MACPAC

Medicaid and CHIP Payment and Access Commission

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PUBLIC MEETING

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National Guard Association of the U.S.
One Massachusetts Avenue, NW
Washington, D.C. 20001

Thursday, September 20, 2012
1:36 p.m.

COMMISSIONERS PRESENT:
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ROBIN SMITH
STEVEN WALDREN, MD, MS

LU ZAWISTOWICH, ScD, Executive Director

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1 P R O C E E D I N G S [1:36 P.M.]

2 CHAIR ROWLAND: Welcome. Let me convene this meeting of the Medicaid and CHIP
3 Payment and Access Commission. I'm glad to open the meeting and to welcome our guests to join us in
4 our discussion today.

5 I'd like to make an opening announcement, which is that we at MACPAC are very sad to lose the
6 wonderful Executive Director of MACPAC since our inception who helped to set it up, to get us going, and
7 to make us an institution instead of a thought. And so we want to congratulate and wish Lu Zawistowich
8 the very best on her retirement, and we'll be looking forward to hearing about all the wonderful things she
9 does in retirement while we sit here and try and struggle through how to take Medicaid and CHIP to new
10 heights and new levels of analysis.

11 I'd like to turn to start the meeting to my Vice Chair, David, to make a few opening comments, and
12 then we'll get underway.

13 VICE CHAIR SUNDWALL: Well, thank you very much, Diane, and welcome to those in the
14 audience that are representing the public. You have a big responsibility to represent the public. That's a
15 big job.

16 But, anyhow, I would just add my vote of thanks or my comments of thanks to Lu Zawistowich.
17 She has really been a terrific leader during this time of establishing our Commission, and we do feel like it
18 has matured and we're stable in every way and look forward to following in retirement. Hope you don't
19 get up to too much mischief.

20 The only comment I'd make is that we're obviously in a very interesting time politically -- a
21 presidential election, possible changes in Congress as well as the White House. But notwithstanding the
22 election, the Commission is especially important now as we monitor the implementation of provisions in
23 the ACA. We don't anticipate there are going to be repealed and replaced right away. We think that we

have a real responsibility to monitor access issues and some very knotty policy issues, and I think that we've proven we can be a resource to Congress and look forward to continuing in that role.

My last comment will just be, because I've made it this morning and I'll keep making it, as a clinician and a public health person, I'm going to try and see if we can as a Commission weave some public health measures into our work, focus on the importance of improving patient health status with Medicaid and CHIP, not just following expenditures or reimbursement policies or trends, because I think that's what would be of interest to most people, regardless of their political persuasion, if we could actually use these insurance tools to improve the health of those that we cover.

So thank you, and I look forward to the rest of the meeting.

OVERVIEW OF COMMISSION PRIORITIES

* CHAIR ROWLAND: Thank you, David, and thank you to the Commission members for their diligence in helping to work through what we are developing as an analytic plan going forward for not just the next few months but also for the coming years. Now that we have developed in our view from a fledgling organization to a more mature organization, we are ready to set out some longer-term goals and to really begin to have the staff move forward on developing some of the evidence-based research that we will use to develop the actionable items that we can have as our future reports.

In developing our work, as you know, MACPAC is statutorily charged with providing policy and data analysis to the Congress on Medicaid and CHIP and for making recommendations to the Congress, the Secretary of the U.S. Department of Health and Human Services, as well as to the states on a wide range of issues affecting these programs. In developing our analytic plan, we have really looked at building on the foundational work of the Commission's first two years and first four reports to Congress, trying to go deeper and provide some basis for really looking at specific aspects of the Medicaid and CHIP programs and how they can be improved or modified to better serve the populations and the goals that we have for

1 those programs.

2 If we think about how we're organizing our work, the Commission has identified five priority areas

3 for the 2012 to 2015 cycle. The first and foremost of what the work of the Commission will develop is

4 looking at the Medicaid and CHIP programs' performance in serving the very different subpopulations that

5 compose the beneficiaries of both programs; trying to look at the role the programs play for children, for

6 infants, and for pregnant women, the original charge of the Commission as set up under the CHIPRA

7 legislation, but moving on to really try and focus on the persons with disabilities, as we have in our March

8 report, to really be able to understand more about how that population is served and how that population

9 uses health care services, what their health care needs are, and what some new models for delivery and the

10 role of managed care for serving that population will be; looking at the dual-eligible population, those who

11 are enrolled in both Medicaid and Medicare, to determine more about their service use and characteristics

12 and how the two programs intersect to serve them or fail to intersect to serve them, and how they can

13 receive better and more coordinated care in the future; and looking specifically at some of the issues around

14 the long-term care population, which, of course, is one of the main components of Medicaid spending, and

15 really is an area in which the Medicaid program carries the national responsibility for our long-term care

16 policy, so how can we make other progress in that area?

17 The key issues that we'll address in looking at these populations include: What are the health needs

18 of these groups? How well are their needs being met today? What are the opportunities and options for

19 improvement in care delivery? And we want to especially begin to look at whether there are exemplary

20 models of care that we could examine by going out and doing some site visits at some of the areas around

21 the country with innovative programs, and beginning to really try and look through the data at where the

22 experience bears some additional analysis to see if there are models there that can be applied.

23 But in looking at these populations, the second priority area for the Commission is to look at access

to care in both the Medicaid and CHIP programs and how well these populations are being served, and especially to look at provider participation issues and enrollee utilization of services to see where the gaps in care are, to take on an area that for adults and for children as well have not been an area of the population being well served, which is that around oral health, and to really try and look at how the oral health issues play out. One of our Commission members -- and you can try and figure out who it is -- often tries to remind us that the mouth is a part of the body and influences how we go forward. But I think it's a critical area that we know can affect overall health care status and that has been very understudied in much of the work on Medicaid and including more recently in the CHIP program.

We also want to look at the prescription drug utilization within the program and the different payment policies around prescription drugs and what access to care issues are there; and then, of course, the emerging role of managed care and how managed care models are developing, how some of the payment issues have developed, and really try and identify what the level of access to services within Medicaid and CHIP really is. Where are there the gaps in care? Are there different gaps for different populations? How do payment rates influence access? And really what's the role of managed care for these populations? And especially to begin to look more deeply at how the Medicaid and CHIP populations use emergency rooms and emergency departments, and does that lead to improved access to specialty care, or does it just lead to care in emergency rooms for less than urgent care? And we're going to really begin some of that discussion today in our first session following this rambling discussion that I'm leading.

The other area that is critical as we move forward with health care reform implementation is what's the impact on the safety net, on safety net facilities, on both safety net hospitals and on community health centers, and how does their role in taking care of the current and the prospective Medicaid and CHIP populations differ across the country? What are some of the payment policy issues that involve their ability to continue to serve that population?

1 And that leads to our third priority area, which is to look at Medicaid and CHIP as prudent
2 purchasers to get a better understanding of how service delivery and payment innovations are being
3 undertaken by the states to support the goal of purchasing cost-effective and high-quality care. Some of
4 the key policy areas are to not only look at payment of different providers but at the financing systems that
5 have developed within Medicaid that sometimes make it difficult to even tease out what the appropriate
6 payment policy is for different providers, and how to look at those and to do further work at explaining the
7 complex intersection in Medicaid between provider payment and Medicaid financing; also to begin to look
8 at some of the quality measures that are being developed so that we have a better way of monitoring quality
9 of care and being able to assess whether payment policy is actually promoting improvements in care
10 delivery.

11 And then as a follow-up area, our fourth area would be to really look at how to improve Medicaid
12 and CHIP program efficiency. We want to examine some of the specific initiatives intended to improve
13 Medicaid program integrity and program management. We want to get into looking at the resources
14 available in the states to actually administer the Medicaid program, at the combination of new requirements
15 on the future direction of the Medicaid program and the ability of states to provide the staff responsible that
16 can carry out those responsibilities, how much is being contracted out in administration, how much is being
17 done directly within state government, what implications this has had for both program integrity, for
18 monitoring and for evaluation at the state level, and then especially to look at the role of waivers and how
19 waivers are being used within the Medicaid program, what they're doing to change the shape and
20 configuration, what lessons we can draw from the waivers, but also how can the waiver experience be made
21 more manageable and be made more streamlined to accomplish some of the goals of the program.

22 In our fifth area, we recognize that now that the Supreme Court has spoken, the Affordable Care
23 Act and the future of Medicaid and CHIP are issues that the Commission needs to add to its agenda and to

1 take on being able to look at the new populations that are going to be served, the ways in which that
2 population may differ from the many individuals, especially children and low-income adults, who have been
3 on the program to date. These are new adults, many of them without any attachment prior to this to the
4 Medicaid program, what kind of delivery systems make the best sense, what kind of benefit packages for
5 these new populations, and how will the Medicaid program and its eligibility systems be interacting with the
6 exchanges and with the simplification measures that are also in place. And we'll begin to talk about some
7 of that in this meeting as well.

8 So that in total we will be trying to focus in our early days on looking at the dual-eligible population
9 and on payment systems and on the interaction with exchanges, leading toward our March report and then
10 going on our June report and our analyses there, to begin to move more aggressively at the delivery system
11 as it affects the disability population, at some of the primary care physician payment bump issues and the
12 safety net implications of some of the payment reforms, and to begin to launch our analysis of the waiver
13 impact.

14 In doing all of this, we will keep as one of our mainstays MACStats, which is a clear service to not
15 only those of us trying to analyze the Medicaid program but to many of you who are trying to get a grip on
16 what the numbers are and what the different populations look like, so MACStats will be an ongoing
17 complement to our work. And we will be adding to some of these agendas after, as you heard the Vice
18 Chairman mention, some consideration of trying to look at how the Medicaid program can be more than a
19 financing program, can actually be a program to provide some interaction with public health objectives.
20 We plan to look more in-depth at the role EPSDT has played in the Medicaid program as well as to look at
21 the better ways to intersect public health and Medicaid policy, and we'll be bringing in some speakers to
22 address that, hopefully by our January meeting.

23 And so as an overview, this is kind of laying out where we think we will be going. It's an ambitious

1 agenda. It requires us to really build our data analysis capacity, which we are doing. It requires us to
2 begin to really think through systematically how to address each of these issues, but throughout we intend to
3 try and weave the issues around the populations to how the different populations get their access to care,
4 and how payment policy and financing policy influences those objectives.
5 So that is a brief overview of where, after our summer retreat, we have come out in terms of trying
6 to set out an agenda for the future, and I would welcome any additional comments that any of the
7 Commission members would like to make with regard to our ambitious agenda.
8 COMMISSIONER ROSENBAUM: I think it's an excellent agenda. It sort of takes all of the
9 themes from the two years that we've been up and moving, and, of course, it's really a testament to the
10 Commission's work, the staff's work, and Lu's work that we're sort of this well grounded now to offer what
11 I think is really a very robust research agenda.
12 And one observation I would have is that we're probably going to want to spend some time in the
13 coming weeks thinking about how best to order the research given the fact that some of the issues are
14 eternal issues in Medicaid and some of the issues are issues that are going to have probably a very much
15 more immediate audience for us to reach because of the significance of the debate that's expected early in
16 the winter, if not during the lame duck.
17 CHAIR ROWLAND: So I think we'll organize this by eternal versus immediate.
18 Other comments?
19 VICE CHAIR SUNDWALL: Can I ask a question of Sara before you talk, Patty? You
20 mentioned this morning the possibility of there not being a lame-duck session. That surprised me. Could
21 you explain that?
22 COMMISSIONER ROSENBAUM: To clarify, I did not mean there wouldn't be a lame-duck
23 session, but it could be that it's a relatively brief lame-duck session in which not a lot happens. It could be

1 that it's a quite momentous lame-duck session. If it's relatively brief, then obviously early in the year will

2 be more momentous, and the observation was made only in the context of the fact that we probably have a

3 four- or five-month window where we're going to have to think about organizing the most important

4 pertinent data that we've got, because we will be introducing ourselves again to new staff, new members,

5 and how to convey the most important points we are in a position to make now given the fact that it's not

6 like a year from now that this will be relevant. It's going to be relevant very quickly.

7 COMMISSIONER GABOW: In the list of eternal things, I think what we discussed this morning

8 about the need to really have a primer on Medicaid and CHIP, that we update on each election cycle of

9 every two years would be very important. And in that same bid, thinking about how we can help

10 governors and others look at what data they would need to think about if there were per capita payments,

11 what data they would need to have to decide whether to accept Medicaid expansion or not now that the

12 Supreme Court has created that as an option. I think that those both we don't want to lose track of as our

13 ways to aid people to make decisions with data, despite the fact they may not want to use it.

14 And I also think that under the program efficiency, just because if I didn't perseverate on this,

15 people would think I was sleeping, that we have to think about administrative simplification, regulation

16 removal, et cetera.

17 And in that same vein, I think we do need to create ideas about what would be useful ways to reduce

18 cost in these programs. There are smart ways to reduce cost, and there are dumb ways, and we should try

19 and provide some insight into those that are smart.

20 CHAIR ROWLAND: Okay. Other comments?

21 COMMISSIONER COHEN: First of all, wonderful job, Lu and staff, with developing, I think,

22 just a great road map for us going forward. I think it's a great thing to talk about it here and, you know, for

23 it to be sort of like a touchstone for us, and there will be times when we know events will overtake us and

1 things will have to move around and our priorities may change because of the world that we're in and
2 changes that are happening in health care and changes that might happen in Medicaid. But I think it's
3 really -- it is excellent, you know, at this phase to have a plan for the next several years that can really guide
4 us, and I think it's a terrific accomplishment.
5 In addition to that, I just wanted to make an additional point about, you know, I think that in much
6 of our work, you know, our goal is to make recommendations and do analysis. Obviously, that is very data
7 driven. I do think that there are -- but it's also important for us to think creatively about ways to make
8 recommendations in a very, very complex program. So I wanted to just make two observations about
9 ways that we can do analysis that aren't always sort of from scratch data analysis.
10 I think one thing that I would just love to recommend -- and Lu knows I have recommended this on
11 other occasions, but just, you know, doing some comparative work looking at other federal-state programs
12 or other health care programs or other programs other than Medicaid and see what lessons we can learn or
13 insights we can derive from looking outside the Medicaid program in order to improve the Medicaid
14 program. So I just think that's like a tool or a technique for us to keep in mind as a way to develop some
15 recommendations about program administration and other things.
16 I think the other thing that we should think about is when there is a developing consensus or other
17 payers in the health care marketplace have developed some techniques for improving health care delivery,
18 we should look at sometimes -- or other groups have done, so we should look sometimes at synthesizing
19 that which has become, you know, a well-accepted recommendation in another place and think about our
20 role as a Commission that can make recommendations for legislation, synthesize some other people's good
21 insights or thoughts, and make them into a recommendation for legislation. So I don't think all of our
22 analysis has to come, you know, straight from data and straight from scratch, but I very much support the
23 areas that we're talking about.

1 I also support David's observation that whenever we can bring the two sides of health care together,
2 bring public health into our discussion more directly and our recommendations more directly, I think that's
3 great.
4 CHAIR ROWLAND: Great. Thank you.
5 COMMISSIONER ROSENBAUM: One other point going to David's earlier comment, which I
6 think is a great one. One thing we haven't put specifically on the list but we might is one of the sort of
7 archetypal examples of this in Medicaid is the Vaccines for Children program, which has been incredibly
8 successful in merging certain population-based management techniques with individual coverage. And I
9 think it might be -- I mean, there have been, of course, challenges in the VFC program, but it was a direct
10 case of taking a population health problem -- i.e., low immunization levels among children -- and trying to
11 respond with the use of Medicaid to deal straight on with a population-based problem. And we maybe
12 could think about whether it offers some ways of thinking about other problems related to chronic health
13 conditions management or, of course, communicable disease management.
14 VICE CHAIR SUNDWALL: That was one of the examples used in this presentation last week in
15 Texas that showed how you can marry public health and primary care. Sorry. Thank you.
16 CHAIR ROWLAND: And on that note, we will move on to our first discussion of the day, which
17 is on emergency room use, going over the recent data and evidence there. Obviously, the use of
18 emergency departments is one in which Medicaid is often discussed as an overutilizer of emergency rooms,
19 and we're really pleased that for this discussion we are joined by two co-authors of a recent study on
20 emergency room use. But one of those co-authors, Dr. Anna Sommers, has now joined us as the Director
21 of Access and Quality at MACPAC, but we're also pleased to welcome Emily Carrier, who is a physician and
22 the senior health researcher at the Center for Studying Health System Change, who together will give us an
23 overview of the work that they've published, and I'm sure give us many insights into where this Commission

1 should be going to further look at the role that EDs play in the case of not only the Medicaid population,

2 but it's a good place to also, to pick up Andy's point, compare how Medicaid relates to other payers.

3 Thanks.

4 #### EMERGENCY DEPARTMENT USE:

5 RECENT DATA AND EVIDENCE

6 * DR. SOMMERS: Emergency department use is an ongoing concern to State Medicaid programs,

7 policy makers, and to this Commission. Concern about ED use arises for two main reasons. First, a

8 body of research has shown that some portion of ED visits would be avoided with appropriate care in a

9 primary care setting. Second, the emergency department is considered a more costly setting in which to

10 provide care for certain conditions that could be treated elsewhere. How people use emergency

11 departments can be influenced by the availability of their primary care physicians, their access to specialty

12 care, the quality of that care, cost sharing requirements, and their own personal experiences.

13 In this session, I will provide a brief overview of the types of interventions that States are

14 implementing in which the reduction of emergency department visits is an objective. Next, I'll present

15 findings from a recent data analysis that provide new information about emergency department visits by

16 Medicaid enrollees. And finally, I'll briefly review the evidence to date about ED reduction efforts.

17 A wide range of stakeholders are now seeking to reduce reliance on emergency departments, and

18 State Medicaid programs have been a partner in many of these efforts. Generally, there are four

19 approaches in play.

20 The first approach is medical home or health home initiatives, which seek to reduce ED visits as

21 part of a broader set of objectives. In 2011, 41 States were implementing medical home programs in

22 Medicaid or CHIP, including some Statewide multi-payer public-private collaborations. These initiatives

23 are redefining primary care and rewarding primary care practices that demonstrate improved quality. While

1 the requirements for certification of a medical home or health home vary somewhat across States, two key
2 features common to most that are expected or hoped to reduce ED visits are care coordination, and after
3 hours phone access to a provider.
4 The second approach to reducing ED use targets only the patients with the highest risk of repeated
5 ED visits and hospital stays. These models commonly use administrative claims or predictive algorithms
6 to identify patients who could benefit from intensive care coordination or care management. Some of
7 these programs seek to address all the needs of a patient, including psycho-social needs and finding
8 permanent housing.
9 The third approach is cost sharing. A few State Medicaid programs have recently sought to modify
10 payments for visits defined as non-emergent or unnecessary. Authority under the Deficit Reduction Act of
11 2005 provided new options for State Medicaid programs to require cost sharing for non-emergency use of a
12 hospital emergency room.
13 And the last approach to reducing ED visits is what we would call the diversion of patients at the
14 time of the emergency to other settings. A notable example is the Centers for Medicare and Medicaid
15 Services Medicaid Emergency Psychiatric Demonstration, which makes Medicaid funds available to private
16 psychiatric hospitals so that non-elderly adults with Medicaid can be diverted away from short-stay acute
17 care hospitals in a psychiatric emergency. Eleven States have been selected to receive up to $75 million
18 over the next three years to test whether such payments could lower State Medicaid program costs by
19 increasing the quality of care for people with mental illness.
20 The study we'll discuss today seeks to answer two basic questions. Are Medicaid patients
21 disproportionately using the ED for non-urgent care relative to privately insured patients? And are there
22 certain health problems that appear to be driving higher ED use?
23 The study was conducted while I was a researcher with the Center for Studying Health System

1 Change in Washington, D.C., and my coauthors are Ellyn Boukus and Dr. Emily Carrier. Dr. Carrier is an
2 emergency physician and researcher and she'll be available to answer questions during the comment period.
3 Interest in cutting back ED visits in Medicaid stems from a very high rate of ED use in this
4 population. This figure shows the number of emergency department visits per 100 enrollees by age group
5 in 2008. Medicaid visits are the dark bars on the left and private visits are the light bars. Across all age
6 groups we see, ED visit rates are significantly higher than the privately insured. This difference has been
7 evident for many years.
8 We analyzed data from the National Hospital Ambulatory Medical Care Survey. The sample
9 provides a national picture of visits to all emergency departments at acute care hospitals in the U.S. We
10 examined triage acuity of each visit measured upon arrival at the ED and the primary diagnosis of each visit
11 recorded by the treating physician at discharge. We then compared Medicaid and privately insured visits
12 for the non-elderly, including children and adults up to age 64 years.
13 To understand the next slide, I'm going to explain triage acuity as it's defined in the NHAMCS.
14 Triage acuity means how quickly a patient needs to be seen. Now, it's based on the initial assessment by a
15 triage practitioner as soon as the patient arrives at the ED and prior to physician examination. So the most
16 acute category is an emergent visit, in which the triage nurse records that the patient should be seen
17 immediately or within 15 minutes of arrival. Below that is an urgent visit, needs to be seen within 15 to 60
18 minutes. And going on down, at the low end of the scale, we have non-urgent cases, to be seen within two
19 to 24 hours.
20 I should note that patients and triage clinicians alike can have difficulty gauging the risks associated
21 with symptoms. This triage acuity scale is predictive of the need for hospitalization, but even some cases
22 initially classified as less urgent can end up being true emergencies and others in the most urgent categories
23 can end up being benign.

1 So this figure shows the percentage distribution of visits by triage acuity for all visits paid for by
2 Medicaid, again, the dark bars, as compared to private visits. So this figure shows the percentage of visits
3 falling into each triage level. The prior graph you saw was of visit rates.
4 Here, we see with the circled bars that less than ten percent of all visits to the ED from both payers
5 are classified as non-urgent. More than half of all visits fall into the two most acute categories on the left
6 side, reflecting urgent or potentially serious conditions.
7 So the take-home point here is that non-urgent visits do not explain higher use of the ED in
8 Medicaid.
9 If we look at the next slide here, this is the visit rates by acuity level in this graph. So we see here
10 that, instead, the story is that Medicaid enrollees use the ED at a higher rate for all acuity levels -- emergent,
11 urgent, semi-urgent, and non-urgent visits.
12 This figure shows the number of ED visits per 100 enrollees for the diagnoses most commonly
13 treated in the ED for children zero to 12 years. The top row shows that children with Medicaid, in the left
14 column, sought care for acute respiratory conditions and other common infections at more than twice the
15 rate of the privately insured patients, 12.7 versus 5.5 visits per 100 enrollees. In fact, these common
16 infections accounted for half of the total difference in visit rates between children with Medicaid and private
17 insurance and accounted for almost one-third of all visits by children in Medicaid. In addition, the
18 incidence of injury visits is high for both Medicaid and private enrollees relative to other conditions.
19 This figure shows the same information for non-elderly adults aged 21 to 64. Those with Medicaid
20 use the ED at more than double the rate of adults with private insurance for all major diagnostic groups.
21 Our study does not explain why rates are higher, but results are consistent with other studies showing that
22 adults with Medicaid have higher illness burden than privately insured adults. The bottom three rows
23 show visits by Medicaid patients more often involved a disabling condition, pregnancy, or mental disorders.

1 As with children, there is also a relatively high incidence of Medicaid visits for injuries.

2 Not shown here is the finding that 27 percent of Medicaid visits by the non-elderly involved more

3 than one major diagnostic category, compared to 20 percent of the private visits. An example would be

4 diabetes and congestive heart failure. Presence of comorbidities like these often call for rapid evaluation of

5 otherwise minor symptoms, like dizziness, and can increase the risk of hospitalization.

6 The take-home point here is that the sheer diversity of conditions among adults seen in the ED

7 suggest a wide array of factors that contribute to high ED use and no single easy solution.

8 So to summarize the findings of the study, the majority of ED visits by Medicaid enrollees are for

9 urgent or potentially serious symptoms. Nonetheless, the high incidence of certain conditions seen in the

10 ED indicate potential for diversion of many visits related to acute respiratory and common childhood

11 infections, and injuries, both minor and moderate.

12 These findings also raise questions about what other care settings could provide at lower cost to

13 address the needs of people seeking care in emergency departments. Could primary care or other settings,

14 for instance, provide screening and triage of urgent cases? Could they provide treatment for

15 uncomplicated cases?

16 And finally, the wide array of acute and chronic conditions among adults with Medicaid that lead to

17 ED use raises questions about how care for adults with chronic conditions, co-occurring mental disorders,

18 and disabilities can be better managed in primary and specialty care settings.

19 So now let's revisit the approaches to reducing ED use that we discussed earlier. An outstanding

20 question, of course, is have there been rigorous evaluations of these programs? The answer, in a nutshell,

21 is very few and not enough. PCMH or medical home initiatives are taking several years to get off the

22 ground, and States and Federal programs are financing many changes needed at the practice level.

23 Evaluations have been based on small pilots, are preliminary in nature, and no clear evidence of cost savings

1 has emerged. While a few interventions are reporting reductions in ED use and hospital admissions, these

2 were tested primarily in integrated delivery systems that may not generalize to other settings.

3 One qualitative study that recently came out by Dr. Ann O'Malley looked at the experience of a

4 diverse number of physician practices that established after-hours coverage for their patients. These

5 physicians in interviews reported that designing new hours of operation and staffing first requires

6 understanding the after-hours needs of patients and locally coordinating with services. Expanded access to

7 a primary care provider is not so helpful to patients if the local pharmacy or labs aren't open.

8 A small number of programs that target care management to a high-risk population are reporting

9 decreased emergency visits and in-patient stays, but program leaders point out that intensive care

10 management is costly and targeting these services to the wrong set of patients can lead to a low return or no

11 savings.

12 Bellevue Hospital Center reported dramatic reductions in service use by a very small pilot program

13 of fee-for-service Medicaid patients, and New York State is now expanding that pilot, so we'll continue to

14 monitor that.

15 With respect to the cost sharing approach, a recent national study on the use of copayments to

16 discourage the use of the ED by Medicaid enrollees found no effect on non-emergent ED use.

17 So that concludes my presentation. We intend to continue to follow the approaches that States are

18 taking to reduce ED use and will keep the Commissioners apprised as more information becomes available

19 that could inform the Commission's work. Thank you.

20 CHAIR ROWLAND: Thank you, Anna. Sara?

21 COMMISSIONER ROSENBAUM: I am always struck in these studies by the time

22 measurements. It's an excellent study. But I am struck by how we classify urgent, emergency,

23 semi-urgent. Do we have any idea to what degree a Medicaid beneficiary who thinks that her child needs

1 to be seen in the next, hmm, one hour, so it's only semi-urgent, could get an appointment somewhere or
2 would be somewhere where she could walk in and get a service anywhere but an emergency department, or
3 a privately insured person, for that matter?

4 I mean, I always wonder in these studies whether we set up a set of assumptions that are an accurate
5 way for us to think about health care. I don't know. I mean, if you live near a community health center,
6 most health centers now have walk-in services. You may be near an urgent care clinic, although I don't
7 know how many of them will accept Medicaid. Or if you're near a public hospital with clinics, you may be
8 able to get in.

9 But I realize that these are clinical measures of emergency and urgent care, but I'm wondering
10 whether we don't end up setting up an assumption about how we might change care that's not accurate,
11 because you couldn't possibly divert somebody in a one-hour period to somewhere else in a lot of areas of
12 the country.

