INTERVIEW WITH

CYNTHIA MANN

H1N1 ORAL HISTORY PROJECT

Interviewed By Sheena Morrison

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Interview with Ms. Cynthia Mann
Interviewed at Ms. Mann's Office.
Silver Spring, MD, U.S.A.
Interviewed on November 16, 2009
H1N1 Oral History Project
Interviewed by Sheena Morrison

Cynthia Mann: CM
Sheena Morrison: SM

SM: The following interview was conducted with Cynthia Mann, Director of the Center for Medicare and Medicaid Services within the Department of Health and Human Services.

CM: Nope, that's not the right title.

SM: Okay, alright. The following interview was conducted with Cynthia Mann, Director of the Center for Medicaid and State Operations within the Centers for Medicare and Medicaid Services. It was conducted on behalf of the National Library of Medicine for the Making History: H1N1 Oral History Project. It took place on November 16th, at the Director's office in Washington, DC, and the interviewer is Sheena Morrison.

So we'll begin with a little bit about yourself. Can you tell me how long you've been in your current position as the Director?

CM: I was appointed by the President and Secretary, and I assumed my position on June 8th of this year, 2009.

SM: Can you explain for me your role in the Federal Government's planning and response efforts to the 2009 H1N1 outbreak?

CM: Sure. The chief responsibility that I have is to oversee the Medicaid program. The Medicaid program is a major component of our health coverage system, and people who qualify for Medicaid are low income people, families and children, people with disabilities, and the elderly. And we have about 53 million beneficiaries across the country, more that are actually eligible but not enrolled.

And so, Medicaid had a key role to play in the response to H1N1: to ensure, first of all, that our beneficiaries were adequately protected; that the providers that were serving our beneficiaries knew what they would get reimbursed for and what they wouldn't get reimbursed for in terms of

treating people with H1N1; helping to administer the vaccine so that the states which actually administer the program knew what the rules would be, and would begin preparations for assuring that as many people as possible got vaccinated.

SM: Okay. Can you recall where you were and what you were doing when it became clear that this novel H1N1 virus was highly transmittable, which meant that certain triggers would have to be in place to respond to it?

CM: Well, since I came in June of 2009, it was already clear within the department at that point (and clear publicly) that H1N1 required a significant federal response. And it was, from the time I joined the Department, a high priority for the Secretary and for the Department. So it was very much a "all hands on deck" kind of attitude within the Department with all of us thinking about what our specific areas of responsibility ought to be doing to contribute to a very thorough and ambitious and aggressive response. So it was really from the jump, I think. When I assumed the job, it was clear that all of us had a role to play, and as I noted, the Medicaid program has a particularly important role to play.

SM: So what were some of the major issues that you immediately had to contend with?

CM: Well, some of the issues were what Medicaid would reimburse for, whether the vaccine was being paid for by the Federal Government. Then, there was the question of the administration fee of, actually, providers administering the vaccine. So, what would we pay for?

We also tried to provide advance information to hospitals as well as to States about - if there was a surge in need for medical care, what kind of rules would Medicaid follow in terms of payment for care? So for example, if an emergency room became overcrowded and a hospital set up auxiliary facilities outside of the four walls of the emergency room, would we still consider it an emergency room? And would we still reimburse states for those services? Would we recognize, essentially, the extension of the hospital facilities beyond the four walls of the hospitals? So those were some of the issues and questions that were coming in, and that we wanted to get out answers to in advance of any problems hitting the streets, that

people would be able to plan and not be in for any surprises.

And of course, we wanted the policy to be as generous as it could be since our goal certainly was to make the vaccine available to the full extent possible, and to assure that there was going to be adequate treatment facilities available for people who presented with H1N1.

SM: And so this came up. And how was it resolved?

CM: There were a number of ways in which we moved forward: we did some questions and answers that got posted on the national website, flu.gov, some questions that were posed by hospitals that we provided policy answers to.

