state and federal agencies to implement new eligibility requirements. States that have combined eligibility for Medicaid with Transitional Assistance for Needy Families or Food Stamps expressed a grave concern about navigating the separate and sometimes slow approval process for changes in systems serving those programs. States like Wisconsin that have already expanded coverage to childless adults and developed integrated eligibility and enrollment systems that allow individuals to enroll in coverage on-line are likely in a better position to implement required health reform changes than other states. The ability to apply on-line may also promote enrollment of younger, healthier populations which may mitigate the effects of adverse selection in expanding coverage to this new population.

Finally, the ACA authorizes states to expand eligibility for Medicaid in advance of the required 2014 implementation date. A few states with a current program for higher-income coverage are the most likely to consider exercising this authority if it financially benefits the state. However, for most states, the ACA eligibility Maintenance of Effort requirement will have the most impact on Medicaid eligibility policy by preventing states from reducing eligibility standards before 2014.

5. Health reform requirements for enhanced collaboration and interaction with the commercial market implies a transformation in organizational culture for Medicaid agencies, a need for different staff expertise, and an evolving public perception of Medicaid.

Beyond the challenges of implementation tasks, Medicaid leaders perceive that reform is deeply transformative for the Medicaid program. Officials said that Medicaid has come to be regarded more as a health coverage program, and health reform reinforces this trend. By enrolling more and higher-income members and increasing integration with the commercial market, Medicaid will move farther away from being a welfare-style or social program. This development has implications both for organizational culture within Medicaid agencies and sister agencies and for the public's perception of Medicaid. As one example, one Director suggested there could be a move in his state to integrate Medicaid with health coverage for state employees to be able to leverage even greater purchasing power in the health care market.

As an example of the significant change that may occur across state eligibility staff as Medicaid continues to evolve, officials noted the lack of any existing structures within Medicaid that deal with employers, employees and payroll-based premium contributions, all of which are likely to be necessary to integrate Medicaid with Exchanges.

Another dimension of upcoming change is the need for Medicaid programs to become more integrated and collaborate with commercial health care plans. One director envisioned a future fully-integrated health plan system where individuals and small employers accessed a single front door for Medicaid, CHIP and exchange coverage and would not need to be aware of whether they were on Medicaid or not. Even absent such a sweeping transformation, health reform opens new opportunities for Medicaid to participate in the broader health care market, to collaborate with commercial payers, and to be a driver of health quality improvement efforts across the health care delivery system.

6. Interest in policy innovation, demonstrations and pilots remains high, particularly in Medicaid participation in payment and delivery system reforms, and in long term care.

In addition to fundamental changes in eligibility processes and Medicaid coverage rules, the ACA presents an array of options and pilot programs for states targeted at advancing specific policy improvements in quality, reimbursement or community-based coverage. Medicaid directors reported significant interest in these demonstrations – especially those oriented to payment reform involving Accountable Care Organizations (ACOs) and bundled payments.

There is notable and widespread interest in policy innovation opportunities that restructure payment incentives or advance long-term care system reforms. Officials singled out the bundled payment demonstrations as having great potential for quality improvement and cost-savings, but expressed concern about having the resources and expertise necessary for a successful demonstration.

Across states, there is considerable interest in the long-term care options contained in the ACA, including new options to expand home and community-based services. That interest was tempered with a concern that those options are oriented to a fee-for-service system. Particularly in the long-term care area, states expressed interest in moving toward comprehensive payment and delivery system reforms. One Director noted that new efforts were needed to yield changes in consumer and provider behavior, to end fee-for-service and pay for care based on outcomes and quality.

Most Directors did not think that the health reform law went far enough to address the serious issues around coordination of care for dual eligibles. There is a high degree of interest in new approaches to structuring services for "dual eligible" individuals who qualify for both Medicare and Medicaid. That said, there is concern from state officials about whether the financing structure of new integrated care programs will be adequate or disadvantageous to Medicaid as compared to Medicare.

Overall, however, enthusiasm was high about the opportunities for fundamental health system improvements based on the options in the ACA. Medicaid Directors conveyed an eagerness to be involved in these broad-scale reforms, whether operated with Medicaid programs, in coordination with Medicare, or as a participant in the broader commercial market. However, directors said that they might need additional resources to apply for and participate in some of these demonstrations and that they were waiting for guidance from HHS before moving forward on any of these opportunities.

CONCLUSION

Medicaid directors gathered in late May 2010 (only 60 days after the enactment of health reform) to discuss the key issues and challenges they face as they enter state fiscal year 2011 and as they evaluate the huge tasks ahead associated with the implementation of the new health reform law. The recession continues to put pressure on state Medicaid programs as state revenues continue to lag, budget shortfalls are widespread and administrative capacity has been stretched to the limit by layoffs, furlough days, hiring freezes and program cutbacks. A major concern of state Medicaid directors was the uncertainty around extending the temporary enhanced ARRA federal matching rates. Without the extension of the enhanced FMAP, further budget cutbacks were regarded as inevitable that would affect all states and all state programs from education to health care. No matter how this issue is resolved in Congress, implementation of health reform will have to occur in a context of extreme fiscal constraint.

Health reform envisions a significantly expanded role for states and for Medicaid, including roles that will be completely new for those who administer the program. The discussion centered on the complexity of the tasks immediately ahead, on the short time timeframes for implementation and the need for the resources to carry out implementation in a skillful and efficient manner.

Despite legal challenges and political controversy about health reform, Medicaid directors were gearing up to begin the task of implementation. In the two months since enactment, hundreds of hours had been spent identifying the tasks to be done and what would be needed to accomplish them successfully. States were awaiting needed guidance from the federal agencies, in particular from CMS, so they can begin to prepare the specifications and requirements for the major system changes involved with Medicaid eligibility re-design and integration with the new health insurance exchanges. These are major undertakings, and Medicaid officials are very aware of the very short amount of time they have to carry out the required work.

This report was prepared by Vernon Smith, Kathy Gifford and Tom Dehner at Health Management Associates and Robin Rudowitz from the Kaiser Commission on Medicaid and the Uninsured. The authors thank the state officials who shared their time and expertise to help make this report possible.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

This publication (#8091) is available on the Kaiser Family Foundation's website at www.kff.org.

THE HENRY J. KAISER FAMILY FOUNDATION

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.