13 DR. SOMMERS: Do you want to take that one?

14 DR. CARRIER: I can try it. So, first, to address your question about what research is out there, I
15 am not aware of any studies that have addressed the specific question of how soon someone can be seen if
16 they felt they needed to be seen within a time period. Probably the closest literature that I'm aware of is a
17 number of studies that have looked at how quickly patients with a variety of coverage, and I'm sure you're
18 all familiar with these studies, can obtain follow-up and whether the time that it takes them to obtain
19 follow-up corresponds with the recommended timeline.

20 Now, to move on to your second question of whether expecting people to be diverted or to find
21 alternative care in the kinds of timelines that we're talking about with these acuity guidelines, these triage
22 criteria, you're absolutely right that it depends a great deal on where you are and what local resources are
23 available.

1 So just to cite an example, we talked about one initiative at Bellevue Hospital. It's actually where
2 I'm trained, so I'm familiar with another initiative that they developed that identified patients with certain
3 diagnoses in the urgent care waiting area and assigned patient navigators to bring them in the elevator
4 upstairs to the primary care clinic. Now, obviously, that would be able to -- yes, and co-location has
5 shown good results in a number of studies. Now, obviously, not possible in many settings. So I think
6 that speaks to Anna's larger's point that there's just a diverse number of factors going on and probably no
7 single solution.
8 COMMISSIONER ROSENBAUM: Well, and just one follow-up question, which is, is it realistic
9 to expect -- again, obviously this is true for adults as well as children, but children are a particularly
10 compelling example -- that regardless of your insurance status, any parent would be able to distinguish
11 between something that needs to be seen in three minutes, something that needs to be seen in 42 minutes,
12 something that needs to be seen in one-and-a-half hours. In other words, are these time frames so, you
13 know -- what's the word I want -- precise that in terms of what we would recommend to Congress about
14 other steps that might be taken to assure more appropriate care settings, that we can't get to that level of
15 nuance in parental ability to distinguish time frames. Can real people distinguish between what's needed in
16 ten minutes, 40 minutes, an hour-and-a-half, I guess is the question?
17 DR. SOMMERS: Right. So the triage nurse in this study is the one making that assessment, but
18 even they can be wrong. And an example of how confusing it can be for parents is if you take two
19 different children, both have the same fever, they're the same age, and the high fever, 103, is what's the
20 concern for the parent, but they have two different kinds of rashes, one is a cheek rash and one is a body
21 rash, well, the cheek rash is the one that parents notice. They're more alarmed by it. They bring them to
22 the ED. That turns out to be just a common childhood virus that's self-limiting. The ED physician
23 wouldn't provide any treatment. Whereas the other case there's a body rash, and it may not even be

1 noticed by the parent, but upon physical examination, it's of tremendous concern to the physician because it
2 may indicate bacterial meningitis. They need immediate assessment, immediate IV antibiotics, a lumbar
3 puncture.
4 And so those -- it's those small differences that parents can't be expected to triage themselves. In
5 some cases, they may be able to do it with a nurse over the phone or a physician over the phone, but often,
6 it requires a consultation and examination. It doesn't have to happen in the emergency department
7 necessarily.
8 CHAIR ROWLAND: First Steve, and then Patty.
9 COMMISSIONER WALDREN: Yes. Those aren't going to go to my point about I think once
10 they've made it to the ER, I mean, if they're not supposed to be there, and still we don't know that, even
11 from this data, because you can talk about the urgency of it and then they talk about it in their study once
12 they make the diagnosis. It may have been urgent because multiple comorbidities and symptoms related to
13 one of those where it's not really related once you do the evaluation. I think it's more important to figure
14 out -- use this as a way to look at and say, okay, what failed to get them to that point when the -- so it's not
15 the question of do they know if it is an hour. Usually when I had patients come into the ER that didn't
16 need to come to the ER, it was usually, a lot of times, too, it was time-based, of I can't get off work. I can't
17 miss any work. So nobody's available in the evening, so I'm coming in. Or I've let it go on for three or
18 four days and now it actually is urgent. So I think us focusing on those times may not be all that helpful
19 for us, but I think as a study when you're trying to figure out where are places to look at, it's more
20 important.
21 CHAIR ROWLAND: Patty.
22 COMMISSIONER GABOW: A couple of comments. Regarding the difference that we see and
23 the assessment of our urgency, not in minutes but, you know, I'm worried. My kid is really sick. Or, I'm

1 worried. I'm really sick. It gets back to the level of health literacy that exists generally between the
2 Medicaid population and the privately insured population. It's not universally different, but certainly -- so
3 their understanding, generally, about their health and the sort of symptoms, signs, medication, et cetera, is
4 generally lower. And so you would expect that their ability to self-triage is not going to be as sophisticated,
5 just because of a difference in understanding measures of health and well-being. So that's one thing.
6 The second is, I would be interested, and you may not have the granularity of this, but if you look at
7 the adults, particularly, and you look at the diagnoses, my guess from having worked in the safety net for
8 many years is that the actual diagnoses are different. If you look at the category of injury, digestive
9 diseases, I would guess you're seeing a higher instance of cirrhosis, hepatitis that's centered in one group.
10 But that also would be relevant in terms of trying to figure out what the alternative appropriate place might
11 be for care. So having some granularity about that -- I don't know if you do -- would be interesting.
12 And my third comment, in the article, you talked about nurse advice lines, how they may not be
13 particularly helpful because they can't do an exam. But at Denver Health, we instituted about seven or
14 eight years ago a nurse advice line. We get 100,000 calls a year. We actually did -- about half the users are
15 Medicaid and about half are uninsured, roughly. And we even give out prescriptions on that by algorithm.
16 And we published that you actually can avert a lot of -- you can go to a lower level of care. Someone was
17 going to an ED. They'd get an appointment to the clinic. If they were going to the clinic, they could get
18 self-care.
19 But the reverse also works around this issue about triage, is that you will get a patient who calls and
20 is having crushing substernal chest pain radiating into the jaw. Well, you actually -- the advice line
21 probably isn't the place for your care. We'll be transferring this call to 911. So it serves to be efficient in
22 triaging in both directions.
23 So I actually think it's an under-used resource and is more applicable than it might seem. And if

1 you think about it, Denver Health's nurse advice line grew out of the poison center, and that's certainly an
2 urgent kind of environment. My kid just ate the dog's food or something. But they could also have just
3 swallowed all my prescriptions. So the ability to go from something that's not important to something that
4 is has been well tested on poison center lines. So I think the advice nurse line is an alternative and it offers
5 the advantage of no copay, which is often critical for these patients, and no transportation, which is also
6 often critical, and the ability to do it in multiple languages. At Denver Health, I think the language line
7 dealt with, like, 60 different languages last year, because their ability to hook into telephonic translation. So
8 I think that is a good alternative. When we think about recommendations that we can make, the
9 availability of that, I think, is really quite useful.
10 CHAIR ROWLAND: Mark, then Donna, then Trish, then Richard, then Burt.
11 DR. CARRIER: We have -- that data is available in an enhanced use data set, and we did not -- at
12 this time, I don't think we have an analysis at that level that we can share.
13 I just, if I may, wanted to mention something regarding -- I think you're absolutely right that nurse
14 advice lines do have real potential, and folks like in Denver have done amazing things with theirs. I would
15 just mention, your point about the poison center analogy is really interesting and, I think, kind of
16 informative, because it shows both the areas where these lines are strong and areas where they're more
17 limited. Having worked in poison centers myself, often what you're hearing about is a known ingestion.
18 For example, my child took this. Tell me what to do. And oftentimes, people can identify the pill, the
19 amount that's taken, and they're very good at being able to provide protocol-driven care around that
20 particular exposure.
21 They're less good if you were to imagine getting a call, my child is acting strange. Do you think
22 they took something? Or, they might have taken something. I don't know what. With those types of
23 undifferentiated complaints, they're much less able to provide the best treatment for that patient. But

1 they're excellent at the kinds of known, fully differentiated problems that they get.

2 COMMISSIONER GABOW: It's just an example that you can build on, and Denver Health did

3 build on that and created a very effective advice nurse line. And I agree with you. You can't do

4 everything on it, but it shouldn't be ruled out as a reasonable alternative.

5 CHAIR ROWLAND: Okay. Mark.

6 COMMISSIONER HOYT: No, I just had one question. My brain is not big enough to hold

7 three thoughts simultaneously. That was about the impact of managed care. I'm not sure I heard you

8 mention managed care anywhere in there and I was wondering if any studies have been done.

9 Longitudinally, it would be interesting, but any type of study around managed care contracting. I guess the

10 thought would be if everybody had a PCP and phone numbers to call for the doctor's office or nurse help

11 lines and that type of thing, does that impact this issue on lower use of ED.

12 DR. SOMMERS: I can't call them up by name right now. I think that there are a small number

13 of studies that have looked at the impact of managed care. Usually, this type of research is reported by the

14 health plan itself and the evaluations conducted within the health plan. I don't know that that's all. There

15 may be other studies.

16 But there's more general literature on the sorts of barriers that people report, that they self-report,

17 about the availability of their primary care physicians. And a very recent study just came out related to that

18 and showed a strong association between having barriers to the primary care and the number of ED visits

19 that they have and the number of barriers that they have, and it showed that people with Medicaid were

20 more often likely to report having a barrier and to have a greater number of barriers, whether it's timely

21 access or ability to get there and a number of aspects of availability.

22 CHAIR ROWLAND: Donna. Oh, Herman.

23 COMMISSIONER CHECKETT: Well, first, a very interesting report and I think something that

1 fascinates providers, States, and legislators and the Federal Government equally. For whatever reason, this
2 has captured our collective imaginations.
3 I wonder, did you see anything at all worth noting, or would this even be perhaps an area for further
4 investigation, which would be the role of behavioral health conditions either as a primary or a secondary
5 reason for coming to the ER, and in particular -- I guess I'm articulating as I speak -- if we were to sort out
6 people who come two or three times a year to the ER as opposed to someone who's there over and over
7 and over again.
8 So I guess there's two questions. One is behavioral health, and then did you look in any way at the
9 so-called frequent flyer, which isn't necessarily someone who's just on Medicaid who goes once or two or
10 three times a year. So two different thoughts.
11 DR. SOMMERS: Okay. So those are two different questions. Related to the comorbidities, the
12 secondary, tertiary diagnoses listed, we did look at that and so overall, if you look at secondary co-occurring
13 mental disorders that are listed, it is significantly higher in the Medicaid adult population relative to the
14 privately insured. I believe it was nine percent of all visits had a mental disorder listed either as primary or
15 secondary.
16 This data set does not allow linkage of visits to individuals, so we can't look at frequent flyers.
17 There have been other research studies that have looked at that. There's no consensus of what's
18 considered frequent ED use. There's been a threshold used of about four visits or more. And that
19 research does show that the frequent users more often are very ill. They have a large number of outpatient
20 visits in addition to their ED visits. They are far more likely to have mental disorders in conjunction, but
21 they're also more likely to have other chronic comorbid conditions, as well. And they're also more likely to
22 report problems with primary care access. So that's an interesting set of factors. Those are factors that
23 have been associated, not causally, linked.

1 COMMISSIONER CHECKETT: All right. So I think I appreciate that. And it is an issue that
2 I guess I'd just like to pose to the Commission as we continue to look at things to look at, is do we want to
3 come back at some point and dig in, because they are two different issues and there's such interest in this
4 issue. And so I think we might really provide value if we could say, look, here's the people who are going
5 -- and maybe they're going a little bit more than commercial insurance, but they're not going all the time.
6 And then these are the people who are really going a lot and could we help States develop effective
7 strategies if they understand that, in fact, and providers develop effective strategies, if we understand more
8 clearly that they are really two different groups of people going to the ER, why, and they happen to have
9 Medicaid. So I throw that out there.
10 CHAIR ROWLAND: Okay. Herman.
11 COMMISSIONER GRAY: I agree. Excellent study. Our hospital, our children's hospital runs
12 the poison control center for the State of Michigan and that's an intriguing idea, to use phone triage as
13 another mechanism for reducing visits.
14 But the difficulties of triaging, particularly in children, as has been talked about, even professionals
15 can't be right all the time and are incorrect a pretty significant percentage of the time. The fact that there
16 probably are health literacy issues, as Patty mentioned, the obvious lack of primary care physicians for this
17 population in most settings that we've described previously, and your study findings, perhaps at the risk of
18 being overly provocative, could one arrive at the conclusion that the ED is actually the appropriate setting
19 for care for these individuals and that it just costs too much?
20 DR. SOMMERS: We did not draw that conclusion in the paper. And I think that a point that we
21 tried to make is that at the time that a patient is deciding whether to go to the emergency room or not, all
22 they know is their symptoms, their prior chronic conditions they're dealing with, and the physician has the
23 benefit of their medical degree and a physical examination. And so when emergency department use has

1 been looked at previously in research, they often use an algorithm that is derived from the physician's
2 diagnosis. And that's really looking at the appropriateness of care in hindsight after a physician has full
3 information.
4 So the take-home point is that there isn't really prospectively a way to accurately put people in boxes
5 according to whether they are seeking appropriate care, particularly just based on claims data. There are
6 certainly many other factors that patients and parents have to consider, including what their doctor told
7 them when they gave them a call, tried to reach them. A lot of physicians have, you know, the robo -- the
8 auto voice mail, "If you can't reach us, go to the emergency room." So there are lots of other factors that
9 aren't visible to us as researchers or as policymakers.
10 COMMISSIONER GRAY: I'm not aware of another setting that is designed to see lots of people
11 really quickly, some of whom are really very sick, including -- and this pains me as a general pediatrician --
12 including in the primary care physician's office. And that's at least part of the reason why I raised the
13 question. We may be asking the wrong questions in terms of, you know -- I mean, this is a question that
14 has been asked for at least the last 30 years, is inappropriate use of EDs. And maybe it's the wrong
15 question.
16 COMMISSIONER ROSENBAUM: Well, I must say that Herman's asking a variation. He's
17 saying it in a different way from what bothers me about this, which is -- not doesn't bother me, but that the
18 study underscores that the assumption is that there are alternatives, and I think as the Commission thinks
19 about this and in doing its work for Congress, the issue that Donna raised about, you know, who has
20 alternatives, what kinds of patients are we dealing with and, you know, what are the realistic alternatives
21 given the current state of access.
22 COMMISSIONER EDELSTEIN: Well, a particularly good example of inappropriate use of the
23 emergency room is care of simple toothache and dental abscess in the sense that it's completely preventable

1 and better managed anywhere but the emergency room, except the Maine Medical Center where the ER

2 docs are being taught to do extractions.

3 Two questions related to your study. The first is: Where do those show up in the study? Do

4 they show up under other common infections?

5 DR. SOMMERS: Yes.

6 COMMISSIONER EDELSTEIN: And what's your sense of the disease burden there? In

7 Herman's construct, I agree, that's the appropriate place to go because there is no place else to go for many

8 people. But, nonetheless, it's useless in the sense that it's not only preventable but there's nothing the ER

9 can do except palliate. But what's your sense of the dental contribution to this?

10 DR. SOMMERS: Yeah, we weren't able to look at that. Like a number of other conditions,

11 because the survey is based on a sample of visits, there just isn't enough power to have enough sample to

12 look at that granular level for particular kinds of very specific diagnoses.

13 COMMISSIONER EDELSTEIN: And then related to that is the question of coverage for adults

14 in Medicaid. Because there is in most states no significant dental coverage, there isn't even the option of

15 trying to find a private provider because there's no funding source for the care, so people end up in the ER,

16 where I assume the ER also ends up without funding because of the lack of Medicaid coverage.

17 DR. SOMMERS: I just want to point out that while NHAMCS is not a good data source for that,

18 there are other data sources like the HCUP where you have a sufficiently large database, where you can look

19 at that, and that would also be possible to do with the MAX data and the MSIS data where you can look at,

20 you know, visit-based diagnoses at a very granular level.

21 COMMISSIONER EDELSTEIN: So perhaps the way the Commission can deal with the adult

22 dental lack of coverage is by seeing what the consequences are both in terms of unreimbursable costs and in

23 terms of co-morbidities and inappropriate uses of the ER that would substantiate the need to address that

1 coverage deficiency.

2 CHAIR ROWLAND: I think you just got an assignment.

3 COMMISSIONER CHAMBERS: Yeah, I just enjoyed the comments about the alternatives.
4 You know, being a health plan administrator, sort of Managed Care 101, figuring out how to keep people
5 out of emergency rooms. And in trying all kinds of experiments over the years of, you know, contracting
6 with urgent care centers, minute clinics, paying supplemental payments to FQHCs and even private docs to
7 have extended hours, still alternatives with real extended hours are really difficult. Even getting FQHCs to
8 stay open after 7 or 8 o'clock at night is difficult. And so it's really like when you show up someplace at 11
9 o'clock at night, there's really not a whole lot of alternatives. But certainly it's something to continue to try
10 to figure out because we need to provide alternatives.

11 But a question. One of your slides talked about cost sharing imposed on beneficiaries for
12 non-urgent were ineffective. I'm curious how high those co-pays were. California this year requested and
13 was imposing a number of co-pays and it requested permission from CMS through their 1115 waivers to
14 impose for non-emergency ER a $50 co-pay. Along with the co-pays was a request to allow denial of care
15 for non-payment of co-pays because oftentimes co-pays end up just being provider rate reductions because
16 providers just eat it. But I was just curious if you have any idea what that cost sharing was. You said
17 Iowa, Tennessee, and Washington State had that.

18 DR. SOMMERS: Oh, the more recent, the 2012 efforts by those states. They are more about --
19 let's see. There's one state that involved a co-pay. I'm sorry, my cheat sheet doesn't summarize those,
20 but the policies do seem to be more directed at hospital behavior so the denial of payment to the hospital
21 was the initial strategy that Washington State took. So deny payment to the hospital for non-emergent
22 conditions, a list of 500 diagnoses I believe it was. And that policy shifted after some negotiation and
23 public debate into more of a best practices kind of strategy.

1 The research study that looked at the effect -- the lack of effect of co-pays was based on data from
2 2000 to 2006, and the states that implemented co-pays implemented very nominal amounts except for one
3 state, I believe, so we're talking about $3 or $5 co-pays.
4 COMMISSIONER CHAMBERS: Thanks.
5 COMMISSIONER HENNING: I just wanted to point out in your study that when you look at
6 emergency room use by pregnant women, you're only probably looking at pregnant women up to about 20
7 weeks that are dealt with in the emergency room. The rest of them are going to be triaged in the labor and
8 delivery unit, so you're kind of missing that other half of pregnancy with the false labors and the pre-term
9 labors and the high blood pressure problems and those kinds of things. You're not even looking at those
10 emergency problems. And I'm not sure if there's a difference between Medicaid and privately insured
11 populations, but we won't know if we don't ever look at it.
12 DR. CARRIER: Yeah, I think that's just an artifact of the way the data is collected. If you're
13 aware of a data source that would allow labor and delivery to be studied, that would certainly be an
14 interesting question.
15 DR. SOMMERS: There is certainly a common practice now to instruct women to go through the
16 ED but then they don't appear as an ED admission, so you don't capture those at all or what the initial
17 problem is, whether it's false labor or something else.
18 COMMISSIONER CARTE: Herman, you raised the question about what are the alternatives, and
19 I think that that is a key question, especially for children. I know in our state with our separate CHIP
20 program, at one time we had a nurse line that did triage. However, over time and in a tight budget year, we
21 decided to discontinue it. But that was in the absence of any look at, even it may have been an expensive
22 service for the program, you know, did it, in fact, achieve a cost saving? And we didn't have the ability to
23 look at that question.

1 Similarly, there is a great book written by nurses in California called "What to Do When Your Child
2 Is Sick." It has a great literacy level. It's very clear. It's been tested. It's not a book that's simply
3 handed to parents. It's one that has been used in groups, teaching groups with parents and looked at
4 through self-report. Parents that actually use the book know where it is, will report later, six months or up
5 to a year later that they did take their child less to an ER. But, of course, that's through self-report, but we
6 have no systematic looks at things like this. I think when parents have more confidence, especially parents
7 in rural areas that have to think about they can't be out of work or, you know, has this gone on too long,
8 how sick is my child, of course they're going to go to an emergency room. And I know in our state and
9 I'm sure it's true in many others, you know, their primary care physician has a message that says, "If you're
10 calling after hours, go to an emergency room."
11 So I think we really need to explore more systematically what those alternatives might be.
12 CHAIR SUNDWALL: This will be quick. I really liked the study and it's provocative on many
13 levels. When Patty suggests we maybe as a recommendation talk about the nurse hotline as an alternative,
14 that's fine, but I'm supposing, because as Herman said for 30 years this has been a problem, and there must
15 have been multiple efforts to address this. I'm just aware of one in Utah where they -- and I don't know
16 the trigger for when they did the patient calls, but Medicaid beneficiaries who had gone to the emergency
17 room two or three times got a call actually from the Medicaid program, and with some patient education,
18 they reduced significantly repeat visits. So it wasn't costly or a difficult thing, and I'm not sure if it has
19 been sustained, but I would be glad to find out because it seemed to me a reasonably simple way to just do
20 some patient education that had a real impact on repeat ER visits.
21 There must be others. I know Kathleen Nolan is here from -- is it NAMD now? We can't say
22 "NAM-DEE"? But, anyway, I'm wondering if they have any composite of best practices on reducing
23 inappropriate ER utilization. And you can tell us now or later, if you'd like, but that would be a resource

1 we might want to check, and then as we make recommendations cite some best practices.

2 COMMISSIONER GABOW: Well, as often the case with an interesting study, it raises more

3 questions, so I'm still on my granularity piece. And I wondered, on your table that has the primary ED

4 visits for adults, if you were able by merging the data on urgent and emergent with these diagnoses, so, for

5 example, would you be able with the data that you have to say the Medicaid group had 15.9 for injury visits,

6 but 90 percent of them -- I'm just creating data here -- were emergent, and the private had 7.7 but they were

7 sprained ankles and were semi-emergent or non-emergent. I mean, it would be another way to sort of

8 parse the use by diagnosis.

9 DR. SOMMERS: Right, that's a very good point, and it's certainly a question that's worth

10 answering. So the Medicaid population and privately insured population could be seen in the ED for

11 similar conditions, but the severity is different. And, you know, that's suggested by the higher rate of

12 co-morbidity and the like. Those kinds of cross tabulations, again, we couldn't do because of sample size

13 issues. On the other hand, that is something that could be done in the HCUP or other data sets.

14 COMMISSIONER MARTINEZ ROGERS: I'm curious as to whether or not on these ED visits

15 you knew which ones were in the rural areas and which ones weren't. Was that information available?

16 And, secondly, was there a breakdown in terms of minorities who used the ED versus those that

17 don't? Because we know that in the Hispanic and African American populations we have so many

18 multiple chronic illnesses that become acute and, therefore, they do use the ED probably, or we do tend to

19 use the ED more often? Was there a breakdown of any of that information?

20 DR. SOMMERS: Unfortunately not. We can't know the location of the emergency department.

21 Do we know even the region?

22 PARTICIPANT: Very broad [off microphone].

23 DR. SOMMERS: Too broad to classify by rural/urban, so we couldn't look at that.

1 COMMISSIONER MARTINEZ ROGERS: And the reason I asked that, between rural/urban,
2 I'm going to go back to something I think it was Sharon or Trish, one of you two, that in the rural areas --
3 or maybe Donna. In the rural areas, sometimes that is the only place, this small rural hospital and that is it,
4 you know, for patients, for people to go, even if they know it may not be something that demands ER, but
5 that is where they can be seen for something that won't get more acute.
6 COMMISSIONER HENNING: I have, I guess, the other look at it, and that is, I work for an
7 FQHC that's out in the middle of nowhere in Florida, and to get from where I am to go to the ER, they
8 have to drive over an hour. So if they have to drive over an hour and it takes them an hour to be seen and
9 then they have to drive an hour back, not to mention a lot of them don't have cars and don't have the
10 money to pay somebody else to take them, they're much better off coming to me because I'll see them
11 quicker than that.
12 CHAIR ROWLAND: They are always much better off.
13 COMMISSIONER RILEY: It is a fascinating study, and it sort of belies a lot of the myths and a
14 lot of the focus on inappropriate use of EDs. So to Herman's point about what's appropriate becomes a
15 good question. But it's a microcosm, it seems to me, of the bigger discussion about the delivery system.
16 And I know this is beyond this study, but are you familiar with -- you did allude to the fact that there are
17 behaviors of hospitals, like advertising, and I'm quite familiar with those. You think the appropriate place
18 to go is the emergency department. They advertise that's where I'm supposed to be.
19 Are there studies that you're familiar with that talk -- and this is really important as we move in a
20 delivery system ACO world. Here are the hospitals, the most expensive site of care, advertising to get
21 people in, admittedly for now urgent issues, so that's good to know. Do we know anything about ED use
22 based on hospital structure? How many hospitals have clinics and urgent care centers? How many
23 physician-owned practices does the hospital have or is there a big environment of independent practice?

1 What is the hospital structure and the community structure look like? It seems to me there's probably real
2 differences in the findings based on whether you have a mega hospital system that controls all the docs or a
3 robust health center, independent practice environment. Do you know of any studies that address that?
4 DR. CARRIER: Our organization does do studies that address that; however, they're qualitative
5 studies so it's based on a longitudinal survey that we've done across 12 different communities. But they are
6 based on interviews. We don't have quantitative data nationwide, so I'm not sure if the kind of work that
7 we do would be able to answer your question. During those studies -- and the most recent round as
8 conducted a couple years ago -- we certainly did hear evidence of the types of growth in consolidation that
9 you're describing and also of the use of the emergency department as part of a hospital's business strategy,
10 and in some cases that would include advertising.
11 Now, which population that advertisement might be aimed at and what the ultimate effect on these
12 hospitals' bottom lines are, I don't think that that data is publicly available. One can draw inferences by the
13 fact that hospitals are continuing to do it.
14 COMMISSIONER RILEY: And the occupancy rates of hospitals -- it would be a fascinating piece
15 of data to get, you know, low occupancy, high ED use.
16 COMMISSIONER GABOW: Just a note of humor to Trish's advertising. One of the for-profits
17 in Denver always had a sign, "Three-minute wait in our ED." And I wanted to put it out in front of our
18 ED. I wanted to move the sign in the middle of the night so that when our ED was filled with uninsured
19 patients, they could all go there for a three-minute wait.
20 [Laughter.]
21 COMMISSIONER GABOW: And I thought this would be a good response to that kind of
22 advertising.
23 CHAIR ROWLAND: That's a good note to end this discussion on, I think. I think this analysis

1 is based on hospital-based data, and obviously another angle to look at this is through people-based data in
2 terms of asking them where they get their care, why they go to the ED, why they don't go, do they have a
3 primary care doctor, did they go after hours. And so I think that would be a nice complement, and that
4 kind of an analysis could also look at the difference between people in urban areas and rural areas and the
5 difference between people in medically underserved areas and in areas that are more resource rich, as well as
6 control for some of the other factors. So as we develop and move forward on our analytic plan, I think
7 that would be a useful answer to some of the questions we've had here today as well as continuing to mine
8 the provider-based data.
9 I thank you both very much, and, Emily, we look forward to continuing to work with you and have
10 you work with Anna even though we've brought Anna over onto our staff here. Thank you both very
11 much.
12 Let's take a 10-minute break, and then when we come back, we're going to talk about the Oregon
13 experience as well as some of the other studies that Kate Baicker has been leading. Thank you.
14 [Recess.]
15 CHAIR ROWLAND: If we could reconvene, please. If we could take our places. I'm very,
16 very pleased to open this session, and we've invited Dr. Katherine Baicker, a professor of health economics
17 in the Department of Health Policy Management at the Harvard School of Public Health, to join us today to
18 begin -- or continue our discussion, really, of access to care in the Medicaid program. We have very few
19 places where we can actually look at a real experiment of what happens when you have coverage and when
20 you don't, and there has obviously been much debate over what difference coverage makes and does it
21 contribute to getting you both to better access to care as well as to better outcomes. And so I'm pleased to
22 have Dr. Baicker join us to share with us the research that she and her colleagues at Harvard have been
23 undertaking on this topic, and really these are some of the very cutting-edge studies that I just really wanted

1 to be sure everyone on the Commission had a chance to both chat with Dr. Baicker as well as learn the

2 results of the study so it can inform our work going forward.