We also did what we call a "Dear State Medical Director letter", which is often a way that we have of conveying policy and guidance to the broader community - state Medicaid agencies being the direct audience. But other people see the guidance as well: hospitals, providers, insurers. And we issued a State Medicaid Director letter over the summer that covered very many different topics around H1N1 in terms of what would be covered, under what

circumstances, alternate settings that would be allowable. So that was really our way to provide comprehensive guidance to States and to the broader community about what Medicaid's states contribution would be.

We also oversee nursing home facilities outside of the Medicaid program. Part of our state operations is to do survey and certification to assure quality and care is provided in our nursing home facilities. So, we also issued regular guidance to nursing home operators, and provided some information too about Medicaid policy with respect to H1N1 to those entities as well. And provide guidance under EMTALA, which are the rules which govern what hospitals must do when somebody presents in a hospital with an emergency situation. So, a number of different ways in which we provided guidance.

We also had a couple of calls with State Medicaid Directors around the country once the guidance came out to clarify what our guidance was if any questions arose, and to make sure that any questions that did arise that we could immediately answer, that we then researched the answer and then provided further information back to them.

SM: Was the decision making process solely within your department, or did you have to engage with other agencies within HHS?

CM: I think there was across HHS pretty fluid lines of communication. The Secretary had one full meeting with all senior staff to talk about our collective response to H1N1. I think that set the stage for really having a very strong partnership within the Department about what we could be doing to stimulate ideas across agencies.

In terms of our specific policies, we consulted regularly with the office of the Secretary that was leading the H1N1 effort as well as with the Director of ASPR, Dr. Nicole Lurie. And then we issued policies like our State Medicaid Director Letter. We will typically (and we did in this instance,) circulate in what's called "the clearance process" so that all interested agencies within the Department get to weigh in, raise questions if they have questions about it, and at a minimum, become aware of what our policy is before it's actually issued to the public. So, I think there's a lot of cross conversation that went on within the agency, within the Department.

SM: It really is a joint effort.

CM: Very much so.

SM: What were some of the underlying assumptions that guided your decision making process? You came in and you hit the ground running, so what guided you in the process to respond to the momentum of the effort?

CM: Well I think it was, as I said, a real high priority for the Department and the Secretary to be as proactive as possible. So I think that was really the guiding force: to be proactive and to have a very aggressive public health response.

Certainly, the emphasis has been on trying to ensure that as many people, particularly the high risk groups, are vaccinated. So we really put a lot of effort into making sure that the Medicaid policies were clear on payment before that vaccination administration. Two of the major higher risk groups are very highly represented in the Medicaid population: children and pregnant women. Medicaid ensures a little over 1 out of 4 children in this country and is a very large source of coverage for pregnant women;

so our mechanisms of not only reassuring providers that they would get paid for the vaccine administration, but also reinforcing the message about the importance of vaccination for these high risk populations. It was very much part of what we were trying to do as a department: to be proactive.

SM: How was it ultimately resolved? Was there anything already in place to handle - I mean this was something new, unexpected. Was there anything in place to assure that the States and providers would get paid? Or was it something that you had to create as you went along?

CM: That's a good question. By and large, we drew upon policies that were in place, but we produced guidance that was H1N1 specific. So, what we did is look at - through the lens of what we were being told by the CDC, by ASPER, by those who were experts in being able to anticipate how the flu might take hold - we were looking at that information and then examining what our policies and what our laws could allow. And then, translating that back out to the communities: So, it wasn't just repeating, "Yes, you can pay for vaccinations." Or, "You can do this in emergency rooms." It was, "We anticipate that the flu could take this

shape under Medicaid policies. You could take these actions." In pointing out also where there is state flexibility to do things that they might not be required to do, but which because of how we were all anticipating the flu might proceed, the State might consider taking advantage of flexibilities that they might even not be aware of. So, the law was pretty much in place, but what we were trying to do is to apply it to a new set of circumstances, and make sure that everybody was aware of the potential opportunities to use that law in ways that would help provide a robust public health response.