3 So, Kate, thank you for being here.

4 #### ACCESS TO MEDICAID:

5 **EVIDENCE FROM RECENT STUDIES**

6 * DR. BAICKER: It's my pleasure to be here, and I'm always so glad to have the opportunity -- oh,

7 a little closer? I pushed the button. It's on. Louder?

8 PARTICIPANTS: Yes.

9 DR. BAICKER: Okay. Excellent, and I will be happy to take clarifying questions as I go along,

10 but I'll try to leave plenty of time for questions afterwards. If you don't interrupt me, I will talk without

11 taking a breath, faster and faster for 15 minutes, because I get very excited about these studies, and I'm

12 really honored to have the opportunity to come share them with you and hope they can provide some useful

13 information.

14 So the questions that we're trying to answer and that many people are trying to answer are: What

15 are the effects of expanding health insurance to low-income adults? Obviously, there's a wider set of

16 questions about children. These studies are focusing on low-income adults in particular, and this is clearly

17 a population of great policy interest as we move into implementing the Affordable Care Act.

18 Now, you might think we should know the answer to this question: What does expanding public

19 health insurance do? Surely we are not the only people to have asked this question, and we are not. The

20 problem is that there are some inherent challenges in bringing evidence to bear on that question. The

21 theory leaves the direction of these effects let alone the magnitudes unclear, and I'll give you just a little hint

22 about why you can't just intuit without data what the effects might be.

23 As other people have tried to investigate using data, they have run into some difficult challenges.

1 The key to that is that people who are insured, either by Medicaid or privately insured, look different from
2 the uninsured in lots of ways, not just having health insurance versus not. People on Medicaid may get
3 there because they're low-income or because they have high health costs or high health needs. So
4 comparing people who are on Medicaid to people who aren't on Medicaid without taking that into account
5 could give some very misleading information about what the -- or the appearance of some misleading
6 conclusions about what Medicaid actually does.

7 For example, people who are on Medicaid have a higher mortality rate than people who aren't on
8 Medicaid. Medicaid kills. Well, no, of course not. People who end up on Medicaid are often entering
9 the program with much worse initial health conditions, and that's part of the channel through which they
10 get on the program itself. So it's not that the program is harming their health necessarily.

11 That's a pretty clear example, but the problem is that out of the world, you are faced with a group of
12 people who are on Medicaid who are lower-income than the privately insured or sicker than people who are
13 eligible for Medicaid but not enrolled, and no way to know what the program itself is doing.

14 If you just used those observational studies, you're plagued by those confounders, so people have
15 tried some more innovative statistical approaches, including some of my co-authors on these studies using
16 quasi-experimental approaches, tried to say, well, what if one state expand eligibility and another state
17 doesn't, or what if you look at a population that ages onto Medicare at age 64, becoming eligible at age 65?
18 And those studies overcome some of the problems with just pure observational studies, but they can't
19 overcome them all.

20 What you'd really like to have is a randomized controlled trial where some people are randomly
21 assigned to have access to Medicaid and some people are not.

22 We have one randomized controlled trial in the world of health insurance in the U.S. that is
23 probably well known to lots of people in this room, and that's the RAND Health Insurance Experiment,

1 which was led by one of my co-authors on these studies, Joe Newhouse, in the 1970s, and it looked at
2 randomizing people into different kinds of insurance plans and seeing what it did to their health care
3 utilization.
4 We still use that data today to give our best guess of how changing co-payments affects people's
5 health care use and health outcomes, but that study can't tell you what the effect of expanding health
6 insurance itself does because everybody in that experiment was insured. They just had different kinds of
7 insurance plans. So we don't have a randomized controlled trial -- or we didn't have a randomized
8 controlled trial that told us the effect of Medicaid itself until a unique set of policy circumstances created
9 one.
10 So I'm going to tell you about two studies today. I'm going to start with that randomized
11 controlled trial of the expansion of Medicaid happening in Oregon. Amy Finkelstein and I are the
12 co-principal investigators on that, but there's a really wide team of people working on it. And I can't say
13 enough about how wonderful it was to work with the people in Oregon, in the state government agency as
14 well as the hospital association that we worked with there. The state folks really were dedicated to trying
15 to bring the best scientific evidence to bear that they could while keeping their policy priorities first and
16 foremost in their minds. So it was really wonderful to work with them, and we had lots of funding on
17 both the public and the private side to help us implement this study.
18 So the Oregon Health Insurance Experiment, what is this randomized controlled trial? Well, we
19 almost never have something like this in the realm of social insurance questions the way we do in terms of
20 medical trials. If you were rolling out a new drug, you would insist on having a control group that was on a
21 placebo to figure out what the drug did. We don't have that in social policy questions because it's usually
22 impractical and often unethical to randomize people into a program versus not. You know, what does
23 education do? Let's take a bunch of kindergartners and lock them in the basement and not give them any

1 education and see how they turn out? We don't do that, and that's good.

2 But there was a special set of circumstances in Oregon that actually created the opportunity to bring
3 that kind of rigorous scientific evidence to bear on this set of questions, and that was the expansion in
4 Oregon of a program for low-income adults called Oregon Health Plan Standard. So as you all know, but
5 as wider policy audiences might not, states have the option of covering able-bodied low-income adults who
6 don't meet other eligibility criteria for Medicaid, and Oregon was one of the states that did up until 2004,
7 and then they closed that program, OHP Standard, to new enrollment. So the program continued to exist,
8 but nobody else could enroll in it.

9 Through attrition over the next four years and through a special set of budget circumstances, they
10 actual decided in 2008 that they had enough money to enroll 10,000 new people in that program, 10,000
11 low-income adults who weren't eligible for any other public insurance program, but not the pregnant
12 women who would be eligible for the traditional Medicaid program, not people over age 65 who would be
13 eligible for Medicare, et cetera. They correctly guessed that they had more than 10,000 people who might
14 like entry into such a program, so working with CMS through a waiver, they worked out what they thought
15 was the only equitable way to allocate those 10,000 spots, and that was through a lottery drawing from a
16 waiting list.

17 So they opened the waiting list for two months at the beginning of 2008. They got almost 100,000
18 people to sign up during that six-week open period. There was clearly a lot of interest in the program.
19 And then they started drawing names by lottery from the list. So this created really an almost ideal set of
20 circumstances to gauge the effects of expanding Medicaid to that people because you have an actual control
21 group. The people on the list all look the same ex ante, except some of them are lucky enough to get
22 selected and others aren't.

23 So we used as our study design a comparison of the people who were drawn from the list to the

1 people who weren't drawn from the list to see what Medicaid expansions actually did for the people who
2 ended up enrolled.
3 Now, there are a couple logistical challenges there -- more than a couple -- that I won't get into
4 detail about unless you ask me, and then I won't be able to help myself. But one of the things I want to
5 highlight for you is that they drew 30,000 names to get those 10,000 enrollees, and that's because when they
6 drew somebody's name, the person then had the opportunity to apply for Medicaid. Not everyone whose
7 name was drawn did, in part because the list of addresses was getting older and older, so some people didn't
8 get the mailings. Of the people who filled out the applications, only about 50 percent were deemed eligible
9 in the end, because to sign up for the list you just had to put your name on the list. Once your name was
10 drawn, you had to fill out the whole application.
11 So they drew 30,000 names. That's our treatment group. They ended up with 10,000 enrollees.
12 We're comparing -- we're using the lottery as an instrument in a two-stage least squares regression
13 framework to figure out the effects of insurance coverage on outcomes of interest. So to do this, we rolled
14 out a massive data collection effort. We used both primary data and secondary data that I'll tell you a little
15 bit more about.
16 I want to highlight, before I run out of time, that there are some serious caveats in generalizing these
17 results to what I think is first and foremost on everyone's mind: What would the Affordable Care Act do?
18 I think this is great information to help answer that question, but we have to be careful. Ten thousand
19 people enrolled in Oregon is a small share of the total population. It's a small share of the uninsured
20 population. So the partial equilibrium effect may be different from the general equilibrium effects, by
21 which I mean when you suddenly insure millions of people, you may get different supply-side responses,
22 you may have different strain on capacity, you may have the system react differently than when you just
23 ensure a few people.

1 I'm going to show you results today looking just one year out after people got access to insurance.
2 We have results coming shortly, I hope, that will be two years out. Those results might be very different
3 from what would happen in ten years. So there's a limited time frame that we're looking at.
4 The population in Oregon also looks a little different from the rest of the U.S. In lots of ways it's
5 the same, but in particular, there's a much smaller share of the population that's African American in
6 Oregon than in the U.S. overall, and so we can't do any kind of racial decomposition in Oregon the way you
7 might want to know how the effects on disparities play out nationally.
8 So there are lots of caveats, but that said, I think we've never had evidence of this caliber before
9 because there has never been the opportunity to have a real control group before.
10 So I'm going to give you results in three broad bins. The first one is what happens to health care
11 utilization. I'm an economist. To me that's costs. I think it's a little bit of an unnatural reaction.
12 People think of health care youth as the goal of the program. Isn't that the benefit of the program? But,
13 really, I'd say that the goal of the program is to improve your health, and the way you get that is by
14 consuming health care. That's the resource use that goes into producing what you hope are improved
15 outcomes. So we're going to look at costs, and it's not clear ahead of time how much expanding Medicaid
16 would affect health care utilization, because you might think, on the one hand -- some people did think --
17 that Medicaid doesn't offer beneficiaries all that much access to care. It doesn't pay providers enough. It
18 doesn't change access because the uninsured are getting access to clinics, charity clinics, uncompensated
19 care. Medicaid people aren't getting access to that many providers, so maybe it doesn't change utilization
20 that much. So we're going to have to show you data on that.
21 For that increase in utilization, you would think that there might be two types of benefits people
22 could accrue. The first one is not talked about very much, and that's financial security. We talk about
23 health insurance as if it's only about health care, and that's not an unreasonable way to focus. But

1 insurance is supposed to protect you against risk. It's supposed to protect you against getting evicted from
2 your apartment because you can't pay your rent because you had medical bills or from ruining your credit
3 because you have bad debt. So we want to look at the effects on financial outcomes as well as health
4 outcomes.
5 But then, of course, the punch line everybody is most interested in is: What happened to your
6 health? What are the health effects of this? And I'm going to show you data from self-reported health
7 measures. We also collected data from the next year on physical aspects of health.
8 So the approach relies on that random assignment through the lottery. We looked at both the
9 effect of getting drawn in the lottery and then the effect of gaining insurance through the lottery, being
10 careful to use the lottery as the only source of variation in whether people had insurance or not. So we're
11 immune to the usual kinds of selection bias, and I can go into the mechanics of that more if you'd like.
12 The data come from a couple of different sources. We have the lottery list from the state. We
13 got administrative data on hospital utilization for everybody on the list, so that's a great universal data
14 source. But it doesn't cover utilization outside the hospital. We got data on credit reports for everybody
15 on the list, so we know what happened to their formal access to credit. Those data sets are great because
16 they're not subject to any kind of imperfect responding because they're from administrative sources, but
17 they don't contain all the outcomes you'd might like to look at, so we also implemented some primary data
18 collection. We ran a mail survey where we asked people about these different aspects of care. We also
19 implemented an in-person data collection effort where we drew blood samples and got blood pressure and
20 got much more detailed questionnaires. Those data are not here today. Today I'm telling you about the
21 first year of data. Those in-person questionnaires came from the second year of data.
22 Yes, please?
23 COMMISSIONER GABOW: A clarification question. After the lottery, the next hurdle was

1 that they actually filled out the insurance form. So was there any difference between the population who
2 went on to do the application and those who didn't? Because you might assume that there would be.
3 DR. BAICKER: Yes, that's a great question, and the people who filled out the forms do look
4 slightly different from the people who didn't, although we have limited information on the people who
5 didn't fill out the forms. We did a survey of everybody, whether you filled out the form or not. But, of
6 course, people who fill out forms are also more likely to fill out surveys. So we don't have great
7 information on the people who didn't fill out the forms, but we have administrative data on them from like
8 the hospital discharges and from the credit reports.
9 Because people who fill out forms are likely to be different from people who don't, and even more
10 because the people who are then deemed eligible from among those who filled out the forms are likely to
11 look different, you can never get a clean estimate of the causal effect of insurance by comparing people who
12 actually enroll to people who don't enroll. We have to compare everyone who was drawn in the lottery to
13 everyone who wasn't drawn in the lottery, even though not everyone who was drawn in the lottery ends up
14 getting insured. You can then scale those estimates up to impute how much the effect was likely
15 concentrated among those who were insured, but all of the analysis differentiates based on whether you
16 were drawn in the lottery versus not, because filling out the forms is endogenous in jargon, you know, it
17 depends on the characteristics of the individual in the same way that whether you're eligible conditional on
18 filling out the forms depends on the characteristics of the individual. So we're very cognizant of that
19 limitation and take that into account in the estimation. So thank you for clarifying.
20 So that's the set-up. I'm going to cut to the punch line because this is only the first study of two,
21 but I promise the second will be shorter.
22 The first set of results is utilization. What happened to people's use of health care once they gained
23 access to insurance through the mechanism of the lottery? The answer is they substantially increased their

1 utilization. The probability of hospitalization, for example, went up by 30 percent. The probability of
2 having an outpatient visit went up by 35 percent. The probability of taking a prescription drug went up by
3 15 percent. Preventive care went up substantially, a 60-percent increase in the use of mammograms, a
4 20-percent increase in the use of cholesterol screening.

5 Now, I think ahead of time people had hoped that perhaps because you got access to this preventive
6 care and primary care you'd actual scale back your hospital utilization and it would somehow save money.
7 I think that that was an unduly rosy expectation and does not play out in these data. The uninsured
8 consumed less health care than the insured. Once this group gains access to health insurance, they
9 consumer more health care. That's primary care and preventive care, but it's also hospitalizations. It's
10 hospitalizations through non-emergency department admission, though, so this isn't people showing up in
11 the ED with a heart attack. It's people who have a scheduled hospitalization perhaps because they saw a
12 doctor who thought that they ought to go to the hospital.

13 Question?

14 COMMISSIONER COHEN: But this is based only on one year of data, right? So it may be -- I
15 assume this is one thing that could change over time because isn't there a well-known sort of phenomenon
16 of when people get insurance, there may be some pent-up demand for services?

17 DR. BAICKER: So absolutely, this is just what happened in the first year, 15 months roughly.
18 We don't see a decline in service utilization over the span of this year, so it's not as though in the first six
19 months that people had insurance they all went to the hospital to get services that they were waiting for.
20 But that doesn't mean at all that over ten years you might not expect it to trail off. So that's very much a
21 limitation of the data to date.

22 Yes?

23 COMMISSIONER HOYT: I wondered if you had any data to compare this group to people who

1 were on Medicaid?

2 DR. BAICKER: Our set-up is ideally designed to say what happens to people who are newly
3 covered by Medicaid versus the uninsured. But we don't have a control group that was already on
4 Medicaid that's drawn from the same list, unfortunately -- that has the same characteristics. So it's a very
5 focused answer that we're giving, which, you know, people also want to know how does this compare to
6 people who are on private insurance. We have no information about that.

7 We don't see any decline in emergency department use in these data, although it is imprecisely
8 estimated. We do now have access to emergency department administrative data, so I expect we're going
9 to be able to drill down in much more detail on that. When you put all this together, it looks like people
10 increase their utilization by about 25 percent when they're covered by Medicaid versus when they're
11 uninsured.

12 That was the first set of outcomes, utilization. The second set is financial strain. We see a
13 marked improvement in financial strain, reductions in bad debt being sent to credit collectors, for example,
14 and this is a really bad outcome both for the providers who weren't getting paid and for the individuals
15 whose credit reports are ruined when things are sent to collectors. We also saw parallel decreases in having
16 to borrow from friends, decreases in catastrophic out-of-pocket costs, et cetera. So there's real
17 improvement on the financial dimension.

18 Then the punch line of health results, I want to highlight that this is, again, limited to the first year,
19 so this is not the long-run health consequence. And it's also limited to self-reports because these data are
20 from the mail surveys. I haven't yet been able to show you data from the physical measures we collected.

21 What we found in the mail surveys, though, was that people reported pretty dramatic improvements
22 in their health, both physical health and mental health. And one thing that I didn't highlight when talking
23 about the population is that there's a huge mental health burden among this population. More than 50

1 percent report having had a diagnosis of depression. So this is a population with serious mental health
2 issues to deal with, and insurance seems to dramatically reduce the probability of screening positive for
3 depression. It improves the probability of reporting being in good to excellent health by 25 percent,
4 40-percent decline in the probability of saying your health has gotten worse over the last six months.
5 Across all the different ways we tried to measure people's self-reported health, there were dramatic
6 improvements.

7 Now, the mental health measures I think correlate pretty well with clinical diagnoses of depression.
8 It's the PHQ-2, it's the POSTA [phonetic] map, what would happen if you went to see your doctor. It's a
9 little harder to interpret the physical health measures in part because we started to see them almost right
10 away, before we even saw increases in utilization. So that makes you wonder: Are people telling you
11 strictly about their physical health? Even though you're asking them specifically about their physical
12 health, maybe they're also telling you about their overall well-being and that things are just much better for
13 them. We saw a substantial improvement in happiness as well as in the physical health measures that we
14 tried to collect through these self-reports. So we're not entirely sure whether to interpret them as physical
15 health improvements or improvements in overall well-being. We may care very much about both, but they
16 may have different implications for long-run health costs or policymakers may care about those dimensions
17 differentially.

18 COMMISSIONER ROSENBAUM: That's what I was going to ask. Is it fair to infer from these
19 findings that the increase in utilization that you saw was not what some policymakers might think of as
20 discretionary, that is, that people went off and used stuff that they didn't really need and so it was a waste of
21 money? If we're seeing these kinds of improvements in the probability of good health, improvements in
22 showing depression, from the point of view of health services researchers and clinical people, that would
23 suggest that it was not a wasted investment, I assume, that these are good investments to make.

1 DR. BAICKER: Well, certainly we can look at the types of utilization that we saw, so the increases
2 in mammograms and cholesterol screening and all of that are in compliance with recommended care. So
3 you can map out some of the self-reports, although we're going to have much more detailed utilization from
4 the detailed in-person questionnaires. When you look at the treatments in the hospital, the biggest
5 category is heart-related stuff. So it looks like real utilization, but I would hesitate to make that last
6 connection you made that these results show that it was good utilization, or utilization that produced a lot of
7 health just because some of these improvements in self-reported health actually predate the increases in
8 utilization. So it's not obvious --
9 COMMISSIONER ROSENBAUM: Hard to know.
10 DR. BAICKER: -- that that's the specific pathway. But we have independent reasons to think
11 that things like cholesterol screening are good. So when we see increases in cholesterol screening, I think
12 people come with clinical evidence that that is a healthful thing to do. So I think the evidence -- you have
13 to take those different pieces from different sources.
14 But I think all of this highlights the importance of the physical measures which we will, I hope, have
15 for you in a few months. We collected those two years after insurance. All of the stuff you've seen so far
16 is from one year after insurance. So we'll have more information on that in the time to come, but that also
17 highlights some of the limitations of the study to date. It's only the first year. Even though we collected
18 these measures from tens of thousands of people, but some things that you care about a lot are small
19 enough prevalence in the population that you're just not going to be powered up to see them here. So
20 enter the second study, which --
21 CHAIR ROWLAND: Kate, let me ask you, did you also find out what kind of medications they
22 were on?
23 DR. BAICKER: In the second wave. In the in-person wave we did a complete medication

1 catalogue, so we had a look-up database, and we have the sort of detailed utilization of the Portland metro
2 area population.

3 CHAIR ROWLAND: So you'll have far more information on the actual documented
4 characteristics of what they're using?

5 DR. BAICKER: In the mail survey we said, "How many prescriptions do you currently have?"
6 In the in-person interview, we said, "Show us all your bottles," and we wrote down everything, and that way
7 we'll be able to say, "Are you taking medication for depression?" for example, which we couldn't from the
8 mail survey.

9 So just a minute or two on the second study, which was aiming to get at this question of what
10 Medicaid does from a different angle. We wanted to know -- this is joint with Ben Sommers, who's the
11 first author, and Arnie Epstein in my department. We looked at the relationship between Medicaid
12 expansions and adult mortality, looking at states that expanded Medicaid relative to states that didn't. So
13 this is a quasi-experimental design where we looked at overall population mortality rates in the three states
14 that had expansions to childless adults in the 2000-05 period compared to neighboring states with similar
15 demographics who didn't have expansion, and we look at differences in the trends in mortality between the
16 control states and the comparison states to try to gauge the effect on mortality.

17 We used all-cause mortality at the county, year, race, age, gender cell from the CDC Compressed
18 Mortality File. We also as secondary outcomes looked at insurance coverage, access to care, self-reported
19 health from survey data sets, the CPS and the BRFSS. We had covariates from the ARF. And the idea
20 was really to do an in-depth analysis where you look at a trend in a comparison state and say that's the
21 counterfactual, that's what would have happened but for the expansion in Medicaid, and then you look at
22 the trend in the Medicaid expanding states and see how they differ. And what we found was that there was
23 a substantial decline in all-cause mortality in the states that expanded Medicaid relative to the states that

1 didn't. It was about 19.6 deaths per 100,000 people, or you need to cover 176 people with Medicaid to
2 avert one death is the back-of-the-envelope calculation there. That went along with expansions in access.
3 We saw increases in Medicaid coverage and decreases in uninsurance, just as you would expect, and
4 improvements in self-reported health and access to care.

5 Now, this is a consistent story. We saw the reductions the most in populations that were most
6 likely to be affected by the insurance expansion in subgroups that were over age 35 where they had a higher
7 mortality rate in minority populations, in counties that had higher poverty rates, so these were the areas
8 where you would expect Medicaid to be most felt acutely. We also used an added control group of those
9 who were over age 65 who shouldn't have been affected to do an in-depth analysis to try to net out any
10 other secular trends.

11 Results were robust to many other specifications, but the limitation to approaches like this is that it's
12 very hard to nail down causality. We did our very best to rule out every possible alternative causal
13 pathway, but it's very hard to do that definitively when really you're just using different states as controls for
14 each other and, you know, we used all of the tools available to us. And I think that the results are very
15 persuasive, but they're not definitive in the way that having a randomized controlled trial might be.

16 But there are pros and cons to these different approaches, and that's why I think all of these studies
17 are helpful arrows in the quiver of trying to figure out what's going on. They're complementary
18 approaches. The Oregon Health Insurance Experiment had real randomization, but it was a limited set of
19 people, and we had a limited time frame to look at, so causality is nailed down more definitively, but there's
20 some limited outcomes that you can look at.

21 The Sommers-Baicker-Epstein paper had much larger sample sizes over a much longer time horizon
22 so that we could look more carefully at what the effects on mortality might be in a way that we weren't
23 powered up to do in the Oregon Health Insurance Experiment. But there are some limits to causal

1 inference. It's harder to nail down causality persuasively. That's why each of these I think is an important
2 component.
3 Putting it all together, my bottom line is that we have pretty strong evidence that when you expand
4 Medicaid, it comes with some costs. You use more resources. But it comes with some benefits.
5 People's health seems to improve through self-reports or other mechanisms, and policymakers then need to
6 weigh those costs against those benefits. But I think all of these studies really eliminate two extreme
7 stories that you'd heard bandied about:
8 One, that expanding Medicaid pays for itself because people's health improves so much that they
9 don't actually need health care anymore, and that would be nice, but I don't think that's true.
10 And on the other side, that Medicaid is a terrible program that doesn't provide any benefits to
11 people given all the costs of the expansion, and I don't think that that's true either. I think it provides
12 substantial benefits so policymakers are left with the difficult choice, you're left with the difficult job of
13 weighing those costs against those benefits. But I hope we've given you some better data to do that.
14 I'll stop there and answer more questions.
15 CHAIR ROWLAND: Thank you, Kate. Questions?
16 VICE CHAIR SUNDWALL: I do. On your slide, I'm just curious. I don't want to get into the
17 weeds here, but on the results when you were talking about -- you showed the state comparisons. You
18 have one bullet here that says, "Improvements in health, 3.4 percent increase in probability report of very
19 good or excellent health." What does that mean? I mean, I should hope that health improved more than
20 3.4 percent, but I think it must be a statistical thing.
21 DR. BAICKER: Yes, so the challenge here is that we don't know who was actually covered
22 because of the expansion, so we're taking a group of people in the states who had the expansion and saying,
23 "How's your health: excellent, very good, good, fair, poor?" Then you ask the same question to the

1 people in the states who didn't have the Medicaid expansion. Then you look at how that trend changes
2 over time in the states with the expansion relative to how that trend changes over time in the states without
3 the expansion, and the difference in the trend you attribute to the Medicaid expansion. If nothing else
4 changed, that's the thing that drove the change.
5 And what we see is that relative to the change over time in the states without an expansion, there
6 was a 3.4 percent increase in the share of people who said, "My health is good, very good, or excellent" --
7 sorry, very good or excellent is the statistic I put up there.
8 VICE CHAIR SUNDWALL: Is it statistically significant [off microphone]?
9 DR. BAICKER: It's statistically significant, yes. And, you know, substantively, it's sort of up to
10 you to decide if you think it's important. It's statistically significant. I can't tell you how much you care
11 about it. But it's a statistically marked improvement in people's self-reported health.
12 We're treating that as a secondary outcome. The primary outcome was mortality, but I think this
13 bolsters the causal pathway. It's easier to believe that it's happening through improvements in access,
14 improvements in self-reported health that then translate to improvements in mortality.
15 COMMISSIONER CHECKETT: Two quick questions. Really very interesting, and so could
16 you give me that back-of-the-envelope calculation again? Because --
17 DR. BAICKER: Which one?
18 COMMISSIONER CHECKETT: The one about how many people you have to cover in order to
19 save a life.
20 DR. BAICKER: 176.
21 COMMISSIONER CHECKETT: 176. Well, that's an important number. Okay.
22 The second question is --
23 DR. BAICKER: They're all important. Every number is important.

1 [Laughter.]

2 COMMISSIONER CHECKETT: I know, but that is really -- you know, for someone who does
3 policy by anecdote, which I do, that's a great number.

4 CHAIR ROWLAND: You know, they used to say to look for the killer number. Well, I don't
5 know, that's the living number.

6 COMMISSIONER CHECKETT: It's close. Well, it's the type of thing that people can
7 remember, and I think for some of us who live in that world, that's an important number.

8 If you could do anything you wanted to do next in terms of like the next phase of this study, what
9 would it be?

10 DR. BAICKER: I think there are some real opportunities when you look at state-level policy
11 changes to implement them in a way where we can actually learn something about what the policies are
12 doing versus -- if one isn't mindful about the evaluation that might happen after a policy change, it's easy to
13 choose among some alternatives that all seem kind of the same and choose the one that doesn't let you
14 evaluate it further.

15 So, for example, if you're rolling something out to a population in stages, if you randomize that
16 rollout, then you can really learn what the population effect is. The reason I am focusing on that is that I
17 think there are a lot of population-level things like mortality that we would like much better information on
18 that you need enormous sample sizes to be able to detect. So the Oregon Health Insurance Experiment is
19 I think almost ideally situated to get that micro level granular data on people's utilization, on their health
20 outcomes, on the individual level. But it's inherently limited in sample size and in duration of study;
21 whereas -- huh?

22 COMMISSIONER CHECKETT: [off microphone].

23 DR. BAICKER: Yes, yes. Whereas, I think every state policy change that gets implemented

1 going forward, if you have good data from before and after, if you get a good sense of who's going to be
2 eligible for the change and who isn't, you can learn a lot of things that would be really hard to tease apart
3 with individual micro data that's not amenable to the kind of experiment that we did in Oregon.
4 COMMISSIONER CHECKETT: And there's the social aspect to it that's challenging. But it's
5 interesting, and I think if you have further thoughts on it, we'd like to hear about it, because we do have an
6 opportunity to make recommendations, and we do have an opportunity to give guidance to both states and
7 the federal government, especially as we look at implementing this very enormous social health experiment
8 in a year or two here. So thank you so much.
9 DR. BAICKER: And I think the states are where all of the next wave of information is going to
10 come from because the states are going to differ in the ways that they implement these things, and let's, for
11 goodness' sakes, take advantage of that to actually figure out what works.
12 COMMISSIONER GABOW: Two comments. One relates to your last comment. I think it
13 would be very useful for us to have -- or for you to provide to CMS some checklist about this kind of thing,
14 that if you're going to do this, if you did it in this way, the data would have usability. Because, for example,
15 Colorado did a lottery also, but I suspect not in a way --
16 DR. BAICKER: I did talk with my co-authors and some folks in Colorado, thinking about
17 whether this was going to be an opportunity for evaluation, and they were definitely quite interested in that,
18 and there were some challenges that -- there's one -- clearly every state's policy priorities have to be taking
19 care of its population and doing what's best for enrollees, and no one would question that that's first and
20 foremost. In Oregon, this was this great opportunity where research happened to fit in with those policy
21 priorities. There are going to be lots of circumstances on the ground where a lottery doesn't end up
22 working out. They ended up being able to draw a very large share of the people in Colorado, so it wasn't
23 really a lottery in the end.

1 COMMISSIONER GABOW: I know they're covering hardly anybody, so I -- at any rate, I think
2 that I'm just saying that while the state individual will make decisions, one of the things we've talked about is
3 State Medicaid agencies have a paucity of resources. So if you could provide to CMS and the states, look,
4 if you're going to do something that's not everybody and everything, there are ways to do it that would
5 enable you to get good data, and there are other ways that are not going to get you good data. And I think
6 that would be a very helpful tool set for states to have. They may choose not to go that way for a variety
7 of reasons, but without the tool set, they can't even make the choice.
8 CHAIR ROWLAND: And I think we'd actually like Kate to share that with us as well. That
9 would be very helpful.
10 DR. BAICKER: That point is extremely well taken, and, you know, I know Amy and I have both
11 tried to put this out there with as many states as possible. But I think any help, any advice you all have on
12 how to be most effective in that endeavor, I would love to have every state expansion viewed with an eye
13 towards within our policy priorities, how can we do this in a way that we can actually learn the most.
14 COMMISSIONER GABOW: And I am a big believer in checklists, so having something like that,
15 you know, that would be simple. If you're not going to do everybody, you could do it randomized. If
16 you were going to do randomized -- I mean, you know, an algorithm that lets you have utility.
17 The second thing is something Sara can comment on. Sara and I were kibitzing here to the side
18 about I'm a data girl and I love this study, but it's interesting that the rest of the developed world actually
19 concluded that health insurance is good, and yes, it does cost money, but that it's worth doing without a
20 randomized controlled study. And what I said to Sara is it sort of reminds me of the parachute study.
21 You know, is a parachute useful if you're going to jump out of a plane? Who would like to be randomized
22 the no-parachute?
23 So my guess is that if we went to our Congress people and said we have a proposal, we're going to

1 randomize half of you to no insurance and see how that works for your overall health. And so in some
2 ways, you know, other developed countries have conclude this is a good thing without the need for a study
3 to show it, and it's probably worth having that remark on the record. And Sara can clarify anything that I
4 misrepresented.
5 COMMISSIONER ROSENBAUM: I'm thinking of raising this to the GW HR department, that
6 as a cost-containment mechanism, we switch over to randomized insurance coverage. I mean, it is a
7 magnificent study, and I cannot tell you how many times I have cited the results, and I think we probably all
8 have. But there is something terminally depressing about having to rely on a randomized assignment of
9 people to insurance coverage to show its value, sort of the moral underpinning of the story, one hopes that
10 when we pursue the Affordable Care Act expansions we are not pursuing them as sort of a randomized
11 assignment, that, you know, states will implement the expansion. So it is always the grim side of having
12 wonderful research opportunities.
13 COMMISSIONER MOORE: You mentioned that in, I think you said, a few months you'll have
14 the results of the second year kinds of things. Could you give us a little bit of a preview? And also then
15 will you be going on to do more things in the third year and the fourth year? What does your future look
16 like with this?
17 DR. BAICKER: So, no, I can't give you a preview, and that's for, I hope, a good reason. One
18 thing I didn't mention with the implementation of this study so far is that we worked very hard to
19 pre-specify all of the analyses before looking at the data. So we said here are all the things we're going to
20 look at, here's exactly the functional form we're going to use, here are the number of regressions we're going
21 to run, here's how we're going to adjust our statistical inferences for the number of regressions we ran,
22 here's exactly how we're going to clean up the data. We publicly archive that analysis plan, and then we
23 produce all of the analysis.

1 So I think we really inoculate ourselves against any concerns about data mining or cherrypicking of
2 results. We laid it all out ahead of time, hands above the table, and then did all of the analysis. So we
3 haven't been peeking under the curtain of the second year data results while we finalize exactly what we're
4 going to do. We've now publicly archived that analysis plan. The results are all running. But we didn't
5 look ahead of time, and I don't want to -- I don't have any information that I can give you.
6 COMMISSIONER MOORE: Time frame [off microphone].
7 DR. BAICKER: Pardon?
8 CHAIR ROWLAND: Time frame.
9 DR. BAICKER: As fast as our little legs can run.
10 [Laughter.]
11 DR. BAICKER: I hope fairly soon, but we're just -- we're working all out on it, I assure you.
12 CHAIR ROWLAND: But are you going -- your time going forward?
13 DR. BAICKER: Oh, yes, sorry. That wasn't the question. Really, we're working so hard.
14 Going forward, Oregon got additional funding to cover more people and started drawing more names from
15 the existing list as well as opening a new list, so that we dovetailed our fielding around that expansion effort
16 so that we could continue to gather data until the last minute. But our primary data collection effort ended
17 at the end of 2010 as the state drew the remainder of the people who were on the list for access to
18 insurance. Our control group was no longer existent after the end of 2010. We will continue to get
19 administrative data from hospital discharges and the like, so we could say what's the effect of two years of
20 insurance coverage five years later, but we can't say what's the effect of five years of insurance coverage
21 because the lottery experiment only lasted two years. So we'll continue to follow people through the
22 lower-cost administrative data angles, but not through the primary data collection.
23 COMMISSIONER RILEY: Thanks for doing this. I'm sorry, though, you're not enthusiastic

1 about it.

2 [Laughter.]

3 DR. BAICKER: I tried to keep it under control.

4 COMMISSIONER RILEY: I guess I look at this from the --

5 CHAIR ROWLAND: And she's an economist.

6 [Laughter.]

7 DR. BAICKER: Which is a good thing.

8 COMMISSIONER RILEY: It's a very good thing. A happy economist. An oxymoron.

9 If you look at this through the eyes of a governor or legislator, as a policymaker, who frequently
10 have little tolerance for research and understanding the nuances of it, it strikes me, even though I'm from
11 Maine and I love the findings after all our hard work to expand coverage, now gone, I would disaggregate
12 that because I think that study is profoundly different and the formulation and the construction leaves so
13 many questions that it seems to me the strength of the Oregon study is where we really have some great
14 capacity to be able to help states answer the question should we expand Medicaid. And I wonder -- but
15 one of the realities is, of course, it costs money to cover people, but money is hard to come by, so
16 convincing legislatures to spend money is always a hard thing.

17 Will you be able to tell us -- I know you're using administrative data. Is there any way to look at
18 more clinical information, or what happened to bad debt and charity care? These people who are sick,
19 what kinds of illnesses did they have? Can we assume that they would have been sick anyway and charged
20 bad debt and charity care to hospitals and physicians? Could we identify people who maybe were diabetics
21 who, because of the early interventions maybe have managed diabetes that the cohort without it was
22 unmanageable? Will we know any of that from this study?

23 DR. BAICKER: Yes, we have -- let me try to pull it apart a little bit. For the second wave of

1 data collection, the in-person data collection, we asked people a lot more questions about chronic diseases,
2 for example, so if you had diabetes, we did a whole drill-down module on diabetes, on asthma, on
3 cardiovascular disease. So we asked people a lot more detailed questions. We also, as I said, measured
4 some of those things directly, and that's important because if you ask people if they have high blood
5 pressure, people who haven't been to the doctor aren't going to tell you that they have high blood pressure
6 because they don't know. So it's important to compare the actual physical characteristics with the existing
7 diagnoses.
8 We only did the in-person physical measures once. It was a very expensive data collection effort,
9 but we asked people retroactively about when they had been diagnosed so that we'll be able to slice those
10 results based on whether you had a pre-existing diabetes diagnosis, for example, and then look at the
11 amount of care that you consumed or your treatment relative to somebody who didn't have that. So we'll
12 be able to do much more of that in the second year data.
13 From the credit reports, we can say definitively, already having merged the one-year credit reports,
14 that bad medical debt sent to collection declined substantially. And one thing that I was very surprised
15 about in looking at these data is, you know, we looked at bankruptcies, we didn't see anything on
16 bankruptcies that was statistically significant. But bankruptcies are very rare. Fifty percent of the control
17 group had a bill sent to collection. I didn't know what a common occurrence this was in a low-income
18 population. So these are substantial effects not only for the individual because having a bad bill sent to
19 collection not only affects your credit record for gaining access to things like mortgages or car loans, but
20 also affects your ability to get a job or rent an apartment. So this is a very bad outcome for the individuals.
21 We also know from these data that less than 2 percent of the bills sent to collection are collected
22 upon, so the providers aren't getting paid even when the bills get sent to collection. So it's a flag for bad
23 debt that is never paid.

1 COMMISSIONER RILEY: And we could document some numbers around that?

2 DR. BAICKER: Yes, and those are in the paper.

3 COMMISSIONER CARTE: Marvelous this study is. One of the things that jumped out at me is
4 the implied 25 percent increase in spending, and I am in a CHIP program, and we did see some pent-up
5 demand. So I will be really hopeful to see other results that follow, as well as looking at questions like
6 uncompensated care issues later on.

7 DR. BAICKER: And I think one thing that highlights the importance of a randomized controlled
8 trial like this is that estimates from observational studies that just compare the health care use of people who
9 are uninsured to those who are on Medicaid suggests a much bigger increase in utilization, more like 50, 60
10 percent increase in utilization, whereas we see a 25 percent. And those observational studies suggest a
11 much smaller improvement in health, whereas we see a bigger improvement in self-reported health. That
12 pattern is consistent with exactly the kind of selection bias that you would expect in observational studies
13 where the people who take up Medicaid are the ones who have higher health needs and worse health
14 outcomes, and so you get a mistaken idea from the observational studies.

15 So these are already substantially smaller than you might think if you just looked at the health care
16 use patterns without taking the selection into account.

17 COMMISSIONER COHEN: Thanks so much. Such an interesting study, and I'm fully
18 persuaded that health insurance or health coverage can improve health, but I'm curious on the mortality
19 study, whether based on what you looked at there's any ability to go deeper or in the future you have plans
20 to do so, to say not just like the binary question of coverage or no coverage but what kind of coverage
21 makes a difference and how much. And so the states you looked at with expansions I think have fairly
22 different benefit packages, for example, New York, Maine, and Arizona, and from the ones you compared
23 against, could you make any observations about whether, you know, more coverage or certain characteristics

1 of the coverage, the delivery, or anything resulted in less mortality or more mortality?

2 DR. BAICKER: Unfortunately, in this framework, really not so much. We did show results for

3 each of the three states separately, and not surprisingly, given that we've pooled these three states, New

4 York tends to drive the results because it's bigger, and we're looking at the typical person covered in that

5 more of those people in New York of those three states. There were no statistically significantly different

6 trends in the three states, but I don't think that that tells us that the results were the same. The states, once

7 you start pulling it apart with only three states, it's very hard to observe any statistically significant

8 differences.

9 So I would love to be able to say what features of a particular Medicaid program drive results. We

10 certainly can't do that in Oregon where there's only the one. Here there are only the three, and so I don't

11 think that we're in a position with these set-ups to be able to do that, unfortunately.

12 CHAIR ROWLAND: Kate, if implementing the ACA we see some states go forward with

13 expansions and other states choose not to, is this a model for how one might evaluate the effects of that?

14 Or can you offer other suggestions for ways in which we might want to look at what happens between these

15 states?

16 DR. BAICKER: So that highlights one of the challenges of the quasi-experimental set-up, which is

17 if some states choose not to expand Medicaid, those are likely not to be representative states. They may be

18 particular states where the characteristics of the population are different from --

19 CHAIR ROWLAND: Like Texas.

20 DR. BAICKER: For example. Now, that doesn't mean that there's nothing to be learned there,

21 especially if you get data before and after. You can look at trends in the treatment states versus the control

22 states, which is the strategy we take here. And here, because it was only a few states that expanded and we

23 could look for states around them with similar demographic characteristics who didn't and we show the

1 trends before the expansion are the same, then it's somewhat reassuring to look at trends afterwards,
2 changes in the trend in the treatment state relative to the control state and say that's the expansion.
3 If the states that choose to expand have similar pre-expansion trends to the states that don't, then I
4 think we can learn a lot. If the trends before the expansion look very different in the states that choose to
5 expand versus those that don't, that casts more doubt on the causal effect being able to be observed by
6 comparing the trends after the expansion. So time will tell on that front.
7 COMMISSIONER MOORE: I seem to recall and I think you mentioned that you had a lot of
8 interaction with, cooperation with the state folks in Oregon.
9 DR. BAICKER: Absolutely.
10 COMMISSIONER MOORE: And I'm thinking about states that may choose not to expand under
11 ACA. Could you kind of -- I don't like this word, but could you -- I was going to say "impose." But
12 could you do this kind of study without some pretty close collaborative relationships with a state
13 administration that was -- you know, as a control over another state, for example?
14 DR. BAICKER: I think the quality of the study is dramatically enhanced with the cooperation of
15 local Medicaid authorities. This study, the mortality study, was just using administrative data ex post.
16 You know, this was publicly available data downloaded from the CDC website. So that didn't require
17 anybody's collaboration. But there's a pretty limited set of outcomes that we can look at where there's data
18 like that available. Whereas, with Oregon, we actually had to go interview -- we sent out mail surveys to,
19 you know, 70,000 people; we got blood samples from 13,000 people. We had a really hard time finding
20 those people. We worked closely with the state to dovetail our fielding efforts with their outreach efforts,
21 et cetera. So when you're trying to get new primary data, I think you can't do it without the cooperation.
22 The set-up, where you have some sort of phased rollout that's randomized or where you sort of
23 know who's getting eligibility this month versus next month versus the month after, that kind of

1 quasi-randomization requires cooperation.

2 So I think the more cooperation you have, the richer the -- the better the design can be, and then
3 conditional on the design, the better the data collected can be. Here we're relying on, you know, an
4 uncoordinated design and publicly available data, so it's just measured more crudely. Those are the two
5 endpoints.

6 COMMISSIONER ROSENBAUM: You know, it's worth -- I'm sitting here thinking about the
7 study that was done -- it's now much older, but similarly, of course, an economist's look at program -- the
8 Grossman study from the early 1990s, which, you know, showed the correlation between the advent of
9 Medicaid and infant health outcomes. And so you do come back to this question, what we have to do to
10 sort of get ourselves over this hump of doubting that it is a beneficial thing for society to try and alter health
11 outcomes for low-income people by giving them a means of purchasing health insurance coverage. And I
12 don't know -- you know, your findings are so powerful, I think, despite the unanswered questions that the
13 other thing I would be interested in is sort of your thoughts on how to most -- without in any way being
14 irresponsible with the findings, how to use the findings most compellingly to explain to policymakers what
15 they can draw from them. And, you know, it's another in a whole cycle of studies that show that health
16 interventions change health outcomes for needy populations.

17 You know, I don't know how we learn to sort of convey the public health value of these results
18 without feeling as if we've got to go back and get the tremendous resources and brain power to do it.
19 Again, I mean, when you talk to policymakers about the results, do you find that they are skeptical? Do
20 you find that they hear what you're saying even with the caveats?

21 DR. BAICKER: There is clearly a wide array of reactions to the study, and I consider it my job to
22 try to convey the evidence as clearly and persuasively as I can, but not say what that implies for what
23 policymakers should do, because I can only tell you the benefits that I can measure and the costs that I can

1 measure, not how you as a policymaker should value those benefits or where you're going to finance those
2 costs. You know, that's beyond the power or appropriate scope of a study like this.
3 That said, I thought it was interesting as the study was released that it dispelled those two extremes
4 of Medicaid has no benefits and Medicaid has no costs. People who read the study reasonably carefully
5 pivoted to other talking points. So I'm not clear that it necessarily changed anybody's point of view. You
6 know, people who might have before said Medicaid doesn't have any benefits perhaps began to say
7 Medicaid isn't as good as private insurance. I don't have anything to say about that.
8 But I think it really makes it much harder to argue either of those extreme views, and I'm hopeful --
9 I don't know whether my hope is evidence-based -- that having data to dispel some of the particularly
10 unsupported hypotheses that drove extreme views of the program on either side might drive us towards
11 better policy. I'd love any advice on how to make that happen.
12 CHAIR ROWLAND: I certainly think that there was an era in which "Medicaid kills" was the
13 predominant comment, and some of the studies there were very narrow, and even the authors of those
14 studies didn't want those studies interpreted that way. But this set of studies has been very important as a
15 very solid foundation of how to look at those issues.
16 COMMISSIONER RILEY: Just a quick question as you were talking. Has anybody ever
17 suggested -- there may be some who would criticize it because it's one state and it happens to be a state
18 that's historically been very progressive, independent of who's governor and who's in the legislature. And
19 it is, I think, a well-recognized good Medicaid program. Has anybody ever questioned whether these could
20 be replicable in different states that don't have as strong a Medicaid program?
21 DR. BAICKER: We tried to provide some evidence on how the Medicaid program in Oregon
22 looks relative to other states. Is it representative or not representative? And there's, you know, the
23 well-known prioritization list from Oregon in the past that is not so binding now in terms of services that

1 are actually covered. When you look at the Oregon Medicaid program relative to other states, it looks
2 fairly similar. The payments to providers are slightly higher than average for other states, but not at all
3 atypical and not at all the top. The number of providers per uninsured person looks kind of similar. The
4 share of medical spending that's uncompensated looks kind of similar. The number of uninsured people
5 relative to the population looks kind of similar.
6 So we tried to look at that for external validity assessment, and we didn't find any smoking gun that
7 says Oregon is different except the demographics, where Oregon is decidedly more white than lots of the
8 rest of the country. In terms of education, in terms of income, in terms of other things, they looked fairly
9 similar, so we flagged that as one outlier, but we didn't see big program differences.
10 That said, I have to imagine that this study could not be implemented in lots of different states
11 where policymakers weren't so genuinely enthusiastic about science and developing a knowledge base.
12 They were all hands in, very much working with us to try to get the best information that they could. So I
13 can't say enough about how wonderful it was to work with them, and that may not be typical, but I don't
14 know how that would roll out in other states.
15 COMMISSIONER HOYT: So Oregon, Arizona, and New York at least all have widespread use
16 of managed care. Were the people in the studies enrolled in the managed care plans?
17 DR. BAICKER: So, yes, Oregon's Medicaid population is enrolled in managed care, and so the
18 results that you see look like what you would expect in a managed care population. Most states do so that,
19 again, is not atypical of other states.
20 In the second study, we were looking at population-level things, but, again, the programs have these
21 particular features. So it's hard to know what enrolling a population in an insurance plan that looked very
22 different from how the Medicaid plans in these states look would affect outcomes in the same way that
23 these studies can't tell you what would happen if you enrolled people in private insurance. They can't tell

1 you what would happen if you enrolled people in a Medicaid program that looks very different from the

2 ones that we're seeing here. So that's an important caveat.

3 COMMISSIONER WALDREN: So when we think about health care and social determinants, we

4 always say the social determinants can impact health. So you started to allude to when you were looking at

5 the issues around the debt and credit rating the potential of helping health to deal with some of those social

6 determinants. So I wondered, kind of going forward in the second and third and fourth year, to look more

7 at those. So that kind of gets back to your point about a parachute. Well, if you don't use a plane, then

8 you don't need to use a parachute. So if we're able to support some of these public finances to support

9 housing and some of these other things, will that do a better impact than spending some money on the

10 Medicaid program in certain ways? So it's the notion of using -- there's a certain set of resources and

11 where do you apply it. Maybe that social determinants, does that resonate --

12 DR. BAICKER: Yeah, I actually a couple of years ago sat on a Robert Wood Johnson

13 Commission to Build a Healthier America that was expressly looking at the non-health care determinants of

14 health outcomes, and I think if what we care about is health outcomes, we have to be looking at a much

15 wider set of policies than just what's going on in health care or even public health insurance. You need to

16 be looking at, you know, early childhood education, you need to be looking at environmental hazards, you

17 need to be looking at the availability of good nutrition and exercise and all sorts of things that are powerful

18 determinants of health independent of the health care system. So I couldn't agree more there.

19 We have in Oregon tried to really maximize the advantage we're taking of this circumstance and

20 have collected a lot of supplemental data sets that you haven't seen yet that are next in the queue to get

21 analyzed. And one of the things we did, in partnership with Bill Wright and our group partners in Oregon,

22 was collect data on those social determinants for this group. So we collected detailed neighborhood

23 walkability, availability of healthy food options, all sorts of inputs into healthful behaviors and access to care

1 and networks of social support that you think might interact with this insurance.

2 Now, those things are not randomly assigned, so all we can do is look at them as, you know,

3 suggestive evidence of mitigating factors or pathways through which -- you might say insurance alone is not

4 enough. Maybe also if your doctor tells you to eat healthier and there's no place to get healthy food, it

5 doesn't do any good. But if you have both, then it's possible.

6 We're collecting data that will help us gauge those questions, although the causal inference won't be

7 quite as strong because those things were pre-existing. You know, the lottery is random. Those things

8 aren't. But without information on those, we don't get anywhere.

9 So I'm very much on board with the idea that those are key co-determinants of the health outcomes,

10 and we need to figure out how those are varying across populations.

11 COMMISSIONER COHEN: I just wanted to go back for a second to the question about -- or the

12 issue of the study design, the beauty of the randomized controlled trial, but thinking a little bit more about

13 kind of how replicable it might be in other Medicaid policy changes. I know actually in New York City

14 there was a housing program that for a period of time was done on a randomized basis, you know, there

15 weren't enough resources and people were randomized into a program, and it was very criticized politically

16 for doing it that way.

17 So I guess I just sort of wonder, you know, in your case, a policy decision had been made

18 presumably before you came on the scene, you know, to allocate the resources in a random way. But can

19 you talk a little bit about the considerations involved there? And was this, you know, an easy call by CMS

20 to allow that? If you know, is this something that you think could be done in other places? And,

21 obviously, there's really tough political considerations. Your idea of doing it with a rollout is interesting,

22 although probably logistically challenging, you know, to randomize enrollment in some sort of a new benefit

23 or something on a random basis. But I just want to talk a little bit more about, you know, what is a really

1 tough and sensitive issue about allocating resources through that mechanism and just sort of what you know
2 about the considerations there.
3 DR. BAICKER: Yes. So I think it's important to highlight this -- that I don't think anybody
4 would say if we have a program that we're pretty sure works, but we're not 100 percent sure, let's allocate it
5 randomly to some subset of people. Even though we have funding to do it for everyone, let's withhold it
6 from some people.
7 There's a reason that we haven't seen experiments like this. There are completely valid ethical
8 concerns with doing that if you think the program is beneficial and you have enough money.
9 This happened not for the sake of science. Science was a wonderful side effect of a difficult
10 situation which was they only had enough money for 10,000 spots. And so, they, being Oregon, worked
11 with stakeholders to try to figure out what was most fair.
12 So, they didn't want to do first come, first serve because they thought that would advantage people
13 who were better educated, more socially tied in, that that was seen as less fair than making sure everybody
14 got information about signing up. Let everybody sign up, and then just draw straws.
15 And, I think they worked in conjunction with CMS to come up with something that was seen as fair
16 to all the stakeholder communities and the state policymakers and fit under CMS waiver requirements.
17 They couldn't, for example, allocate based on who had the greatest health need. That wouldn't have been
18 acceptable under the waiver.
19 So, I think this was a real partnership between -- and there was real stakeholder buy, and I think
20 that's part of the reason that this was successfully implemented as a public policy in Oregon is that they
21 worked very hard.
22 Again, I did come on the scene afterwards, as you highlighted. So, this is my understanding, talking
23 with people, is that they worked hard to make sure that the stakeholder community was onboard. They

1 developed a plan that seemed fairest to everyone.

2 Then, this happens to provide an opportunity to do this evaluation, and they worked with us to help

3 us collect the data and the like. But, the policy was we've got 10,000 spots and more needy, and we're

4 going to draw straws.

5 Now how does that translate going forward? In some ways I think there are lots of opportunities

6 that aren't capitalized on, and this goes back to the conversation we were having before -- that rolling

7 something out in phases is sometimes easier than trying to say everybody changes on January 1. That's

8 sometimes logistically untenable, especially if you're looking at, you know, changes in provider networks,

9 accountable care organizations or coordinated care, changes in coordinated care organization plans.

10 You may say, you know what? We only have the resources to pilot this in five sites before we then

11 roll it out more widely. You can decide we're going to take the first five people who raise their hands.

12 Or, you can say, we're going to take the first 10 people who raise their hands and pick five of them.

13 The former design is going to be much harder to learn from because the first 5 people who raise

14 their hands may be very different from everybody else whereas if you take the first 10 people and randomize

15 among those, you still only have the 5 slots you had for the initial rollout, but now you can learn a lot more

16 from it.

17 So, I think as we see major policy changes they present opportunities because there are real logistical

18 constraints.

19 So, you don't impose the science on the policy. You take advantage of constraints that might be --

20 you know, that you wish weren't there, to actually learn more.