SM: You mentioned AMATALA.

CM: EMTALA

SM: EMTALA, right. Can you explain to me the significance of the Emergency Medical Treatment And Labor Act in the overall response efforts to the outbreak?

CM: EMTALA is a law that basically requires hospitals to screen, treat, and stabilize anyone that comes to them that's presenting with an emergency medical condition regardless of their insurance status. So it prevents what's

often known as patient dumping. Somebody can come into the emergency room, maybe they have insurance maybe they don't have insurance, but if they're in an emergency situation, then under certain circumstance the hospital has to treat that emergency and at least stabilize them regardless of their ability to pay for care. It's a very important provision of the law, and our obligation of course is to oversee it and to clarify what the rules are.

We wanted to, on one hand, make sure that EMTALA was being properly followed so that everybody with an emergency was being cared for, but at the same time what we wanted, what we were hoping to do also is to prevent people who didn't have an emergency from going to the emergency room. For two reasons: one is, they would get better and more timely and more appropriate care outside of the emergency room - at least we'd like to hope and wanted to set up that opportunity. Secondly, we didn't want a situation where the emergency rooms were so overcrowded with people with relatively mild flu symptoms that they then wouldn't have the capacity to treat true emergencies. So part of our EMTALA work has been to try - and while reinforcing the EMTALA obligations - to make sure that there were opportunities for people who didn't have emergencies as

medical problems but had medical problems, had a place to ask their questions, get treatment, and be seen without overburdening the emergency rooms.

SM: And this they could do within the scope of-

CM: That's right, they could do within the scope of the Medicaid program and other insurers. So, trying to encourage as a public health message to contact your primary care physician; don't immediately go to the emergency room. Unless of course, somebody perceives that it truly is an emergency. We made clear where there's opportunities - for example, under the Medicaid law - to provide information to people over the phone, and to triage in health clinics and outpatient clinics, and make sure that facilities were available to see people without forcing people to get care only in the emergency room.

SM: And have you been able to document that this was actually a process that was made available to your beneficiaries?

CM: I think it's still unfolding. As we see now, I think there's a very high level of awareness on some of these

issues as a result of some of the outreach that we - when I say we, many parts of the administration - have undertaken. There's just been lots of outreach and communications with various different organizations and groups and subgroups. So, I think at this point, the information is pretty clear as we see the trajectory of the flu. Hopefully, we will see what we hope to happen, happen, which is that people will get the care that they need in the most appropriate setting. And if it's an emergency setting, they'll go there, and if it's not an emergency setting, they will have the ability to go elsewhere. Of course, we have lots of uninsured people in this country, and they may not have alternative sources of coverage. So, we'll see how that transpires as we go forward.

SM: And those would be the people who it would actually be an emergency for if they don't have a primary-

CM: The fact that they don't have a more appropriate source of care doesn't necessarily mean, in EMTALA terms, that it is an emergency. Certainly for that family, it feels like an emergency because they have potentially the flu, and they don't have anywhere else to go. So, they will go into the emergency room, and often, emergency rooms will

care for them even if it's not an emergency. They're not obligated to do that under the law. Obviously, a goal of health reform is to ensure that nobody is in that situation, and that people really do have a place to get care that's the appropriate setting.

SM: Can you explain how an 1135 waiver facilitates emergency and disaster related policies in general and then, more specifically, as it relates to your efforts to meet the needs of your beneficiaries?

CM: 1135 waivers are actually not within my province. They are handled in another division within the Centers for Medicare and Medicaid Services, on the Medicare side of the shop. So you probably should follow up with somebody more specifically. They are waivers that generally allow hospitals to set up different types of facilities to extend what they would normally certify as a hospital facility during different kinds of emergency situations, and they are permitted once the President has declared a public health emergency which, as you know, he has recently.

SM: Can you tell me what are some of the major issues you're contending with right now in terms of funding, messaging, and any legal barriers?