21 And, I think that's part of the reason that a lot of the evidence we have on these points is for things

22 like 64-year-olds who age onto Medicare at age 65.

23 Or, kids -- there's a lot more quasi-experimental evidence on kids because there's a lot more

1 variation across states in the age of eligibility for Medicaid or CHIP for kids, or the income thresholds for

2 them. So, researchers have really tried to take advantage of policy choices made by states that have some

3 sharp boundaries. You know, if you're six, you're eligible; if you're seven, you're not. And, in this state

4 it's six, and in this state it's eight, to try to take advantage.

5 That evidence is much better than the observational studies, but it's necessarily around the edges

6 because around the edges are the only places you have those policy experiments to take advantage of.

7 COMMISSIONER MARTINEZ ROGERS: That was the question I was going to ask. Thank

8 you for asking it.

9 DR. BAICKER: I knew that's what you were going to ask.

10 CHAIR ROWLAND: Sara.

11 COMMISSIONER ROSENBAUM: I do think it's worth a footnote, which shows my age. In

12 1982, on an emergency rulemaking basis actually, the Reagan Administration suspended the human subject

13 protections in 1115 demonstrations. And, the justification for given for the suspension of the human

14 subject standards; there had been a fair amount of litigation around the application of the human subject

15 standards to 1115 demonstrations. So, this sort of put an end to that.

16 And, one of the things -- and that goes to Andy's point. One of the -- the justification given was

17 that "High-ranking federal officials were in charge of the experiments, and they would be careful."

18 And, you know, it does -- you know.

19 I should note that back in those days the experiments being discussed were notably, I would say,

20 more modest, but -- they were mostly around Medicaid co-payments, and the specific triggering event was

21 the number of states that wanted $10 co-payment on emergency department visits, which as you know -- I

22 mean, it seems almost quaint.

23 But,

1 CHAIR ROWLAND: The dollars in that year were quaint too.

2 COMMISSIONER ROSENBAUM: Yeah, everything was quaint. I mean, it just -- it was a
3 different world.

4 But, it does -- I mean, your very thoughtful discussion of sort of what do you do when you don't
5 have the resources is both, I think, very important and hopefully does inform these kinds of design
6 questions that CMS faces.

7 It also, of course, is quite poignant given the expansion financing available to states under the
8 Affordable Care Act, where states really don't have to make those kinds of choices because the federal
9 funding levels are so generous.

10 And so, I think that hopefully we will not face a situation, at least going into the Affordable Care
11 Act, where a state feels it doesn't have the resources although Trish's point earlier about Woodwork Effects,
12 I think, is the one real issue that kind of hangs over our head, which is why connecting the Woodwork
13 Effect to just the existence of an exchange, not only to the Medicaid expansion, becomes so important to
14 sort of bring down this feeling that we're working with limited resources in this context.

15 You know, for the first time ever, from my perspective, states will really not be working with highly
16 constrained resources, but I realize that there are -- there is this sidebar issue. And, I think it makes the
17 Woodwork Effect analysis that much more important for us. So.

18 DR. BAICKER: And, as a footnote to your footnote, I would highlight that our study, our
19 Oregon study, was overseen by four separate institutional review boards.

20 COMMISSIONER ROSENBAUM: Yeah.

21 DR. BAICKER: So, we took human subjects protections very seriously.

22 CHAIR ROWLAND: Well, I want to thank you. I think we look forward -- we've got a trailer
23 now on the second year analysis, and we're all anxious to have you come back and share the results of that

1 with us and also your suggestions, if you can, of ways in which as we go forward -- Patty's checklist would

2 be helpful because I think this is an area where we can provide advice to the Congress and to the

3 Administration on ways in which we could learn more.

4 And, we certainly need to have better resources, but your studies have really helped give us very

5 important findings.

6 And, we thank you for your time, and we look forward to having you back to share with us more

7 results as time goes on. Thanks, Kate.

8 DR. BAICKER: Thank you.

9 [Applause.]

10 CHAIR ROWLAND: And now April can come talk to us about data.

11 I don't know about saving data development activities for the end of what has been a very full day,

12 but as we know, April is always capable of keeping us alert. We've been in research now for the last two

13 panels. So, I think learning about how we're putting our data together, what capacity we may have to

14 answer some of these questions internally, is a great way to conclude a very packed fact-filled day.

15 So, April. It's not MACStats this time.

16 #### **STATUS OF MACPAC DATA DEVELOPMENT ACTIVITIES**

17 * MS. GRADY: Not MACStats.

18 CHAIR ROWLAND: It's data development.

19 MS. GRADY: Thank you, Diane.

20 I'm going to talk to you today about five areas where we've been working on some data

21 development activities, and for each of these I'm going to try and give you a flavor of the kinds of questions

22 and policy issues that we might be able to have a look at now, that we couldn't previously as a result of these

23 new resources that we're dedicating to data activities.

1 The first thing I want to talk about is the merging of Medicare and Medicaid data, and a key
2 component of that is the collaboration with MedPAC. We just recently kicked this work off, and it's a
3 joint project to merge the Medicaid and Medicare data for individuals who are eligible for both programs.
4 We're looking at three years of data, and we're hoping to have a data book produced in 2013. So,
5 we're just beginning to work with each other on specifications for outlining who's a dual eligible and how
6 we're counting those folks and then some more detailed work, looking at their service use and their
7 spending, chronic conditions, any number of issues that the commissions may be interested in.
8 We also have an ongoing analysis of merged Medicare and Medicaid data that couldn't form a
9 potential chapter in our March report. So, this is working on two tracks.
10 Obviously, here, what we're going to get that we didn't have previously is a comprehensive picture
11 of spending for dual eligibles, both in Medicare and Medicaid. And, I think some of the things we want to
12 look at in terms of the spending and the utilization data are what can those things tell us about the varying
13 care needs of this diverse population and how do those differing needs set the stage for a policy discussion.
14 So, I'm not going to get into a lot of that right now because I think that's an open question for you
15 to discuss during Ellen O'Brien's presentation tomorrow on dual eligibles and a potential research agenda
16 for that topic.
17 The next area I want to talk about is survey data analysis, and here, what we're doing is updating and
18 augmenting some previous analyses of federal survey data, in particular the National Health Interview
19 Survey that you've had a lot of discussion of in previous meetings.
20 We're looking at the health and other characteristics of the Medicaid/CHIP population in terms of
21 looking at their characteristics, and we're also looking at access to care issues. And, this is building on and
22 continuing the work we've done for MACStats, looking at those characteristics. So, that's sort of a
23 standing analysis that we've done.

1 We also had two chapters on access to care last year -- one for children and one for adults. So,
2 what we're hoping to do here is replicate those analyses and build a foundation for being able to look at
3 trends over time in these characteristics and also access to care issues.
4 We're going to have the ability to look at urban versus rural breakouts that we did not previously
5 examine, and we're also hoping to have some state-level estimates where we previously had only national.
6 So, that work is all in development right now.
7 The next area I want to talk about is building our own infrastructure and capacities to analyze data.
8 Right now, we have a contract in place to help us acquire data, store it and manage it and get some
9 programming support so that we're able to perform some more complex analyses. Previously, it was just
10 me and, you know, one or two other staff. So, we've got some more capabilities in place now.
11 The other thing that we're doing is also sort of building staff expertise. So, in addition to this
12 contract, how can we sort of improve our own staff capabilities in this area?
13 And, I think these activities are going to help us on two fronts, and one is improving our processes
14 for analysis and making us more efficient in being able to replicate and automate production of MACStats
15 and other routine analyses that we do on an annual basis, but also to be able to quickly turn around new
16 analyses in response to the interests of the Commission over time.
17 I think the second area where this is going to help us is in carrying out more substantive analyses
18 that drill down into claims-level detail, looking at more detailed information than we have previously. And,
19 some of the questions we might be able to look at, for example, could be what is known about care received
20 by managed care enrollees.
21 One thing that we've talked about over and over again is encounter data, and we know that states
22 are submitting that information. Some states are submitting that information, and it hasn't been widely
23 analyzed. So, that's something we'll have the capability to look at, where it's available.

1 I think we can also explore some issues related to the use of specialty care and, more generally, the
2 types of providers that are used by Medicaid enrollees. It's not sort of ready for primetime in all states yet,
3 but to the extent that national provider identifiers are being used, we could use that information to link and
4 to look in more detail about the characteristics of providers that Medicaid enrollees are seeing.
5 So, a lot of these are aspirational, but I want to give you an idea of the kinds of issues that we might
6 be able to look at.
7 Another example might be, you know, what do we know about populations with high rates of
8 potentially avoidable hospitalizations. There's been a lot of work done on that issue, and so we might want
9 to think about how we could build on what's out there already.
10 The last area I want to talk about is qualitative information. I think when we talk about data we
11 tend to focus on quantitative information -- spending, utilization and that sort of thing. But, it's also
12 important for us to build sources of information on state programs and initiatives that provide context for
13 those quantitative analyses.
14 And, what we're doing is developing some state profiles on key policy issues, so going out and
15 looking at long-term services and supports, behavioral health and also some of the administrative and
16 organizational aspects of state Medicaid and CHIP programs -- something we've talked a lot about.
17 Right now, some of the issues we're considering are looking at what states are covering certain
18 services, whether they're using certain models of care. And, the kinds of questions that we could -- or,
19 issues we could look into in terms of whether it's useful for ID-ing states to follow up on best practices,
20 perhaps case studies.
21 So, this will just provide a sort of richer set of information to inform the work that we have going
22 on.
23 So, this is real quick today, and I want to take any comments that you have or ideas that you have

1 for us to focus on in the near future.

2 CHAIR ROWLAND: Mark.

3 COMMISSIONER HOYT: Well, talking about data, I'm just tingly all over. This is the best part

4 of the day. I'm feeling like a one-track mind kind of.

5 So, you didn't mention managed care. Inside the data, will there be flags for whether these people

6 were enrolled with managed care plans or medical home models or things like that so you can do some of

7 those comparisons?

8 MS. GRADY: There are flags for managed care enrollment. For some of these other care

9 models that are not plan-driven we probably won't be able to identify that information, but managed care

10 enrollment, certainly.

11 CHAIR ROWLAND: Burt.

12 COMMISSIONER EDELSTEIN: In order to reach Mark's level of --

13 COMMISSIONER ROSENBAUM: Tingling.

14 COMMISSIONER EDELSTEIN: -- enthusiasm, I just want to know -- and especially after the

15 two access reports, one on children and one on adults. Both mentioned oral health services only by their

16 exclusion. I'd just like to know that dental care, oral health, dental financing, dental systems, dental

17 managed care are all being included in these efforts.

18 MS. GRADY: I can't speak to the survey data analysis project in particular -- I'm looking at my

19 colleague -- about whether dental is addressed in that, but I do think we have a series of analyses that are

20 sort of being discussed in terms of what's available on the dental data front.

21 COMMISSIONER EDELSTEIN: Yeah, and it's not just the analyses. It's whether we're

22 building the data sets and including the information that will make it possible later to write something other

23 than we're excluding it because we don't know.

1 MS. GRADY: I can speak to the administrative data. The dental is in there, and we do plan to
2 use that information.
3 And, I think I'll defer on the surveys to my colleagues and follow up with you after the meeting.
4 CHAIR ROWLAND: April, I think one of the other things to assess -- we've had HRSA come
5 talk to us at various times about the provider databases and about provider availability. To what extent are
6 we building those into our data capacity?
7 MS. GRADY: So, as I mentioned, one of the potential areas that we can look into is the provider
8 identifiers that are on the Medicaid claims and looking at those. There's also been some discussion of
9 there are proprietary databases out there that ask physicians about their Medicaid participation and
10 potentially using that as a resource. So, we are discussing ways in which to come at this from different
11 angles to get the complete picture because I'm not sure that there's one data source out there that's going to
12 give us --
13 CHAIR ROWLAND: I'm thinking a little more of supply data rather than participation data,
14 about availability of certain types of providers in communities where Medicaid patients live.
15 MS. GRADY: That's not something we've focused on, but it's certainly an area --
16 CHAIR ROWLAND: It would go in part to some of Burt's concerns about where are there dental
17 providers, where are they using extenders and where are they not because I do think one of the issues that
18 we're going to have to get into is how to match the provider capacity side to the availability of insurance.
19 I have Mark, Andy, Sara. Do you I have you, Steve? Okay.
20 COMMISSIONER HOYT: Safe to assume you'll distinguish kids who are in CHIP to kids who
21 are in Medicaid?
22 MS. GRADY: That's a good question. Yes. So -- and further distinguish between Medicaid
23 Expansion CHIP enrollees and separate program CHIP enrollees.

1 In the administrative data, we do have relatively complete information on Medicaid Expansion
2 enrollees. It's still optional for states to be reporting person-level and claims-level data on separate CHIP
3 enrollees. So, that's something that we'll have to look at if we want to examine the separate CHIP
4 enrollees. We might have to go to multiple data sources.
5 CHAIR ROWLAND: Andy.
6 COMMISSIONER COHEN: April, this might be a little bit out of left field. Forgive me if it is.
7 It just crossed my mind.
8 You know we've talked a lot about various data limitations in Medicaid, but obviously, this is like a
9 very fast moving area. And, one of the reasons it is fast moving, not specifically with regard to Medicaid
10 data but just because of the -- in the last few years, pretty rapid deployment of electronic medical records
11 and a lot of providers and practices all over the country. I'm not sure that Medicaid is at the forefront of
12 that exactly, but nonetheless, it's nonetheless affecting Medicaid providers.
13 So I guess I'm just wondering; for a long-term strategy, are we thinking about ways that we could
14 someday not just rely on four-year-old claims data, if we're lucky, you know, coming from the states to CMS
15 to us, but thinking a little bit more about more direct routes to getting some richer, actual clinical data by,
16 you know, sort of leveraging REAs in New York State or I don't know what other mechanisms other states
17 are using.
18 But just, are we thinking, or are we -- is it more like we have to walk before we can fly?
19 Again, I caveated this by this may be left field and may be a conversation for more like a strategic
20 planning discussion, but it crossed my mind that, you know, there is this whole new world coming and do
21 we have -- are we thinking ahead to be prepared to take advantage of it.
22 EXECUTIVE DIRECTOR ZAWISTOWICH: I think you have to walk before you can fly, but
23 something that we would be interested in doing.

1 And, we've also been talking about what kinds of state-specific analyses that we could do, and this
2 may be conducive to that rather than trying to think more broadly, globally, nationally, to do something like
3 what you're mentioning.
4 COMMISSIONER MOORE: On that point, I understand Massachusetts has made a commitment
5 to drive EHR development and adoption throughout the state for all payers under Medicaid, and it might be
6 useful and interesting to have Julian Harris [phonetic] or some folks from there come and give us a briefing
7 on that because I think they're in a good position to be able to do that, a better position than most states.
8 And, I know that this is a commitment that the governors just made in the last few weeks, I think.
9 CHAIR ROWLAND: There are several states that really have looked at all payer databases too.
10 This is, of course, our knotty issue: When do we do all 50 states and when do we do 2 or 3 states
11 where we might dig deeper?
12 And, I think one of the things we ought to think about in our planning is what -- are there some
13 states out there like Massachusetts that we can learn from without the ability to be able to do it across all 50
14 states?
15 As Kate Baicker's presentation shows, sometimes you can learn a lot from one state. You may not
16 be able to generalize it all, but you can learn a lot.
17 Next, I have Sara, then Steve, then Judy.
18 COMMISSIONER ROSENBAUM: Just quickly, I would -- going back to the oral health issue, I
19 think one source of information we might take a look at to learn more about the growth of need and the
20 ability of the system to respond and what is shaping the scope and depth of the response is what has
21 happened to health centers. I mean, they have grown over the past 10 years. The numbers are
22 outstanding -- the dental capacity that health centers have run.
23 And, of course, with the health centers you have standardized data at the facility level, which means

1 we should be able to look at both trends in dental capacity growth, what it took HRSA to get dental capacity
2 growth off the ground, what happened in state -- and in various -- under various state Medicaid policies
3 because some of the growth was stunted by the fact that there was no money to support the service for
4 adults once the capacity was grown. Some growth efforts had to stop because there was no capacity once,
5 you know, once up and running.

6 And, we also could look at differences in scope-of-practice laws that might explain some difference
7 experiences of health centers in growing capacity.

8 I mean, I just -- I can't think of any place else where the government was able to mount a response
9 to the shortage of oral health services, where you get a sustained and potentially valuable examination of
10 what does or does not allow a system servicing the poor to grow capacity and then sustain it.

11 COMMISSIONER WALDREN: Yeah, my point was to -- I think we should start to look at -- I
12 really like the idea of the profiles and more quantitative data. And, in that, I think creating ontology to
13 start to be able to do roll-ups and move up and down in regards to that complexity, and I think that would
14 also help us as we get ready to fly with the EHRs.

15 I would say that about 85 percent of federally-qualified health centers have an EHR today. Each
16 one of those EHR databases are completely different. Even if they're using the same vendor, the data,
17 how it's structured, how it's coded, how it's put together is completely different. So, that notion of
18 ontology to be able to manage that complexity is going to be more and more important.

19 So, I want us to kind of consider that as we look at that qualitative data.

20 COMMISSIONER RILEY: April, could you speak a little bit about the state effort? Is this
21 mostly data mining to go and find what's web-based, or do you envision surveys and other kinds of more
22 in-the-face state activities?

23 MS. GRADY: I think the first step is certainly to use publically available information, mining state

1 web sites, and then based on sort of priorities that the Commission identifies if there is additional work to

2 be done. Sort of, checking in first and discussing that before a survey or anything like that is rolled out.

3 COMMISSIONER COHEN: That's also an issue that just -- I don't know -- leapt out at me a

4 little bit. From my very anecdotal and random efforts to go on a web site and learn something about a

5 state Medicaid plan, I found that often for major parts of the program there is nothing and often for small

6 parts of the program there is lots that may not actually correspond with what's been done over the last 10

7 years.

8 So, I do wonder a little bit about the quality of what you'll find online and whether -- I mean, I don't

9 know how you can do a little test to figure out whether this endeavor of using what's already on the web site

10 is worth it, but I might suggest that you try that. You know, do a few and validate them in some way or

11 another and see if that -- because it's a major effort, you know, to see if it is actually worth it, if the quality is

12 good enough.

13 MS. GRADY: And, I think just starting with topic areas and not going all out is one step in rolling

14 this out.

15 And, I should say it's not just state web site information necessarily. It's also compiling what's

16 available at CMS but might not be all in one spot for a particular topic, like behavioral health or long-term

17 services and support. So, it's a sort of gathering of information.

18 But, you're right; there are going to be things we cannot find online, and we'll need to do --

19 COMMISSIONER COHEN: Actually, I'm more worried things that you will find that are wrong

20 or outdated. That's actually my bigger worry.

21 CHAIR ROWLAND: And, I think you'll find that you could find the same data three different

22 places and it's all different data, which is sort of then what do you use.

23 But, it's not that we don't want you to try.

1 Mark.

2 COMMISSIONER HOYT: One thing you might try if you have time sort of reminds vaguely in a

3 way of when I did rate-setting in the 1930s. You would -- there were these HCFA-64 reports --

4 CHAIR ROWLAND: It's taken you one minute, and he's in the 1930s in another minute.

5 COMMISSIONER HOYT: And then, something else; there's this thought that was expressed of

6 these states were each doing it differently. It was more of a compliance effort, that we're required to do

7 this or expected to do this CMS. And then, once you started digging into it, you would never use that for

8 rate-setting.

9 So, my thought was if you can find the actuary of record who's signing -- if it's a state that does

10 managed care and somebody is certifying that rates are actuarially sound, ask the actuary of the firm: Do

11 you use this data source at all, or how do you use it? How does it impact your rate-setting?

12 And, if they sort of giggle or shrug, then that would be a bad sign. Or, they might say, yeah, that's

13 awesome. It's based on that.

14 MS. GRADY: I think you're raising an important point, which is what gets reported to the federal

15 government may or may not be what's actually used at the state level for various purposes.

16 And, one thing I didn't mention, that we will follow up on and have been sort of monitoring, are the

17 ongoing efforts at CMS that we talked about a lot in our first year. They have, you know, a number of

18 pilot projects underway for MSIS data and trying to look at what states are reporting there and mechanisms

19 for improvement, and that's something we can report back to you on in the future.

20 CHAIR ROWLAND: April, to go to Andy's point too, I mean, this may be an area where doing

21 not big, long case studies but where you go out and actually go to the state, two or three states, get some

22 information and talk to their budget people, talk to their Medicaid people and really be able to put together a

23 better profile of what's going on.

1 I'm not for 100-page case studies, but I am for getting some observational data from the -- on the
2 ground that might help explain and interpret some of these numbers that you would get off of a web site
3 and you couldn't really tell what they were saying.
4 Other comments for April?
5 Well, I think that building the data system that we're talking about is going to be really a requirement
6 for us to be able to produce the kind of recommendations and analysis that we're supposed to produce.
7 But also, bearing in mind that the Congress has asked us to provide cost data on any of our
8 recommendations that have cost impacts, it's going to be just critical to be able to have this capacity.
9 So, we're glad that we have April helping us to do this and Amy Bernstein helping us to build a data
10 library and really another sign of the maturing of our staff efforts. So, thank you very much.
11 MS. GRADY: Thank you.
12 CHAIR ROWLAND: And now if there any comments, questions or keen observations that
13 anyone from the public would like to share with us, we would welcome you to do so at this time.
14 Sure. And, please identify yourself and your organization.
15 ##### **PUBLIC COMMENT**
16 * MS. TOMAR: I'm Barbara Tomar from the College of Emergency Physicians and I just wanted to
17 make a couple of observations from the initial presentation by Anna Sommers and Emily Carrier.
18 I mean, we would totally agree that the training and the stand-by capacity of the emergency
19 departments in most places around the country are really more than what's needed for an average primary
20 care visit, but I think you just have to keep in mind, as Dr. Gray pointed out, that access is a huge problem.
21 We're very concerned about what's going to happen in 2014 when the demand outstrips the primary care
22 supply. And then you've got EMTALA. So you just can't get around that. And also, there's been some
23 studies about patient preference. I mean, patients like one-stop shopping.

1 And to that end, I just wanted to mention that right after the Deficit Reduction Act, when States
2 were allowed to have hospitals impose copays on non-emergency emergency visits, CMS and HRSA worked
3 together to provide a $50 million grant to 20 States to try to test different modes, like patient navigators,
4 folks that would be involved to help sort of wean some of the Medicaid patients away from the emergency
5 department. And that effort was really never -- the results of that effort were really never publicized and I
6 think there were probably some good lessons learned, that if we could have had them, it would have been
7 useful. But one of the things they did find out, at least from an anecdotal basis, is patients do like going to
8 the emergency department, even though you have to sit for hours at a time.
9 One other thing I just feel compelled to mention, if you will, is the whole idea of some of the States,
10 particularly Washington State, now Virginia, Tennessee, and some of the others, who don't want to pay for
11 emergency visits using the final diagnosis that turned out not to be an emergency as opposed to the
12 presenting condition. Emergency departments, emergency physicians, they have to deal with the
13 presenting condition. And in an imperfect world where everyone doesn't have data about patients and
14 doesn't have electronic health records, to get that data easily, it's just not right and it's really a violation of
15 prudent layperson. So I hope you don't support any States moving in that direction.
16 In fact, Billings, the algorithm which was developed really for a population base, as Dr. Billings has
17 said, he would be glad to go anywhere and testify that that is a very inappropriate use of his data.
18 Thank you.
19 CHAIR ROWLAND: Thank you very much, and your comments will be entered into the record
20 along with our discussion today.
21 MS. HOWELL: Hi. I'm Embry Howell from the Urban Institute, and all of the researchers, of
22 course, were drooling with data from the Oregon study. It occurred to me that one opportunity might
23 arise -- in a way, one side of me hopes not -- but if some States don't take up the option for the Medicaid

1 expansion uninsured adults, or if they want to look for ways to take it up in a limited way, that perhaps your
2 recommendation could be to CMS to be alerted to the opportunities that the Oregon study kind of set the
3 stage for as those options go forth.
4 CHAIR ROWLAND: Thank you, and we're hoping that Dr. Baker will also give us some
5 guidelines as to how those comparisons might be put together in terms of the evaluation. I think one of
6 the things we've all learned is that there used to be far more intensive evaluations of the early Oregon
7 experiment and of the 1115 waivers, and one of the issues that I think we need to take up is to what extent
8 should we be trying to evaluate and put resources or have CMS put resources into the evaluation of some of
9 these efforts. It's great that Oregon is cooperating and that that study is being funded, but there's probably
10 a lot more we can learn about what's going on in very different States.
11 Well, this will conclude today's session of MACPAC. I thank all of the presenters, who I think
12 gave us a lot of food for thought, and the audience for being with us. And I really appreciate the fact that
13 today we actually had comments from the public, and we would welcome more in the future. Thank you
14 very much.
15 Adjourned for today.
16 [Whereupon, at 4:54 p.m., the meeting was adjourned, to reconvene at 9:00 a.m. on Friday,
17 September 21, 2012.
18
19

MACPAC

Medicaid and CHIP Payment and Access Commission

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

Hall of States
National Guard Association of the U.S.
One Massachusetts Avenue, NW
Washington, D.C. 20001

Friday, September 21, 2012
9:06 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
ANDREA COHEN, JD
BURTON L. EDELSTEIN, DDS, MPH
PATRICIA GABOW, MD
HERMAN GRAY, MD, MBA
DENISE HENNING, CNM, MSN
MARK HOYT, FSA, MAAA
NORMA MARTINEZ ROGERS, PhD, RN, FAAN
JUDITH MOORE
TRISH RILEY, MS
SARA ROSENBAUM, JD
ROBIN SMITH
STEVEN WALDREN, MD, MS

LU ZAWISTOWICH, ScD, Executive Director

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P R O C E E D I N G S [9:06 a.m.]

CHAIR ROWLAND: Good morning, and welcome to the continuation of the Medicaid and CHIP Payment and Access Commission September 2012 meeting. We had a very productive day yesterday and are looking forward to similar productivity today. In terms of the agenda, we want to begin first by updating you on the work underway and the chapter in preparation for our next report that will deal with persons enrolled in Medicaid and Medicare.

As everyone knows, it's a very topical issue today. Medicaid plays a critical role for low-income Medicare beneficiaries. In fact, many say it makes Medicare work for those with the lowest incomes, especially those who need not only health care assistance in terms of premiums and other supports, but especially the long-term care services that Medicaid provides.

So we're going to ask Ellen O'Brien on the Commission staff to update us on the work that is underway and the plans for our chapter.

UPDATE ON PERSONS ENROLLED IN MEDICAID AND MEDICARE

* DR. O'BRIEN: Thanks, Diane. I'm doing the update, but I'm just representing a number of my colleagues who are working on these issues as well, too many mention, but everyone's playing a role here. Chris Park, Jim Teisl, April Grady, and Molly McGinn-Shapiro are providing incredible support.

So just in terms of a context for today's discussion, you will recall that we have been talking about the duals for some time. In September of 2011, you heard from representatives from the federal government, from states, and from beneficiary advocates talking about the continuum of care for people who are dually eligible for Medicare and Medicaid and issues related to the coordination of care for these oftentimes high-cost, high-need populations.

In April, Melanie Bella joined us to discuss the activities of her office, the CMS Medicare and

1 Medicaid Coordination Office, activities related to fee-for-service alignment, data issues, their own
2 coordinating working with merged Medicare-Medicaid data to describe these populations; and, of course,
3 the CMS integration of care and financial alignment demonstrations. And then in May, we continued the
4 discussion with an update from the staff on issues related to the design and implementation of those
5 demonstrations.

6 The staff in addition have been developing our research agenda on dual eligibles, and you heard
7 from April Grady yesterday about our work with Medicare and Medicaid claims data and survey data to
8 develop a population profile on dual-eligible subpopulations. We in addition are doing work on integrated
9 programs for duals, focusing on the PACE and special needs plans for duals.

10 We are continuing to track on an internal basis the CMS demonstrations. We have a project
11 ongoing related to enrollment of special needs populations into Medicaid managed care and want to draw
12 out lessons for potential enrollment of duals into managed care plans.

13 And then we have a project tracking state policies on Medicaid payment for Medicare cost sharing,
14 and I'm happy to come back and discuss any of those projects and how they're related to a potential chapter.

15 So the purpose of this session is to take a bit of a step back and broaden the discussion of dual
16 eligibles to talk about sort of the core policy questions and to have you weigh in on your priorities for our
17 research agenda and for a chapter in March of 2013.

18 So broadening the discussion, what do we mean? We want to take a step back and focus on the
19 key policy questions related to duals, and here are some of the questions that we have identified, but we'd
20 like to hear from you about whether these are the right questions and how we might frame this discussion.

21 So the key questions: What is Medicaid's role for low-income people with Medicare? We'd like to
22 describe the program's role and then understand who those dual eligibles are. We'd like to know about the
23 quality and appropriateness of the services duals receive. And then we'd ask, What do we know about how

1 the programs can be improved to provide better access, higher quality of care and services, and better

2 outcomes? And then, finally, what do we know about the impact of these kinds of program improvements

3 on cost?

4 So in this presentation, I'm going to use these key questions as a guide and a potential -- in thinking

5 about a potential framework for a chapter, and I'll briefly present a few key findings related to these

6 questions to provide a sense of the kinds of information and evidence we can bring to bear. This is not a

7 systematic presentation, but more in the spirit of providing a few highlights to help get the conversation

8 started and invite your comments on the population, the programs, what we know, and how the programs

9 could work better and have you identify key priorities.

10 So starting with the first question: What is Medicaid's role for dual eligibles? As you well know --

11 and this is all a review -- Medicare is the primary payer for duals and covers hospital and post-acute care,

12 physician services, and prescription drugs until the implementation of Medicare Part D in 2006. Medicaid

13 covers long-term care and related services and provides assistance with Medicare premiums and is a

14 secondary payer for Medicare-covered services.

15 So as indicated in this slide, Medicaid's role for dual eligibles varies depending on individuals' needs

16 and circumstances and also clearly state policy choices. This presentation provides a national lens and a

17 few national averages, but the benefits dual eligibles receive through Medicaid vary across the country

18 depending on those state choices.

19 All dual eligibles gain Medicaid eligibility by meeting financial and categorical criteria defined by

20 federal and state rules, including age or disability-related criteria. Most non-elderly adults who are dual

21 eligible come into Medicaid through the Supplemental Security Income program, SSI, which is available to

22 very low income adults who are disabled, according to the SSI definition of inability to engage in substantial

23 gainful activity due to a medically determinable physical or mental condition. SSI is also available to the

1 elderly poor with incomes below 73 percent of the federal poverty level who have also very limited assets.

2 Others qualify for full Medicaid benefits through a medically needy or spend-down pathway, and

3 low-income beneficiaries in Medicare may become eligible for Medicaid assistance, only limited assistance

4 from Medicaid, with Medicare premiums and cost sharing through one of the four Medicare savings

5 programs established by the Congress in the 1980s and the 1990s: the Qualified Medicare Beneficiary

6 Program, the Specified Low-Income Beneficiary Program, the Qualifying Individuals Program, and the

7 Qualified Disabled and Working Individuals Program. Each of these four programs has different income

8 eligibility requirements and levels of benefits.

9 So, in sum, people come in through different ways. About two-thirds of duals are over the age of

10 65, about a third are under the age of 65. More than two-thirds receive full Medicaid benefits, and about a

11 third Medicaid provides only assistance with Medicare premiums and potentially cost sharing.

12 As shown in this slide, then, to sum up Medicaid's role, again, on a very aggregate basis, on a

13 national basis, long-term services and supports account for 69 percent of all Medicaid spending on duals;

14 about 5 percent is for other medical services not covered by Medicare; and 25 percent of Medicaid spending

15 on duals is for Medicare premiums and cost sharing.

16 Since people come into this program through different pathways at different ages, young and old,

17 some with lifelong disabilities, some who have become disabled at midlife, some who are frail or disabled in

18 old age, who arrive at Medicare eligibility -- or, I'm sorry, and who arrive at Medicare eligibility with very low

19 incomes, dependent perhaps on a very modest Social Security benefit or an SSI benefit but in relatively good

20 health. But on average across the nation, most people in Medicaid then are poor or have very low incomes

21 and have indicators associated with being very poor or low income. More than 60 percent of duals have

22 less than a high school education. Again, since they come in obviously with high medical needs and high

23 medical spending, 60 percent of duals have multiple chronic physical conditions; 20 percent of duals have

1 more than one mental or cognitive condition. Nearly a quarter have three or more limitations in activities
2 of daily living; they have a disability of some kind. Roughly 17 percent of elderly dual eligibles are
3 receiving long-term services and supports in a nursing home or other institutional setting. About a quarter
4 of duals use any home and community-based services in Medicaid. I'm sorry. Did I say -- about a quarter
5 of elderly duals and about 20 percent of non-elderly duals use any home and community-based services in
6 Medicaid.
7 VICE CHAIR SUNDWALL: Ellen, I just want to clarify and go back a little bit. Did I
8 understand you to say 69 percent of the money spent on duals is for Medicaid?
9 DR. O'BRIEN: This is just Medicaid spending. Of the Medicaid spending on duals, nearly 70
10 percent is for long-term services and supports. This presentation gives you a Medicaid perspective, and as
11 April discussed and we'll discuss some more here today, we are working on an analysis that will combine the
12 Medicaid and Medicare spending so you can get a complete picture. But today I decided to focus from a
13 Medicaid perspective, thinking of the Medicaid program, what is Medicaid's role for duals.
14 Okay. So that was just a flavor. Those statistics come from various sources. I didn't cite them
15 all. But we're in the process of developing our own analysis, and in the chapter we could clearly describe
16 characteristics of dual-eligible subpopulations for you. And so I wanted to ask you today then what your
17 priorities would be for how we should describe these dual-eligible populations. We could look at them by
18 age. We could look at them by how they came into Medicaid; whether they came into Medicaid first and
19 then aged into Medicare, or acquired Medicare benefits after a two-year waiting period, for example, in
20 SSDI; whether they are full-benefit duals or partial-benefit duals. We can look at them in terms of the
21 extent of disability they may have and their needs for assistance with those activities of daily living. We can
22 look at them in terms of the kinds of chronic conditions that they have, the diagnoses they have. We can
23 look at them in terms of their service utilization across the programs. What kinds of services are they

1 using in each program? What is the intensity of their service use in each program? And how do duals
2 receive those services today?
3 We could focus on those who are receiving services in the fee-for-service setting, in managed care,
4 either Medicare managed care or Medicaid managed care or both, or sort of the mix of possibilities. We
5 can look at those who are receiving home and community-based services through waivers versus state plan
6 services. We can look at those who are in integrated programs today, like PACE or potentially a fully
7 integrated D-SNP.
8 We could look at them in terms of those who are most costly or least costly to Medicare or Medicaid
9 and across both programs. What would your priorities be for how we should describe these populations to
10 make them concrete to inform our discussion of the need for policy reform and to shed light on the kinds
11 of issues that product reforms must address.
12 So hold that, but we're going to come back at the end and revisit this and ask you to hold forth.
13 Our third question then is: What do we know about the quality and appropriateness of services
14 duals receive? Well, we know, I think, that Medicaid provides critically important benefits to more than 9
15 million dually eligible beneficiaries. We want to know, though, about the importance of these services in
16 terms of health and well-being and the importance of Medicaid's financial protections for improving access
17 to Medicare services. You know, we heard from Kate Baicker yesterday, and she used the results of the
18 Oregon health insurance expansion to demonstrate the importance of expanding health insurance coverage
19 to previously uninsured adults in Oregon, demonstrating that there were statistically significant increases in
20 the utilization of health care services for those people who were newly covered by Medicaid and that there
21 were significant improvements in their health and well-being.
22 In the case of dual eligibles, and in particular in the case of people using long-term services and
23 supports in Medicaid, I think it's harder to find studies that demonstrate the value of these services and their

1 impact on individual health, function, and well-being, and family well-being as well. But there are some
2 studies, and they warrant careful study, and I think we would propose in a chapter to go through some of
3 that best evidence to shed light on the importance of Medicaid for people who are dually eligible.
4 So the programs fundamentally alleviate financial burdens and improve access to Medicare services
5 for people who are enrolled in those Medicare savings programs, for example, and they provide substantial
6 assistance to some people with needs for long-term services and supports.
7 Nevertheless, gaps and challenges remain. We know there are opportunities for program
8 improvement. We'd like to try to find out where they are and for whom. There are important
9 opportunities to improve the programs. Dual eligibles generally express satisfaction with the availability of
10 care and quality of care, but we do know from survey data that duals are less likely than non-duals in
11 Medicare to report satisfaction with the availability and quality of care, for example.
12 Other challenges. Thinking about the clinical quality of care for duals compared to non-dual
13 populations in Medicare, researchers have developed a relatively comprehensive system for measuring
14 underuse of necessary care among elderly patients who have used services in Medicare, inpatient and
15 outpatient services in Medicare. They look at those Medicare claims data to see whether the elderly have
16 received appropriate care, and these indicators show the proportion of beneficiaries receiving care by
17 indicators of necessary care, necessary acute care, necessary preventive care, as well as indicators of
18 avoidable outcomes.
19 I couldn't put all this on the slide, but analysis of these indicators shows that the elderly often do not
20 receive necessary -- the indicated care, and there is significantly more underuse in populations known to
21 receive less than average medical care. These indicators tend to show that dual eligibles fare worse than
22 other Medicare beneficiaries. African Americans, across the elderly, African Americans tend to fare worse
23 than -- receive lower-quality care than whites. Residents of high-poverty areas fare worse on these

1 indicators than non-residents. Residents of health professional shortage areas fare worse than
2 non-residents of those areas.
3 These indicators cross a range of conditions and services. They look at people with heart and
4 circulatory system disorders, with breast cancer, with diabetes, with gastrointestinal bleeding, with anemia,
5 with visual impairment. But just looking at some heart and circulatory condition indicators here, you see
6 that analysis of these data suggests that duals receive lower-quality care. And the first one, actually -- most
7 are receiving the indicated care, and duals do far about as well as non-duals in Medicare. They receive a
8 chest X-ray within three months of initial diagnosis of congestive heart failure. But looking at the other
9 two indicators, the duals receive lower-quality care. Among patients with known angina, what proportion
10 had three or more ED visits for a cardiovascular-related diagnosis within one year? 9.5 percent of duals,
11 3.4 percent of non-duals.
12 COMMISSIONER RILEY: Are these risk-adjusted, or do we assume the characteristics of a
13 non-dual and a dual are about the same?
14 DR. O'BRIEN: These are risk-adjusted, I believe, yeah.
15 CHAIR ROWLAND: Do they include duals in all settings, including in the nursing home? Or
16 do they just include duals in the community?
17 DR. O'BRIEN: I believe this is looking at all Medicare inpatient and outpatient claims. I don't
18 know that they know the residence of the individual Medicare beneficiary.
19 COMMISSIONER WALDREN: I'd just also say that not only do we have to look at it
20 risk-adjusted, but I think we also have to look at prognosis-adjusted as well. So if the majority -- if a large
21 proportion of the non-duals are in long-term care, there may be advance directives that say that they don't
22 want certain things to be done, so if it's new onset with congestive heart failure, known co-morbidities that
23 cause CHF, I'm probably not -- I don't practice now, but when I did, I probably wouldn't do another chest

1 X-ray because it's not going to change the way that I would take care of that individual. It might be all
2 palliative and trying to do that. And the same thing with angina and other things. So I think we have to
3 also maybe look at some of the prognosis-related adjusting as well.
4 DR. O'BRIEN: I knew I was going to invite more questions than I could answer with this one,
5 but I wanted to toss it out there because I think it's interesting. I don't think we see this kind of detailed
6 look from the Medicaid perspective, and we'd like to look with this new merged claims data analysis at
7 whether we can look at these kind of quality indicators for our populations and potentially make it richer
8 because we have access to the Medicaid claims to look at people by setting, for example, by their residence,
9 whether institutional or community.
10 CHAIR ROWLAND: So you will be able to tell that from the merged data?
11 DR. O'BRIEN: Well, we're going to look into whether we can. April? You know, we are just
12 starting to think about what -- to assess the feasibility of doing this.
13 CHAIR ROWLAND: I mean, one of our key points has been that one dual is not the same as
14 another dual eligible, and that you have to take into account the diversity of this population, which clearly
15 includes whether they're institutionalized or in the community, whether they're using long-term care services
16 or not. So I think it's really critical that those kind of factors be weighed in whatever the numbers we
17 produce.
18 COMMISSIONER COHEN: Just to echo the point, we've all seen many, many descriptions of
19 dual eligibles as a group, but they're so different, and just a listing of how different they are also doesn't
20 really, you know, sort of move the ball that much. So I think if, for example, we can't tell with the merged
21 data set where someone is living or what's the reason that they're a dual or whether they primarily have a
22 behavioral issue, you know, a behavioral health issue or something else, I mean, I think we really have to
23 look at analyses that can move towards new models or that can identify particular issues that are relevant to

1 them -- you know, that are relevant to the fact that they're in two programs.

2 We learned in our report on people with disabilities that even in one program, when you have

3 people with disabilities, we haven't found the silver bullet for necessarily understanding how well we are

4 improving or maintaining the health of that population. So there's lots of interest in talking about duals.

5 There's a sense in the health policy community that there's a great potential to save money and improve

6 outcomes. But I think until we can really isolate the specific nature of the problems or gaps by the

7 individual's primary issues or location or setting, we're not able to really move the ball forward.

8 So to me, these are foundational questions on whether we know setting, whether we know primary

9 sort of diagnoses, things like that. If we can't get that from claims data, I'm a little bit at a loss as to what is

10 the best way to move forward to get us to, again, an actionable recommendation.

11 CHAIR ROWLAND: Lu, did you want to comment?

12 EXECUTIVE DIRECTOR ZAWISTOWICH: I was just going to say that in our proposed

13 analyses looking at the merger of the claims data, we will be able to look at the duals by setting. So, for

14 example, we will be able to answer the question, for individuals that are institutional, are they primarily

15 Medicare service-oriented -- are the services that they are getting primarily Medicare-oriented or are they

16 Medicaid-oriented? We'll be able to look at individuals in the community and answer the same kinds of

17 questions.

18 So I think as we begin to profile the duals in these various settings, we'll be able to answer the

19 questions about what co-morbidities, what care coordination issues are needed to address their total care

20 needs.

21 COMMISSIONER MOORE: Not to pile on here, but the next step beyond identifying where

22 people are and what their needs are and so forth is questions related to these outcomes and the quality that

23 may be inherent, and I don't -- with claims data you always have problems getting to that. But to the

1 extent that we can, I think that's a very high priority as well.

2 VICE CHAIR SUNDWALL: A question. Thank you for this. It is frustrating because it gets

3 to be very complicated if you slice and dice this data so many ways. But my clinical experience would

4 suggest that overutilization is as much of a problem as underutilization. I shouldn't quantify and say "as

5 much as," but it is a problem. Do you have any measures where we can -- is there any way to measure

6 overutilization of services among the duals when there are various categories?

7 DR. O'BRIEN: I'm not sure. I mean, we should definitely look into that. We should definitely

8 add it to our list. Is there evidence of duplication of services? I'm sure we'll be getting some counts of

9 service utilization for the dual-eligible population compared to the non-duals.

10 VICE CHAIR SUNDWALL: The point is there's no end to the needs because of their

11 complicated situation, but there's such a thing as too much medical care. And I think if I were a staffer, I'd

12 want to know if there were ways where we could have it more medically necessary services than what the

13 patient wants.

14 DR. O'BRIEN: Right. I suppose that sub bullet on ED visits some might say that's an indication

15 somebody's coming to the ED for cardiovascular-related diagnoses, this person may not be adequately

16 supported at home. Who is this person with congestive heart failure coming in with pain that's not

17 managed, whose home care aide or family cannot adequately manage them at home?

18 CHAIR ROWLAND: Well, and clearly, you're going to look at hospitalization rates, too.

19 COMMISSIONER ROSENBAUM: So trying to think at the most global level for a minute, it

20 seems to me that the question everybody's trying to answer is how do you best organization a care system

21 for a heavily health-burdened population. And I think that if we -- I mean, there are a number of

22 questions there. There are, of course, the clinical social questions, social service questions. There's also

23 the question of whether and what can be gained, if anything, by, in fact, having people establish membership

1 in such a system, a formal membership that essentially both gives them a place that's truly a health home but
2 also limits their freedom of choice. That I think is sort of the crux of the question here, and if we --
3 because then underneath it you have questions. I mean, those are the policy questions. Should states be
4 able to have the option or at least through a waiver the ability to assign people to a system with some limited
5 choice options? If so, if they're going to have that option, what are the criteria by which we would
6 measure whether the system is a system that qualifies as one that can accept enrollment from this kind of a
7 population?
8 And so all of these issues -- who are they, what is their health profile, where do they live, are they
9 residents of institutions -- and it's not just sort of at any given time, but what's the likelihood that they're
10 going to be residing in an institution? That doesn't mean you can't have them in a delivery system, but it
11 means that you want them in a system that can hopefully minimize their lengths of stay in any residential
12 institution.
13 But unlike some populations -- I mean, in the end the question is the question that bedevils
14 Medicaid, I think, regardless of who the population is. But here, if we make clear to policymakers in our
15 writing that getting to the answers to this question involves in some ways -- I don't want to be dismissive of
16 other subpopulations, but it's more complex both because they're extremely complex patients and because,
17 unlike with most Medicaid, there are two payment systems that have in many respects highly incompatible
18 internal operating procedures.
19 And what I've lost track of, quite frankly, with this population is whether what we're thinking about
20 -- and I think this is where MACPAC plays the great contribution role -- is how much it's two payers
21 fighting with each other about how they want to do things versus what are the choices that have to be made
22 about matching this population with a delivery system that makes more sense than what they're in today.
23 I have raised this with a number of people, and I'll say it again for our public meeting. I have been

1 watching with, quite frankly, alarm for the past decade, decade and a half, as the number, the sheer number
2 of Medicare beneficiaries in community health centers doubles. Now, it's not because I have any doubts
3 about the ability of community health centers, but the steep increase started after the 1997 coordination of
4 benefits statute was enacted. And what I think is happening is that some of those folks are aging in place,
5 but a lot of them are settling into life in a community health center, which is fine, but they're settling in there
6 because they have no other access points. And so I want to be sure, as we're thinking about what's best
7 for this population, that we have a real understanding about how the health care system is relating to them
8 today, because, in fact, if they have little in the way of realistic access, then that may lead us to a more
9 ambitious set of recommendations about changing the delivery system than if, in fact, they're using care with
10 ease today, they're just not connecting with care that's good for them.
11 And so I don't know if there's any way that we can shed light on how this population gains access to
12 care. How many of them have a choice in their entry point into care? How many of them have an entry
13 point into care that is the result of being shut out of a lot of other places? And I don't know that anything
14 that we have can do that, but I would think if we're going to try and invest a little bit of money in whether
15 it's focus groups, surveys, anything that we can do to learn a little bit about how they use care and their ease
16 of access into care, that would be a good investment.
17 CHAIR ROWLAND: Sara, I think that that's a point that when in our discussions with MedPAC
18 was a priority for MedPAC as well, to know where is the -- and where are the acute care services for the
19 Medicare population being delivered and how do those relate to that for other Medicare beneficiaries. So,
20 I think MedPAC, in your joint analysis of some of this data, would be interested in some of the same
21 questions.
22 The next I have Burt, then Patty.
23 COMMISSIONER EDELSTEIN: Yeah, recognizing how diverse this population is, I wanted to--

1 I was reflecting on and wanted to follow up with Steve about how you do prognosis-adjusted analysis.

2 Is there anything better than just if they're on hospice, not in hospice?

3 Is there some way that the MACPAC data set as it's developed can truly pull out those people for

4 whom levels of medical care, and certainly intensive medical care, are not appropriate?

5 COMMISSIONER WALDREN: Well, I mean, the short answer is no. I don't think we have

6 good data to do that. And, it's probably more of saying -- instead of saying that we have to do that kind of

7 analysis but to put that as a caveat.

8 So, one of my big challenges is when we talk about quality around this table and when I talk about

9 quality around other tables, the definitions are not the same.

10 So, when I think about quality, I think about all those issues around these things, but then when

11 we're talking about these things, we're really talking about also performance because we're going to tie that

12 to utilization and payment and those types of things.

13 So, you know, I think what we don't want to do is say, okay, if we use this as the measure, then

14 people that don't need a chest x-ray are going through the hassle and the potential harm of getting x-rays so

15 we can make sure that it's the same as, you know, non-duals, for example.

16 So, I think it's more just a realization that that's an issue than I think we can really do any thoughtful

17 analysis because we just don't have the data.

18 COMMISSIONER EDELSTEIN: And, Ellen, do we have any idea how big that particular

19 populations is -- those end-of life?

20 I mean, we're noted in this country for doing far more at end-of-life than other systems of care

21 provide. Do we have any idea how many of these duals are in that place in their lives?

22 DR. O'BRIEN: Well, we will know the age. We'll know whether they use hospice services. I

23 don't know that we'll have -- we'll be doing claims analysis where we look back to see -- you know. We

1 have a death date and then look back at what the service utilization and expenditure was for somebody who
2 died in a particular calendar year. But, we can assess the feasibility of doing that as well.
3 COMMISSIONER GABOW: In line with this conversation, I do think that as we look at quality
4 it's very important in this group to look at overuse as well as underuse, as we've been talking about.
5 And, since I have a mother with dementia who is in a facility and I'm over there a lot, I would say I
6 see a lot of overuse, and I'll give you just one example that may relate to the ED visits is that the -- we run
7 the -- Denver Health runs the ambulance service for the City and County of Denver, and we all -- there's
8 always an ambulance there, virtually all the time when I go there.
9 And, I think what -- I don't know what happens, but my perception is this: That they're in a facility.
10 The facility doesn't want -- if they don't have a clear advance directive, the facility always wants to err on the
11 side of sending someone to the hospital whenever they have an issue, and many of them are not able to well
12 articulate what's wrong. So, the sort of answer to the question is to call the ambulance, and the ambulance
13 takes them to the ED.
14 I think -- so, I think one of the things we could add to this discussion is really having clarity about
15 what people want done, which I think is often lacking, and so caregivers resort to the safest for them
16 solution.
17 So -- and I could give you many other examples of overuse that I've seen from this, but -- so, I think
18 as we look at quality we really need to be -- I want to underscore that we really need to look at overuse as
19 well as underuse.
20 And, I think in that regard the ABIM, which just put out this Choosing Wisely, these 50 things that
21 you probably don't want to have done, that -- I think thinking about recommending that a Choosing Wisely
22 list for the various segments of this population would be valuable resource because people really don't know
23 what they should be doing for this group.

1 The other thing I would hope we come out of this with is simplification because that's what I always
2 say. But, just to talk about how absurd one of these things is, whenever I hear that Medicaid is paying
3 premium support for poor elders who can't afford Medicare, a reasonable person would say, why doesn't
4 Medicare simply waive the premium for people who have a certain income level? Make it simple for the
5 person. Make it simple for the system.
6 So, I think that we should not -- while we can't make that as a recommendation because we don't
7 have the analytics, I think thinking of putting things in the chapter to say, a reasonable person would not do
8 it this way. Maybe we should look at this sort of simplification and at least throw out some potentials that
9 people should do the financial.
10 I mean, I get that, you know, the state is paying some of it with this supplement, but the cost of
11 moving money around has some cost then. So, I think we should look at some -- throw out some
12 alternatives for simplification.
13 CHAIR ROWLAND: Patty, I think that that's a really good addition to our discussion.
14 Clearly, the history was that Medicare was not means-tested, so we were going to have any
15 means-related program be Medicaid that picked up those premiums. But, when Part D was enacted and
16 the low income subsidy was put into Part D, it really opened the ability for Medicare to do things on a
17 income-related basis.
18 And, as Ellen pointed out, a substantial share of what Medicaid is spending on some of this dual
19 population is exclusively for premiums and cost-sharing.
20 So, I think that as we work with MedPAC that would perhaps be a reasonable place for us to offer
21 some guidance.
22 COMMISSIONER GABOW: And, clearly, wealthier people do pay a higher premium for
23 Medicare. So, why can't poor people pay a lower premium and have it all within the system?

1 I mean, I don't know that that's the ultimate answer, but I think putting out things to be considered

2 toward simplification, like that, make sense.

3 CHAIR ROWLAND: Andy, then Mark, I think. Yeah.

4 COMMISSIONER COHEN: Two quick points. So just to follow up on the point about looking

5 at the location or the setting of care, I'm also interested very much. I think it would be useful in the

6 discussion around some of these duals demonstrations too because there is sort of fundamentally a bit of a

7 struggle here, whether -- which program is better equipped to manage the dual eligible population.

8 And, I think one of the pieces of information that's very important to that is to understand where

9 these people are receiving care. And, when I say where, I don't mean in a nursing home versus not -- you

10 know, in the community although that's a very important one too, but also the types of acute care entities

11 that they are going to.

12 Are these -- is this the -- you know. What proportion of them are seen in the safety net kinds of

13 hospitals and institutions that probably -- that care -- that potentially cared for them when they were under

14 65 or not disabled and in Medicaid? And those -- many of them are extremely Medicaid-dependent.

15 Medicaid is their dominant payer, and really, it's Medicaid incentives and payments that really have more

16 ability to drive or impact the way they deliver care.

17 So, I do think this question of how many of them are seen in settings where Medicaid is the

18 dominant payer versus I guess, you know, other institutions that are sort of more -- I hate to sort of put it

19 this way, but mainstream health care system, I think is an important question that could help with this

20 question of how these demonstrations might be designed.

21 And, there might be great variation by place and by state and even by city. I have a strong sense of

22 what that might look like in New York City, but that might be very different from other places.