CM: You know, I think the couple of the areas that we're continuing to pay attention to - any questions that come up, you provide guidance about what the rules are. And what's important is to provide that guidance over and over again so that everybody's clear and so that you're consistent. So, I think we're continuing on our communication efforts, meeting with state Medicaid agencies, with provider organizations. We're meeting with community organizations to make sure they're clear what the Medicaid program can be doing to help them contend with the onset of the flu.

We are continuing to explore opportunities within the Department and across the administration for ways to help pay for uncompensated care for those people who aren't eligible for Medicaid and don't have other insurance. So that if it becomes a heavy burden, we certainly don't want anyone to be denied care because they are uninsured. At the same time, if certain providers and hospitals take on a heavy responsibility on our compensated care, they may be

in difficult financial situations. So we're working across agencies within and across the administration to look at what some of the opportunities are to help shoulder some of the cost on uncompensated care.

SM: Okay.

CM: The other thing I think we're working with, with other agencies in the department (I know we're working with, but I think it's useful to mention,) is workforce issues. We want to make sure that health care workers who are a high risk group are vaccinated. They may not be Medicaid eligible, but they are caring in many cases for Medicaid beneficiaries. So, if they're in home and community based services - your personal care attendant, your worker in a nursing home - the patients are Medicaid patients (and they tend to be very vulnerable, very frail individuals), we're also working with the Medicaid agencies, the home and community based service agencies, to make sure that their workers are adequately protected so that they can continue. Obviously, so that they don't contract the flu, but also so that they continue to provide care to Medicaid beneficiaries without any break in continuity.

SM: And so that's an entirely different messaging.

CM: That's right. That's right. And a different audience.

SM: Acknowledging that hindsight is 20/20, is there any thing that you would have done differently up to now?

CM: There's some issues that have been raised about the level of the payment for vaccine administration through the Medicaid program, and the last time that vaccine administration fee was updated was in 1994. We are now updating that, and its been an issue that I've been paying attention to as soon as I got here, but it would have been nice to have had that updated prior to the onset. I have not seen any instance where it has resulted in providers not administering the vaccine, but it's something one would have wanted to have in place before hand. It's one of the those issues that wasn't identified till the new administration came in, and we looked at all the different components. So, it would have been nice to have done that in advance. It is however just an upper limit, and it really allows states to - states are still free to raise their vaccine administration fee. But the Federal Government could be doing more to ensure that that fee is

adequate to assure full access. (I think I'm getting a call here. Yeah. 11 o'clock.)

SM: Okay. Lets see. I can-

CM: Do you have much more?

SM: I have just a couple of questions.

CM: If they're quick. I just have several people waiting on a call.

SM: Well basically are there any documents that-

CM: I mean the hindsight question is - we're not quite that much in hindsight yet. So, I think it's a question I would also ask maybe 6 months from now, and a year from now.

SM: Right. And I will come back to you. (Laugh)

CM: Okay, fair enough.

SM: I will come back to you. Well, are there any documents that I should be reading that would give me further insight into what your responsibilities are, and your efforts to-

CM: I think it might be helpful if you looked at that Medicaid Directors Letter, which had sort of an overview of all the ways in which H1N1 and Medicaid intersect, and provided guidance to the States. So, that would give you a sense. You can put aside the weeds of it, but give a sense of the different areas in which we interacted with H1N1 and also a couple of fact sheets that we sent out to nursing homes on EMTALA. So, we can pull those materials together for you, if that'd be helpful.

SM: Yes, that would, and I can archive them.

CM: Okay, great.

SM: And also one last question, is there anyone else you think that I should talk to who might also give a perspective on your efforts to-

CM: In our agency and Medicaid, Christa Drobac was our person who was helping to coordinate within CMSO what our various responses were on all those fronts.

SM: How do you spell her last name?

CM: D R O B A C.

SM: Okay. Well thank you.

CM: Okay.