23 So, anyway, that's one nuance on the place of care question.

1 The other thing that I wanted to raise as a possible area of exploration -- and I've been interested in
2 this for a long time. Again, maybe I'm showing a bit of a New York bias here, but this question of the
3 extent to which Medicaid benefit packages and what they cover, especially in the long-term service and
4 support arena, impact spending and utilization of benefits that are otherwise covered by Medicare.
5 So, again, just using New York City as an example because it's one with which I am more familiar,
6 personal care service has been quite available in New York City, heavily used. It's now moving into a
7 managed arrangement out of a Fee-for-Service arrangement but still is going to be available to people who
8 need it in the community.
9 You know, people have views and instincts. The degree to which that presents unnecessary
10 hospitalizations, unnecessary nursing home stays, the nursing home rate actually is extremely -- is quite low.
11 But, you know, some real analysis about the extent to which a Medicaid benefit package impacts the
12 Medicare benefit, other and institutional use I think would be a very interesting place to look with that
13 merged data.
14 COMMISSIONER HOYT: I'd like to quote that famous Congressional staffer, Tom Cruise, and
15 scream "Show me the money!"
16 I'm not being totally coy. I think if we're hopeful of making recommendations in the March report
17 I would splash dollars all through this, much more than I'm seeing so far, in terms of who are the duals,
18 both on an individual -- what does a Medicaid dual cost just on the Medicaid side? What does it cost
19 Medicare? What's the total?
20 If there are nine million of them, you know, multiply it out. Get to an aggregate amount.
21 It's a pretty confusing topic area to the uninitiated, and you just get kind of lost in the weeds, but I
22 think the money is always a big attention grabber. If we're hoping to actually make some changes here, I
23 think that would be helpful trying to drive some of that.

1 DR. O'BRIEN: Mm-hmm.

2 COMMISSIONER HENNING: Well, it's hard to top "Show me the money," but in my clinic I
3 have the same, "It's Medicaid. It doesn't have to make sense." That's usually associated with birth
4 control issues.

5 But, you know, I was thinking when Patty was talking. A hundred years ago in this country most
6 births happened at home and most people died at home, surrounded by their family members.

7 And, we have gotten so far away from the natural cycle of life, such that family members are scared
8 when their family members or loved ones are nearing the ends of their lives and they really don't know how
9 to handle it. They may know they're terminally ill, but what they -- their first instinct is to call the
10 ambulance and to take them to the hospital, and then they end up eventually dying there when that's
11 probably not what that person really wanted.

12 And, I can tell you from experience that when you call the ambulance it doesn't matter if you have
13 advance directives because they won't follow them. They pretty much -- they have to do everything.
14 Because you called them, you basically now voided that advance directive.

15 So, I think that one thing that would be really helpful somehow is to expand the hospice model such
16 that Americans could make decisions for themselves way before they need to and be more cognizant of
17 what these interventions are like. You know, what being on a vent is like, what having someone do CPR
18 on you is like. You know, do you want this done? And make the decisions way ahead of time and make
19 sure that your family knows what you want so that you don't have to be in that situation at the end of your
20 life.

21 You know, I personally would rather die at home, and I hope that I die doing something that I really
22 like doing, but I don't want to be in a hospital bed. That much, I can tell you.

23 COMMISSIONER RILEY: I'm well aware that we are messing up Ellen's presentation, and I'm

1 eager to get -- but we do that so well.

2 But, I want to get to the opportunities for program improvement, but I think we almost need the

3 construct first of how do we break this down. I'm channeling Patty and Andy and Mark a little bit.

4 I wonder if there's a way to sort of restructure the approach here, how to disaggregate this big

5 monolith. Is there a way to look at the data in three different buckets, which would be people who are

6 premium support only, where Medicaid is only paying premium support, people for whom the majority of

7 their care is paid for by Medicaid, people for whom the majority of care is paid by Medicare?

8 It seems to me that that captures all the subsets but gives us what we really need for policy

9 recommendations because it really identifies where the money -- what was that thing, Mark? Show me the

10 money?

11 CHAIR ROWLAND: There's an older phrase called "Follow the money" --

12 COMMISSIONER RILEY: Follow the money.

13 CHAIR ROWLAND: -- which came from the Watergate era.

14 COMMISSIONER RILEY: But, none of us remember that because we're not old enough.

15 Certainly not you, even if it is your birthday.

16 I want everybody to know it is Lu's birthday today.

17 But, if there's a way -- I don't know if the data lets us do it, but it seems to me those buckets make a

18 ton more sense for policy analysis and may get at some of the issues we talked about this morning.

19 CHAIR ROWLAND: We also do know from some of the data that some of the highest cost

20 Medicare duals are high cost to Medicare but not to Medicaid, and vice versa. And, a lot of that depends

21 on services that they're using.

22 COMMISSIONER RILEY: And, who -- and the distance then is between the two programs

23 become -- the misalignments become clearer that way, where the money goes. It seems to me that might

1 be a construct that would really help us.

2 CHAIR ROWLAND: Okay.

3 COMMISSIONER GABOW: I want to second that.

4 CHAIR ROWLAND: You can because it sounds like it's a simplification.

5 Norma.

6 COMMISSIONER MARTINEZ ROGERS: I was going to add something to what Denise was

7 saying, but it's really -- I guess we should move forward. Thank you.

8 CHAIR ROWLAND: Good.

9 DR. O'BRIEN: I think we can definitely do that -- array people in terms of where they are in the

10 distribution.

11 COMMISSIONER RILEY: And then, we'll say, now we want to drill down. But, we will.

12 DR. O'BRIEN: Right.

13 I've just been staring at this slide, so I do want to note that this was just a subset of the duals. This

14 was for elderly dual eligibles, these clinical quality indicators, elderly duals only.

15 I was going to point to this next factoid which relates to utilization and potential points to --

16 potential issues on quality and appropriateness of people using home and community-based services in

17 Medicaid. This factoid from a recent Health Affairs article suggests that duals and HCBS users were more

18 likely to have a potentially avoidable hospitalization than Medicaid only.

19 You might think, does that tell me that there's something about the way these two programs

20 work together that's causing that? It turns out that the duals are far older and more likely to have the

21 conditions associated with these potentially avoidable hospitalizations.

22 But, these are the kind of evidence we'll be looking for to draw conclusions about whether it's

23 people's underlying health care needs and health status that's driving their utilization or whether it's

1 something about the health care delivery system or the way these programs work together.

2 So, I don't think -- well, here on -- we'll look at all kinds of studies about what is working. We will

3 look at the cost issues. Just recently in JAMA, very recently, evidence, new evidence that the Medicare

4 Group Practice Demonstration, for example, achieved significant savings for dual eligible beneficiaries.

5 Not all institutions were able to document those savings, but some were, and on average, duals -- more cost

6 savings for duals than for non-duals in Medicare.

7 And, I suppose related to Andy's point, maybe this Kemper study about reducing unmet needs.

8 We have a point -- this study looks at states in the top quartile of personal care spending, and do we see in

9 those states that the amount of unmet need for assistance with the activities of daily living is lowered.

10 And, it is.

11 So, the spending works. When we see these high spending states, they do reduce the extent of

12 unmet need in a low income community. So, we should have confidence that the programs are doing

13 something good for people.

14 And then, again, the final bullet makes reference to a recent study that looked at the integrated

15 program in Massachusetts, the Massachusetts Senior Care Options, and found comparing people enrolled in

16 that Senior Care Options program -- they did find evidence that the program, the way the services were

17 being delivered helped to prevent or delay nursing home use for its enrollees.

18 So, we'd like to continue to document those kinds of --

19 CHAIR ROWLAND: To pick up on Kate Baicker's point from yesterday, none of these are

20 random controlled trials. These are all very small demonstrations for the most part, with

21 quasi-experimental design. So, I think one really has to weigh this evidence very carefully.

22 DR. O'BRIEN: So, in terms of a chapter, we'd like to hear from you, in terms of where we should

23 look for these opportunities for program improvement.

1 Do we want to look at subpopulations?

2 Do we want to look specifically at the Medicare savings programs?

3 Do we want to look at how long-term services and supports are organized?

4 Do we want to focus on the cross-program interactions?

5 How should we do that?

6 This slide repeats some of those same questions:

7 You know, do we want to look at access to high quality Medicaid services for these distinct

8 subpopulations that you will help us define?

9 You know, how do states put different programs in place for duals?

10 How does clinical and financial eligibility for service vary across states, and how does that affect the

11 Medicare services that duals use for their spending?

12 What do we know about unmet needs for long-term services and supports from duals across states?

13 What do we know about the quality of the services?

14 Are there things we could say about payment adequacy, about the workforce available to provide

15 services to duals?

16 Do we want to look specifically at the Medicare savings programs?

17 There is evidence, post-BBA 97, that in states that reduced limited state payments for Medicare

18 cost-sharing, that access was affected, that duals were less likely to receive outpatient services, to receive any

19 services and to receive fewer services when they did receive them. That was a study produced for a report

20 to Congress in 2003 that looked at only 9 states.

21 Now we have much better data. We could look across 50 states and see what the impact is on

22 access to care for duals, of these states' choices.

23 So, lots of ways we could look at opportunities for program improvement, and we'd like to hear

1 what your priorities would be.

2 We also need to address this question of what we mean by program improvement and what should

3 we -- how should we define success. What should we be looking for?

4 Access to care?

5 Reductions in unmet need?

6 Improved quality?

7 Moderation in cost trends?

8 Improved enrollee and family satisfaction with services?

9 What would we be looking for?

10 So, just a summary then. We've had a lot of discussion already, but we'd like to come back and talk

11 about what your priorities would be for a March chapter, how you think we should frame this, in what

12 context should we address this issue, what populations should we look at, how should we describe how the

13 programs work, what kind of evidence should we look for about what works.

14 And, we come up with an approach for you to think about. One approach would be to choose

15 several key subpopulations that reflect a diversity of needs and circumstances in the dual eligible population.

16 Here, I list a set. Trish has already proposed one. But here, this one maybe chooses people with

17 different age, in different age groups, with different service utilization, with different diagnoses and frailties,

18 levels of frailty.

19 We could look at people with development or intellectual disabilities in Medicare and Medicaid who

20 use HCBS and look at their specific needs, to try to make this concrete population and understand what

21 policy reform would mean for them.

22 What about frail elderly in nursing homes who have spent down to Medicaid? Is that a population

23 that's worth focusing on?

1 People with extensive medical needs who are very high cost to Medicare but maybe not high cost to
2 Medicaid.
3 Non-elderly persons with three or more ADL limitations, living in a community -- again, what are
4 their care needs? What special considerations would we need to take into account as we develop policy
5 options?
6 And, what about non-elderly duals who maybe come into Medicaid through the MSP programs,
7 who are low income but have relatively low health care needs and health care costs to either program?
8 And then, we would describe their needs and circumstances and Medicaid's role and Medicare's role,
9 reviewing the demographic characteristics of these populations, their service use and expenditure, how they
10 receive services today and looking at measures of access, quality and cost.
11 And, we would review evidence on what works for these distinct groups.
12 So, that's just an approach that we could take in this chapter, but we'd like to hear more from you
13 about what makes sense.
14 CHAIR ROWLAND: Okay, Trish, then Mark, then Andy.
15 COMMISSIONER RILEY: I guess I'm channeling Patty's simplicity, but it strikes me that this is
16 too much of a drill-down to start.
17 Just as we need the bigger categories of who they are, I think we have to recognize that one of the
18 problems with these approaches and so much of the work that's been done in the last 423 years, it feels like,
19 on dual eligibles -- certainly, the last 20, 25 years -- looks at the system as it is.
20 And, the system as it is, is designed in these silos. One is a Medicare silo, and one is a Medicaid
21 silo, and they have all the different rules and expectations. And, there's no care coordination that
22 effectively can allocate resources from both silos.
23 So, you've got the combination of the lack of a care management capacity that can actually allocate,

1 develop a care plan for an individual, regardless of the source of Medicare or Medicaid -- (a) can't do that,
2 (b) can only buy the services that are currently available in Medicare and Medicaid when we know for lots of
3 these populations their needs are housing needs, their needs are support needs, their needs are community
4 needs, which certainly the home and community-based waivers have begun to explore in very big ways.
5 But, it strikes me that we almost are trying to fit the square peg in the round hole.
6 First, I'd like to disaggregate by the categories we talked about -- who these folks are. Then, think
7 about what their needs are independent of what the service structure that exists because it's just so bound
8 up in sort of the regulatory construct. And, yesterday's news was a population of people who are very
9 different.
10 Supply drives demand -- if a nursing home is all you have, if a PCA is all you have, if you don't have
11 housing options.
12 We ran a state-funded home care program a gazillion years ago, and one of the things we did most
13 effectively with one -- there was a woman who was malnourished because she wasn't eating her Meals on
14 Wheels because she was feeding her pets. We bought pet food. She stayed home.
15 I mean obviously a simplistic kind of example, but that's the kind of stuff that needs to happen in a
16 truly consumer-directed kind of long-term care system. And, I think we don't do it in the current
17 construct.
18 Certainly, there's an incredible experimentation out there with the waivers and the state programs,
19 but I just worry that studying what was doesn't get us to what needs to be.
20 CHAIR ROWLAND: Mark.
21 HOYT: So, I can tie into the simplicity theme. I don't know if this is too radical, but food for
22 thought maybe at the beginning of the chapter.
23 I'm sitting here thinking if I was consulting to CMS and you had kind of an open book on how to

1 do this, we are so wrapped around the axle trying to figure out how to get these two entrenched programs
2 to talk to each other and to coordinate. I would just ask, why are you doing that? Stop.
3 You know, it seems like an obvious solution would be form a new group. Merge the eligibility
4 criteria and take them away from Medicare and Medicaid. Call them the really special people.
5 I'm being facetious, but name a new program. Put all the money over there. And, end the whole
6 discussion. Quit trying to figure out how to coordinate all the care and everything else. Just put
7 somebody new in charge of this group of people and let them manage the care.
8 Now that may not be political reality. I see that. But, maybe it's worth being said that there's kind
9 of an obvious answer here, but everybody just ignores it because they just go, well, nobody would ever agree
10 to that.
11 But, that doesn't mean that we can't say it.
12 CHAIR ROWLAND: I think one thing to go with that point is to figure how much interaction there
13 actually is between the two programs, and I think that's a key part of what we need to look at is where do
14 the two populations really intersect other than on the financial and premium side.
15 I mean, where is this service disconnect?
16 I mean to go back to simplicity. I like to know what problem it is I'm trying to address before I
17 come up with solutions. And, I think really being able to tease out where the problem is, where the rubber
18 doesn’t really meet the road appropriately is how we have to look at the population and then how we have
19 to figure out where there is a coordination, where the silos are really obstructing care.
20 Andy.
21 COMMISSIONER COHEN: On a different note, so as you know, I'm very interested in, you
22 know, we need a long-term research agenda, but we also need to think short-term because our budget issues
23 and human issues are immediate. So, I wanted to just pose as a possibility taking a concrete issue and

1 trying to take a good look at it relatively earlier on in our research work

2 So, I'm not an expert in this area, but I've been around the health policy world enough to know that

3 a commonly cited area of problems and potentially even abuse the directly -- that relates at least in some way

4 to these two siloed programs is the issue of people who are living in nursing homes being hospitalized

5 frequently, maybe when they didn't need it and then coming back to the nursing home with a different --

6 Medicare becomes the payer again to the nursing home.

7 And, you know, probably many of us have heard about this problem. It's very real in human

8 terms. It's very real in budget terms if the facts bear out that this happening a lot.

9 I know that a lot of -- that Medicare is doing some things to address this. I know that some states

10 are doing some things to address this in Medicaid. Again, New York State, I happen to know has, you

11 know, changed their policies with respect to bed holds, for example, in nursing homes.

12 So, I don't know if our data are too old to get at the efficacy of some of these newer actions, but it's

13 old. So, at least we can take a look at the problem and try to specifically tease out is this a real problem, is

14 it really hurting people, is it really a budget abuse, and to really, you know, see if there is -- and I'm just

15 throwing this out as one option.

16 But you know, let's see if we can look at one problem that at least by anecdote we have all heard --

17 anecdote or research, we have all heard a lot of problems about -- and with this merged data, try to attack

18 something very concrete at the same time that we're building a longer-term agenda.

19 Again, I want to be -- I'm throwing this out as one option. I'm not an expert in the issue. There

20 may be many others. But, I'd like us to look at some sort of shorter-term, more concrete questions at the

21 same time that we're doing something long-term.

22 COMMISSIONER RILEY: I think that's a great idea because it's mythic and it's -- and it's also -- I

23 know there's a number of initiatives underway, but I know of one in Massachusetts called "Phone Doctor"

1 where a bunch of ED docs formed this company that supports nursing homes, puts video cameras in the
2 nursing home with the staff, and is able through telemedicine to see patients who are whipped into the
3 ambulances for a UTI and shipped off. You know, by their anecdotal discussions, it seems to work with
4 quality of care. It seems to support the nursing staff because, you know, on Friday afternoon they don't
5 have to hurry and find a doctor. Last I knew, there was an evaluation of it being done by somebody at
6 Harvard who I forget, but I'll find out. But those kinds of little models would probably help us to be able
7 to make a really important recommendation in a very concrete area. It's a neat idea.
8 CHAIR ROWLAND: Great idea.
9 VICE CHAIR SUNDWALL: One more question. It has been frustrating because we've heard
10 since the get-go about the duals, the duals, the duals, aren't they a problem, isn't it costly. If I were still on
11 the Hill, which I was many years ago, I would really be disappointed if the MACPAC didn't come up with
12 recommendations that, like Mark has said, did something about the money. If we can't together and soon
13 come up with some specific recommendations that would alleviate the money drain for the duals, I think
14 we'll be -- I mean, maybe we can. Maybe we're going to find out that underutilization is really the big
15 problem. But I hope not, and I should imagine in our work that you're at least going to collate or bring
16 together all of the demonstrations that have been done.
17 We heard great stuff on the PACE program, some things that really seemed to work, and I don't
18 think we have to continue to wring our hands about the problem. We need to put the spotlight on some
19 of these, like Trish just said, the little programs or the big demos that have shown they work.
20 So I just kind of put myself in the place of a Hill staffer, and they're really anxious for some good
21 news about what we might do to reduce the cost of the duals.
22 DR. O'BRIEN: Great.
23 CHAIR ROWLAND: And, Ellen, I think you've gotten sort of new buckets to define our units of

analysis, but I think this has been a very helpful step in guiding Ellen and the staff's work on this topic, and we'll keep pushing.

DR. O'BRIEN: Yes, we will. Thanks so much.

CHAIR ROWLAND: Thank you.

Jim? Well, show me the money, follow the money, money spending is clearly a key part of any discussion of health policy these days, and clearly, part of our title is the word "payment," which implies money and how it flows and to whom it goes. So we've asked Jim to really kick off this session by looking at the proposed research agenda for payment over our next year, both some of the short-term and then launching some of the longer-term and what some of the projects are to review with you the agenda in that area. Jim?

2012-2013 PROPOSED RESEARCH AGENDA

PAYMENT

* MR. TEISL: Yes, thank you. So what I am going to do is run through a few projects that we have in progress as well as a couple that we have planned to kick off in the near future. We very much want your feedback both on the projects that are underway as well as others that you think we might want to consider.

So in our first couple years, as you all remember, our focus was mostly foundational. We included the basics of Medicaid payment in both fee-for-service and managed care, as well as a discussion last March of the interaction between how States finance their Medicare programs and how providers are paid.

This year, our agenda is going to focus on some key payment-related aspects of the Patient Protection and Affordable Care Act as well as help contribute to the discussion of payment for persons dually eligible for Medicare and Medicaid and continue to build on that work that we started last March

1 related to the intersection of payment and financing. So we have a few projects which you can see up here
2 that have been initiated, and I'm going to walk through them, as well as others that we're planning to initiate
3 soon.
4 As you'll recall, Medicaid payment for primary care physicians for primary care services must be no
5 less than 100 percent of Medicare payment rates in 2013 and 2014. This applies to both fee-for-service
6 and managed care. States will receive 100 percent federal funding for the incremental cost of increasing
7 these payment rates, and you can see it includes the specialties of family medicine, internal medicine,
8 pediatric medicine, as well as related subspecialties.
9 A proposed rule was issued several months ago. There were a lot of comments on the rule, and
10 the final rule is pending.
11 CHAIR ROWLAND: And for Denise's purposes, the statute defined who could be eligible for it.
12 MR. TEISL: That's right. Thank you.
13 Our project kicked off just a couple of weeks ago in anticipation of the ramp-up in implementation
14 activity for a January 1st effective date, despite the fact that the final rule is not yet out. So our objective
15 here is to assess the potential implications of states' implementation decisions around this requirement.
16 For example, how might states' implementation decisions ultimately affect physician participation and
17 delivery of services? Are there any apparent potential unintended consequences of the ways that states go
18 about implementing the requirement?
19 We are doing structured interviews in eight states. You can see up here some of the policy
20 questions we're trying to address.
21 We're now preparing to contact the eight states to participate in the structured interviews. We've
22 selected states to have variation in size of the state in the Medicaid program, the region that the state is
23 located in, as well as managed care enrollment, current physician participation in Medicaid, as well as

1 payment levels. And I'd draw your attention to the physician participation variable. We relied on a paper,
2 which we've included in your handouts, by Sandra Decker at the National Center for Health Statistics, and
3 she based her calculations of physician participation based on the 2011 National Ambulatory Medical Care
4 Survey.

5 We're currently developing interview protocols for state policy officials, and, in fact, I just received a
6 draft of the interview protocols. We're going to focus on Medicaid leadership in the eight states as well as
7 technical staff. We'd also like to talk to provider groups and representatives of the Medicaid managed care
8 plans in those states. We're hoping to complete the project by early 2013, so hopefully have results not too
9 long from now.

10 Another project that we're preparing to kick off is to further understand total Medicaid payments to
11 hospitals and nursing facilities. So our objective here -- and, again, this is building off that chapter that we
12 did last March -- is to demonstrate the effect of state, non-federal financing decisions, including the use of
13 health care-related taxes, intergovernmental transfers, and other financing approaches, as well as
14 supplemental payments, which we know come in a number of different varieties, on the total Medicaid
15 payment amounts to these providers. In this case, we're planning to do five state case studies, which
16 would, again, including the structured interviews, as well as trying to collect some data on the total payment
17 going to these providers. On policy questions you can see here, which I just sort of went over, how do the
18 payment and financing methods affect the total payments? How do the payments to these providers, the
19 total payments through Medicaid, vary from what we see in the claims data, which is just the rate for the
20 services provided? And what other factors might play a role in total Medicaid payment amounts? Here
21 we're hoping to have results in mid-2013 -- which is ambitious.

22 One other study that we're working on -- and we talked about this a little bit this morning -- is
23 intended to complement the work that Ellen just described in our upcoming chapter on dually eligible

1 individuals. As I think Sara mentioned earlier, state Medicaid programs are required to cover cost sharing
2 for most dually eligible individuals, but in 1997 were given the authority to pay Medicare co-insurance and
3 deductibles up to the standard Medicaid state plan payment amount, and then providers are required to
4 accept the combination of Medicare and Medicaid payment as payment in full. So in order to complement
5 the work that we're doing with the data, we're also working on collecting policy information in this area, so
6 we're reviewing cost-sharing payment policies in all states for the four services that you see listed here.
7 The work that we're doing is primarily reviewing publicly available policy documentation, though in
8 some cases obviously we need to follow up with state officials by phone to clarify exactly what we're able to
9 find.
10 Some additional work that we have planned, as if those weren't enough, is an analysis of emerging
11 advance payment models. All of you have been hearing a lot about the use of patient-centered medical
12 homes, accountable care organizations in Medicaid, bundled payment methodologies. A couple of states
13 have been in the news quite a lot lately, including Oregon with their coordinated care organizations, as well
14 as Arkansas's Payment Improvement Initiative. We want to identify some of these models to take a closer
15 look at, and so we very much look forward to your input in that area.
16 We also are prepared for the fact that we're going to have to review CMS' proposed methodology
17 for the DSH reductions that are scheduled to begin in 2014, and as well as a review of Medicaid managed
18 care payment for persons dually eligible for Medicare and Medicaid.
19 That's it. Thank you.
20 COMMISSIONER EDELSTEIN: In many federal programs, if not most, dentists fall under the
21 definition of physicians, but the provision in ACA does not apply because there is no dental benefit in
22 Medicare. So I've already railed yesterday about the fact that there's no dental adult benefit in Medicaid.
23 Similarly, there's no dental benefit at all in Medicare. And, therefore, there's no rate setting in Medicare for

1 dental services.

2 But if we're going out as a Commission to eight states and knowing that provider payment for dental
3 services is a significant issue, is there any reason that MACPAC staff would not add to the interview
4 protocol and the plan to collect information about dental payment, both managed care and fee-for-service?
5 So my request of the Commission is that the Commission charge the staff to include dental payment in the
6 eight states for which interview protocols are being developed now.

7 CHAIR ROWLAND: I think the staff has already noted that they're going to do that.

8 MR. TEISL: Noted.

9 COMMISSIONER ROSENBAUM: A couple of things. I was actually going to raise Burt's
10 point, but I'm going to say it a little bit differently and a little bit more expansively.

11 I would like the interviews to include questions to Medicaid staff about how certain medically
12 necessary services are paid for for Medicaid beneficiaries. And that's a question that's broader than how
13 does Medicaid pay for the services. Falling into that bin are dental, in some states it may be vision care; it
14 may be hearing aids, you know, depending on what the state's range of services for adults are. It could be
15 certain kinds of durable medical equipment.

16 I would like to have a sense of how much Medicaid programs are sort of conscious of the limits of
17 their own state plan design and what they see as falling outside the design. Because when we're thinking
18 about payment for Medicaid beneficiaries, I want to be sure that we are thinking about payment, whether it
19 is actually happening inside the four corners of the Medicaid state plan or not. For example, going back to
20 yesterday's discussion about dental care, to the extent that it's public hospitals and community health centers
21 that have developed and are supporting, out of non-Medicaid revenue really, a range of services that you
22 can't get if you're a Medicaid beneficiary, we should be understanding that, because I think it will inform
23 how we think about Medicaid payment issues.

1 The other thing that I would suggest -- and I'm sure probably you're going to shoot me -- is that
2 while the primary care payment bump under the ACA is an interesting thing and I'm certainly interested in
3 knowing what, if any, impact it has, it also has been implemented in a way that I think is quite limited,
4 number one.
5 Number two, I think our more pressing issue, quite frankly, going into this coming year is the
6 payment models, is the health home and other advance payment models that involve risk shifting and
7 essentially the creation of new kinds of entities that can accept financial risk, in addition to the ones that we
8 normally think of as falling within the construct of the Medicaid statute. And because this has emerged as
9 such a big focus, and because I expect that it's going to be an intense issue in the winter, I would
10 recommend myself that we reorder some of what's going on to put the payment innovation models, like
11 health homes, up higher on our agenda and hold the primary care payment bump until later, because I think
12 that's going to turn out to be an interesting -- an interesting issue. You know, what happens if you get the
13 primary care payment up some, but there are so many complexities around the federal regulation that
14 implements the primary care payment bump, around how states are implementing the primary care payment
15 bump, that I have relatively modest expectations for what we're going to learn from it; whereas, I think if we
16 try and grab what's happening in payment today, what the emerging models are, where states are trying to
17 get to, what are the benefits of some of what they're talking about, what are some of the real limitations of
18 what they're talking about, is what they're talking about consistent with anything that the statutory structure
19 supports at the moment, we may be doing more of a service.
20 CHAIR ROWLAND: The only counter I would put to that, though, Sara, is since it is a specific
21 piece of legislation, I expect that the Congress will be expecting us to at least comment on how well --
22 whether this provision of the ACA worked or didn't work, or to come back, I mean, it has been one of the
23 identifiable things that we could comment on, and I'm sure we're going to end up having to comment on

1 the final regulations as part of our responsibilities.

2 So I take your point that we should be looking more broadly at some of the other models, but I

3 don't think we can exclude at least some preliminary assessment of the primary care payment bump.

4 MR. TEISL: Yeah, and I would only add that, you know, the timing has sort of been forced on us

5 by the fact that it takes effect January 1st, and we wanted to be able to take an initial look now in order to

6 set the stage for the work that we're going to do after the fact. So we wanted to sort of get this

7 implementation baseline going so that, you know, when we look at what the potential effect of the increase

8 was, we'll have this information to sort of fall back on.

9 COMMISSIONER ROSENBAUM: Just to follow up, you're obviously correct, and I'm not

10 suggesting that we not look.

11 CHAIR ROWLAND: [off microphone] shoot you.

12 [Laughter.]

13 COMMISSIONER ROSENBAUM: No, but I still have a chance of being put out of my misery

14 here. I'm only thinking -- I don't know -- I mean, I know that the staff's agenda is so full. If we got some

15 of the work going but didn't treat it as intensively in the beginning of 2013 in order to leave some space to

16 sort of grab onto this thing that has whooshed up, you know, and sort of is reaching a crescendo around

17 payment where -- I'm just worried that as we're looking at primary care payments in, you know, isolation,

18 that what's happening is people are moving real fast in bundled global payments that basically makes this

19 sort of an interesting issue but not as big for the beneficiary population as what may be coming.

20 MR. TEISL: Yeah, and one thing I guess I would add to that is one issue that has sort of emerged

21 is whether the payment increase being implemented in such a way as to have states pay for those services

22 essentially in the way that Medicare pays has had an impact on states' decisions about moving towards those

23 new payment models. So that's part of what we want to think about.

1 COMMISSIONER RILEY: Just as a follow-up, there might be some middle ground, because it
2 strikes me that, you know, the most complex thing about this is it's two years. So it invites sort of gaming,
3 or it invites states to say, Can we use this two-year payment as an incentive to motivate all-payer medical
4 homes, to sort of move an agenda on payment reform? So maybe if we take that focus on it, it might give
5 us some -- be able to put you out of your misery.
6 COMMISSIONER HENNING: I just wanted to point out that the survey that you guys are using
7 for this is based on an AMA thing, and so there are no nurse practitioners or nurse midwives included in
8 this. So you're losing out on a whole provider group that's seeing an awful lot of patients. I see 50
9 percent of the OB/GYN patients at my clinic. There's a lot of FQHCs that employ nurse practitioners
10 and nurse midwives. Fifty percent of all the vaginal deliveries in Lee County are to nurse midwives.
11 So I think that you kind of have to not forget us, understand that we serve a lot of these patients,
12 and probably I would say a larger percentage of Medicaid patients, partly because our salaries are lower and
13 clinics can afford us in order to take care of these patients that have a lower reimbursement schedule.
14 The other thing I wanted to mention is that there really isn't very many pregnant Medicare patients,
15 so there's not really a structure in Medicare that translates well to Medicaid. So most of the times when
16 they do something in Medicaid they base it off of what does Medicare do. Well, there isn't anything that
17 really relates when it comes to OB care. So I think we have to look at that as a separate animal.
18 I know that you guys had the really nice roundtable at the end of June where you did a
19 maternal-child health focus, and I really would hate to lose that, because I think that what they've done with
20 that roundtable is they've brought together a lot of the really high thinkers, the big-picture thinkers around
21 the country. And what we really need is some sort of coordination of that data to make sure that it's not
22 lost and that it moves forward. So not only reducing Caesarean section rates, which in some places -- in
23 South Miami, it's 80-some percent now, which is just like unconscionable -- but reducing inductions, which

1 tend to lead to C-sections, but also preterm birth. I mean, there's a lot of things that could be done that
2 would reduce costs to the system as well as disabilities and downstream costs to the system if we focused on
3 eliminating or at least reducing preterm birth. We're never going to eliminate it all, but there are a lot of
4 things that can be done to bring that rate down.
5 COMMISSIONER HOYT: I'm trying to connect in my head a little bit the chapter you did before
6 to where we're going now. I think I heard yesterday that the chapter or financing and payment was one of
7 the better received chapters or just highly praised. And so coming away from that, what are the takeaways
8 from that? Thinking about maybe something Diane said this morning, I think it was, is there something
9 broken that needs fixing? Or the simplification theme in my mind would clearly apply to that. Somebody
10 could read it and have the, "OMG, are you kidding me, this is how we pay providers?"
11 Was there any kind of reaction like that? I don't know what I'm reaching for, maybe from staff or
12 somebody else, like this is what I'd like you to do next, or where are you going to go with this? Did we get
13 a sense of direction from the audience?
14 EXECUTIVE DIRECTOR ZAWISTOWICH: The Hill staff, by and large, really found it to be
15 very informative, and what we had done is we had broken down the supplemental payments and the
16 provider tax payments, and they had never seen that done so clearly, and we provided some tables that
17 showed the flow of the money, which they found very helpful.
18 I think that this question that Jim has raised about the composition of Medicaid payments to
19 providers, institutions, and hospitals is an area that they're very, very interested in. And it dovetails nicely
20 to what we had done last year.
21 COMMISSIONER HOYT: If I can, the area I think is pretty sensitive. Maybe they all are. But
22 I'm guessing if we were going to make a recommendation, next year would be a good time to make
23 recommendations on this. I haven't circled around what some of those recommendations might be yet.

1 Maybe you've got some ideas.

2 EXECUTIVE DIRECTOR ZAWISTOWICH: I think understanding payments to providers

3 stretches across many different categories. The first is when you're thinking about setting managed care

4 payment rates, what are those rates comprised of? What is a true payment for a provider as you're

5 bundling up to set a pathway either for the duals or for other populations?

6 The other area where it comes in is better understanding the new payment models that Sara had

7 talked about. If you're going to create new payment models, understanding what the current payment rates

8 to these providers is very critical as you're thinking about different approaches, global payments, bundling

9 payments. So understanding the base, which is the project that Jim described, is a critical step to that.

10 MR. TEISL: And the one thing I'd add about sort of moving from last year to this year is the work

11 that we did last year was descriptive and it provided sort of hypothetical examples, and what we're trying to

12 do now is move to the next step, which is actually get out into the field and collect some actually

13 information to continue to advance the discussion.

14 COMMISSIONER GABOW: As you select the states for any study that we do, one variable I

15 think that should be included is the overall quality of care in that state, so that you have some at the bottom

16 and some at the top. And if you look at the Commonwealth national scorecard, they're really -- there's a

17 cluster in both places, and they tend to stay in the cluster. The top tend to stay in the top year after year,

18 and the bottom in the bottom. And I think making sure we have some who are at the top and some at the

19 bottom -- I don't know exactly how it relates to this particular study, but in general, as we're looking at that,

20 I think not -- making sure we're not clustering at one group or the other.

21 The other comment I wanted to make is about DSH reductions, something close to my heart, but

22 actually I think this could be a catastrophe in certain states for the public hospitals. So if you take the

23 states where the governors have said they don't plan to do the Medicaid expansion -- whether that happens

1 or not is another question. But if you take those states, those tend to be states with high uninsured
2 populations. So the perfect storm will come if the DSH reductions occur, there are high uninsured rates,
3 and there's no Medicaid expansion.
4 When you look at the margins of the public hospitals in those states, they couldn't survive that.
5 Simply the math just does not work. And I know there has been discussions about what do you do if you
6 -- are you going to let them get more DSH, which actually rewards them for not participating in the
7 Medicaid program? What is going to be the approach?
8 So I think now that we have this choice for Medicaid expansion, I think that comes to be an
9 important part of this whole discussion about DSH.
10 And one thing that I think we should look about is how this -- well, there are two things. One is
11 how it relates to provider fees or provider taxes, because in some states those are intimately tied together,
12 and how that's going to work with the DSH reductions and what the domino is on provider fees I think are
13 going to have to be elucidated. And the other thing is getting this simplification thing, what about getting
14 the state out of this and directly paying the DSH payments to the hospitals that are actually doing
15 disproportionate care for the poor? This will become particularly important in those states where the
16 storm happens together. It would have to be very clear that one isn't diverting these DSH monies away
17 from those entities that are, in fact, going to bear the burden.
18 So I think this one sentence here about DSH reductions has a lot of variations that would be
19 critically important for the providers who are serving both the current Medicaid patients and those who
20 were supposed to be Medicaid patients after 2014.
21 CHAIR ROWLAND: You know, I think that in our discussion yesterday, the overall research
22 agenda for the coming year, we highlighted that safety net facilities and what happened to them under either
23 choices in the ACA. So I think, Jim, this is clearly an incredibly important part of what is a more

1 staff-wide focus that I think we want to have on what's going on with the safety net, how it's financed now,

2 and the implications of the different choices ahead. So that's a great point, Patty.

3 COMMISSIONER MARTINEZ ROGERS: And actually I was going to ask about the selection

4 of the states. Are you leaning towards something? Are you looking at demographics of states also? I

5 know what you wrote here is the size, region, managed care. But have you kind of made some choices of

6 states, and what are they?

7 MR. TEISL: Let me get the list to you because I don't want to say them off the top of my head

8 and be wrong and have a state think we're going to reach out to them. But I have it, and I can give it to

9 you afterwards.

10 COMMISSIONER MARTINEZ ROGERS: And are they throughout the United States, or is all

11 leaning towards the east coast, west coast?

12 MR. TEISL: No, no, no. Yeah, we definitely very intentionally selected states so that we had

13 variation in the region of the country that they came from. So we have some from the Northeast, some

14 from the Midwest, some from the West, some from the South.

15 CHAIR ROWLAND: And some that are highly ranked --

16 COMMISSIONER MARTINEZ ROGERS: Most of us would --

17 CHAIR ROWLAND: -- and some that are lowly ranked with one of Patty's criteria to add in.

18 MR. TEISL: Yes.

19 CHAIR ROWLAND: So we don't always just do --

20 COMMISSIONER HENNING: I'm glad Norma asked that question, because I was thinking

21 about that, too, when you were going through that.

22 But I also wanted to comment on Patty's point by expanding on that. Once health care reform is

23 totally implemented, there are still going to be a lot of uninsured people out there. There's a lot of

1 undocumented people out there that do not have insurance at all. They will never have insurance. So
2 these hospitals still need to take care of them when they come in the doors. So that care still needs to be
3 provided, and one of the things that the ACA was trying to do, I think, and probably one of the reasons
4 why it's that long, is it was trying to make everything work together as a whole. And when the Supreme
5 Court made the decision that they could kind of piecemeal it out and the governors didn't really have to do
6 it, or expand Medicaid in order to do it, then the whole idea of decreasing DSH because the hospitals
7 weren't going to need it as much anymore in the states like Florida where the governor isn't going to
8 implement it, the hospitals are going to get hit, and, you know, they're not going to be reimbursed for that
9 care because they're not going to get the extra Medicaid payment that they would have gotten for people
10 that were previously uninsured that are citizens and can now be insured under Medicaid, those people aren't
11 going to be allowed to be insured under Medicaid in the State of Florida.
12 So a lot of our hospital systems are looking at this, and they're going, you know, we are in big
13 trouble because of the way it was all supposed to work together. I don't think that when they wrote it they
14 thought that, you know, parts of it were going to be taken out of it.
15 COMMISSIONER MOORE: I just want to flag again a subject I brought up before that comes a
16 bit off of some of this, and that is, the need for more transparency and federal requirements around
17 transparency for DSH and state methodologies, amount of support going to which kinds of places for all
18 the supplemental payments, and I hope we can move in that direction in our work this year off this research
19 agenda and the work we've done before.
20 CHAIR ROWLAND: Okay. Other comments?
21 [No response.]
22 CHAIR ROWLAND: Well, Jim, I think you had an ambitious agenda when you sat down. I
23 think it got a little more ambitious as we talked, but I think it's very important, and thank you for sharing

1 your agenda and for letting us add to it.

2 So we'll take a brief break now and then reconvene to talk about the ACA and eligibility.

3 [Recess.]

4 CHAIR ROWLAND: If we can take a few minutes and reconvene please.

5 Thank you, and we're going to move on in this session to begin to explore some of the work that

6 the Commission may be able to undertake that really begins to address the interaction between the Medicaid

7 and CHIP programs and the exchanges to be implemented under the Affordable Care Act. There's lots of

8 coordination issues, and there's a lot of potential for simplification of the eligibility system if it works

9 correctly. So, Chris, take us to your findings.

10 **#### KEY ISSUES AND DATA:**

11 **MEDICAID, CHIP AND THE EXCHANGES**

12 * MR. PETERSON: All right. Great. Thank you.

13 So as Diane mentioned, I'm going to present today on key issues and data with respect to Medicare,

14 CHIP, and the exchanges. Remember, under current law, in 2014 exchanges will exist in every state,

15 regardless of the extent to which the state expands Medicaid to the new adult group. And state Medicaid

16 and CHIP programs must interface with those exchanges, with their IT systems, for example, to make

17 eligibility determinations seamless across programs.

18 In addition, all states under current law will have to make other changes to their existing Medicaid

19 and CHIP programs -- again, regardless of what they do with respect to the new adult group.

20 For example, for most Medicaid and CHIP Medicaid/CHIP enrollees, states will have to implement

21 the new national income counting standard Modified Adjusted Gross Income, MAGI. So there are

22 number of technical and statutory issues the Commission may want to weigh in on prior to 2014, and I look

23 forward to your direction and feedback.

1 For my presentation, I'll briefly describe the context and provide an update on implementation, and
2 then we'll look more closely at issues for your consideration, specifically state decisions and the implications
3 of those decisions, eligibility and enrollment, benefits and cost sharing. And then we'd like to hear your
4 thoughts on next steps and issues we should be looking at for 2014 implementation.
5 As you know, there are numerous changes to Medicaid and CHIP as a result of the ACA. For this
6 presentation, I am focusing on children and non-elderly adults.
7 With respect to implementation, the only change that resulted from the Supreme Court decision in
8 June is that if states do not expand to the new adult group, the Secretary cannot withhold Federal Medicaid
9 funds from their existing Medicaid program.
10 So implementation is moving forward in the federal government and in the states to varying degrees.
11 However, there are still many unknowns. For example, to what extent will states implementation the
12 expansion to the new adult group? Will they do only a partial expansion? In that case, what funding is
13 available to states?
14 Questions remain about MAGI and how states figure out who is newly eligible and, therefore,
15 eligible for that 100 percent match.
16 You may remember the proposed Medicaid eligibility rule from last August, which we commented
17 on in an October letter. Although the eligibility portion of that proposed rule was finalized, we are still
18 waiting on final guidance to states on how to determine MAGI and who is newly eligible.
19 So states have many decisions to make for 2014 implementation. With respect to exchanges, will
20 they operate their own state-based exchange? And at last count, approximately 15 were expected to move
21 forward with a state-based exchange. For those states, they have to submit their blueprint to HHS by
22 mid-November, with HHS needing to okay those plans by January 1, 2013. States can also go with the
23 default federally facilitated exchange or do a hybrid, the so-called partnership model. Then there's essential

1 health benefits and benchmark coverage.

2 To meet the Secretary's current requirements for exchange plans, states have to choose one of ten
3 plans that exist in the state as the benchmark for covered services in the exchange. States have to choose
4 their exchange benchmark within the next couple of weeks, and most are choosing as their exchange
5 benchmark the largest plan in the state that is offered to small employers.

6 States will also have to choose a Medicaid benchmark plan for the new adult group. There states
7 theoretically have only three plans to choose from, although they can use a Secretary-approved option,
8 which could even be full Medicaid. But since the largest small group plan is not an option for the
9 Medicaid benchmark, we already know there could be some differences in covered benefits between
10 Medicaid coverage and exchange coverage. How much of a difference? That will depend on state
11 choices. And we are still a ways from knowing what states will choose for their Medicaid benchmarks.

12 As I mentioned, it remains to be seen what states will do for expanding to the new adult group, and
13 regarding the last bullet, in our comment letter last October, we said -- and this is a quote -- CMS should
14 consider using a single, consistent approach for determining who is newly eligible. However, if the
15 Secretary ultimately decides to give states options on how they assess who is newly eligible, that could have
16 very important implications for states.

17 On this next slide, we propose then to examine issues around eligibility and enrollment and the
18 interaction between Medicaid, CHIP, and exchange coverage. So, for example, there's the issue of
19 churning where relatively small changes in income can cause individuals to move back and forth between
20 Medicaid and exchange coverage. There are many papers examining the possible magnitude of churn. In
21 a paper co-authored by Commissioner Rosenbaum, they estimate that among non-elderly adults under 200
22 percent of poverty, 35 percent would shift between Medicaid and exchange coverage in a six-month period,
23 and half would shift in a year's period.

1 So among the possible options to reduce churning is 12-month continuous eligibility. This means
2 it is not necessary for a family to report changes in income within a 12-month window. The Medicaid
3 statute explicitly permits 12-month continuous eligibility for children. Although this is not explicitly an
4 option for adults, states currently have flexibility to count income however they want. And some states use
5 this authority to say, well, for adults then we're going to disregard changes in income within a 12-month
6 period. However, once MAGI goes into effect, this state flexibility is gone. So this is an example of
7 options the Commission may want to consider.
8 Another example of issues around the interaction of Medicaid/CHIP with exchange eligibility has to
9 do with what some call split family coverage. So take, for example, a family of four at 150 percent of
10 poverty with a dad, a mom who has recently given birth, a six-year-old, and the newborn. In this case, in
11 many states in 2014, the dad would be eligible for subsidized exchange coverage; the mom would be in the
12 postpartum period for Medicaid coverage but soon to flip back into exchange coverage; the six-year-old
13 would be in a separate CHIP program; and the newborn would be in Medicaid. So the family members
14 may have different insurance cards, different provider networks, different covered benefits.
15 So there are options that could address this. States could try to have plans participate wholly in
16 Medicaid and CHIP and exchange coverage. But he plan requirements in Medicaid are different from
17 those in exchange coverage, so it's not clear that states have been successful in that regard.
18 A more limited option, Tennessee has sought approval of what they call a bridge plan. They want
19 Medicaid managed care plans to be approved to offer coverage to exchange-eligible individuals if they have
20 a Medicaid enrolled family member. So in my example, mom and baby are enrolled in Medicaid. This
21 option would let dad and the six-year-old be enrolled in that same Medicaid managed care plan with the
22 same network of providers and let dad use his exchange subsidy in that way. But it is not clear as yet as to
23 whether this option or something like it would be permitted.

1 VICE CHAIR SUNDWALL: Chris, could I interrupt you?

2 MR. PETERSON: Yes.

3 VICE CHAIR SUNDWALL: I don't understand the tie between the MAGI and whether or not
4 states have the flexibility to do this 12-month extended enrollment? Why couldn't they? What is it about
5 MAGI or the --

6 MR. PETERSON: So the way that states are accomplishing 12-month continuous eligibility for
7 adults right now has to do with a section of the statute that says, states, you can count income however you
8 want. So the way that states are doing it is they're saying, okay, we're going to disregard any change in a
9 person's income in a 12-month period. That's the way they're accomplishing that.

10 What MAGI says is you no longer have that flexibility, you can't -- and we think of it usually in the
11 context of you can't disregard child care, you can't disregard, you know, $30 a month for this type of
12 income. But it also has the implication in this case that states can no longer do this disregard of changes in
13 income in a 12-month period.

14 COMMISSIONER ROSENBAUM: There's no federal -- it's like not having a federal tax
15 exemption anymore. It tightens up the standards to whatever the federal methodology is.

16 PARTICIPANT: [off microphone].

17 COMMISSIONER ROSENBAUM: Exactly.

18 MR. PETERSON: Right. I mean, remember, the impetus in the ACA was right now states are
19 using all kinds of disregards for different populations and you can't keep it straight and there's no national
20 standard. So the idea was, well, MAGI will now fix this for many populations; it's just going to be a
21 national standard, no disregards. But then there are these unintended consequences, if you will, of, you
22 know, the flexibility that states had to do 12-month continuous eligibility for adults is now gone.

23 VICE CHAIR SUNDWALL: So any change in income has to be reported, right? [off

1 microphone]

2 MR. PETERSON: Correct. Again, though, except under current law for the states that said

3 actually we're going to disregard changes in income, so you don't have to.

4 VICE CHAIR SUNDWALL: MAGI [off microphone].

5 MR. PETERSON: Yeah. So now talking about --

6 CHAIR ROWLAND: It's an interesting example of a simplification that creates a complexity.

7 [Laughter.]

8 VICE CHAIR SUNDWALL: Sounds like a nightmare [off microphone].

9 MR. PETERSON: Okay. So now let's set aside -- we'll go to the second main bullet here on this

10 slide. Setting aside where Medicaid and CHIP interact with exchanges and focusing on eligibility and

11 enrollment issues that are limited to Medicaid and CHIP. There may be issues for specific subpopulations

12 that the Commission wants to examine. For example, in the proposed eligibility rule from last year,

13 individuals who qualified for the new adult group would have been put in that new adult group, case closed.

14 We and many others commented on this as an issue that if these individuals wanted to go through a

15 disability determination, maybe to access benefits that may otherwise not be available, that should be

16 permitted. And ultimately in the part of the rule that was finalized, the policy was changed to permit a

17 disability determination even for optional disability pathways into Medicaid. So the point is this is an

18 example of how certain subpopulations can be affected by a policy change.

19 Another potential issue is TMA, transitional medical assistance. In most states, very low income

20 parents qualify for Medicaid, and TMA provides an additional six months of Medicaid coverage if their

21 income rises. So this provision was enacted to ensure that the possible loss of Medicaid did not serve as a

22 deterrent for these parents to work. However, in states where coverage for adults goes up to 138 percent

23 of poverty in 2014, it doesn't make sense for TMA to continue. And then what are the tradeoffs in terms

1 of covered benefits, cost sharing, and federal and State costs?

2 So TMA is something that Congress has to appropriate money for nearly every year as part of a

3 package of Medicaid extenders, so that's what makes TMA different in that regard from what we're used to.

4 And it currently expires December 31, 2012. So we will likely see activity around this very soon.

5 But just as an FYI, let me mention that even if Congress didn't appropriate funds past 2013, TMA

6 for four months is a permanently funded part of Medicaid, so congressional action would be necessary.

7 This slide, the Commission may also want to weigh in on technical issues around benefits and cost

8 sharing. So, for example, currently and continuing past 2014, very low income parents will be eligible

9 under the Medicaid pathway, referred to as 1931. But in 2014, many other parents will be eligible through

10 the new adult group along with parents without dependent children.

11 So enrollees in the new adult group, including parents, must receive benchmark coverage while

12 those very low income parents, 1931 parents, cannot be enrolled in benchmark coverage. So questions are:

13 Will full benefit Medicaid under 1931 differ markedly from benchmark coverage? Of course, if states

14 choose full Medicaid as their Medicaid benchmark, then there won't be any difference. But as I said, it will

15 be a while before we know that.

16 Beginning in 2014, does it even make sense to have this separate 1931 coverage? The Commission

17 raised this as an issue in our comment letter last October where we said statutory alignment between the

18 current parents and caretaker relatives eligibility group and the new adult group could avoid unnecessary

19 administrative burden for states that will have to separately determine which group parents and caretaker

20 relatives belong and the different benefit packages to which they're entitled, suggesting the possibility of one

21 adult group rather than a new adult group and parents over here.

22 Children may also be a key subpopulation to look at comparing what is available in Medicaid

23 through EPSDT compared to benefits in separate CHIP programs and, moving forward, exchange

1 coverage. And there may be other subpopulations the Commission is interested in, for example, new
2 enrollees with mental health needs, there could be other benefits that are not in the essential health benefit
3 package that Commissioners may be interested in. Then there's cost sharing. So for all these groups,
4 once you've decided what is covered, then how much do families have to pay out of pocket?
5 So for next steps, we would like your feedback in terms of are these the right areas of focus for
6 eligibility and enrollment. I have talked about, not necessarily in this order, TMA, churning with options
7 such as 12-month continuous eligibility, split family coverage with options such as bridge plans, benefits and
8 cost sharing, coverage for parents, coverage for kids. Are there other issues that staff should examine?
9 Are there other analyses or options that should be examined?
10 Thank you.
11 COMMISSIONER ROSENBAUM: I have so many -- it's like drinking out of a fire hose here.
12 Thank you. That was incredibly thorough. Everybody has been incredibly thorough, but this raises so
13 many issues.
14 I think the more we can do to rationalize the eligibility groups, especially since MAGI now covers an
15 entire cohort, so to the extent that you might have argued that it makes sense to keep 31 million eligibility
16 groups because you can have different methodologies, assuming any state were suicidal enough to want to
17 do that, but that's not what's going to happen. What's going to happen is that MAGI is very global, and so
18 getting to a point where I think there are three categories of eligibility -- there's income, there's disability,
19 and there's Medicare status. To me those are like -- when you scrape everything away, that's what's left.
20 And I'm in the middle of writing a long Law Review article now about this, and I have concluded that, you
21 know, if anybody had just had more time and rational space to work in, they would have reworked the
22 Medicaid eligibility rules in the Patty Gabow Memorial Simplification, you know, wave the flag. So there's
23 that issue. And I think the first step is aligning eligibility so that it's seamless across the two markets --

1 exchange and Medicaid, a potentially basic health program which we have not talked about.

2 The second is aligning the benefit designs so that we have a prayer of getting companies, entities
3 that are capable of being certified under both markets, which I'll get to in a second, to bid for business so
4 that the eligibility shift is a back-end transaction and has nothing to do with the family's coverage, that's step
5 number two.

6 And step number three here is aligning the conditions of participation for managed care entities with
7 the conditions of participation for being qualified health plans so that, again, you've got a prayer of
8 attracting enterprises that are willing to play in all the markets.

9 That, of course, ultimately brings us to what will they be expected to do to end up with aligned
10 networks so that you don't have network members who will say we'll see them when their subsidy's coming
11 through the exchange, like they would ever know, versus seeing them when their subsidy's coming from
12 Medicaid. So I think if we're going to do low-income families any justice here, we've got to get there. So
13 that's number one.

14 I mean, everything you have is here, and I would, like the earlier discussion, put it in those buckets.

15 The other thing, though, I want to flag, because I have now sat at my desk for hundreds of hours
16 worrying about this, and I'd like you to worry about it too -- is --

17 COMMISSIONER GABOW: Worry transfer [off microphone].

18 COMMISSIONER ROSENBAUM: Right. I need a friend to worry with. So there is an
19 exclusivity provision in the Affordable Care Act that has never applied to Medicaid before, right? You
20 could have Medicaid -- you couldn't have CHIP and have something else, but you could have Medicaid and
21 have employer coverage or Medicare coverage. So now we're in this world where being a Medicaid
22 beneficiary disqualifies you from entering the exchange. So we're going to have a lot of people who are
23 over the cutoff, wherever the cutoff ends up being, who want to go into the exchange for their standard

1 benefits, but who have significant disabilities and who were, in fact, getting Medicaid coverage as optional
2 eligibility folks, or even mandatory but with extra disregards, and a lot of families with kids with disabled
3 children.
4 States are going to have a natural incentive to cut back on those -- either it's going to be cut back for
5 them because of MAGI or they're going to cut out optional groups because the pressure to get people into
6 the federally financed exchange is going to be great. And I think what we need at this point -- and I've
7 been sort of a broken record on this for four years, so I might as well continue -- is at a minimum a state
8 option to extend supplemental Medicaid coverage for people with disabilities who are going to need all
9 kinds of things that their exchange plans just simply won't cover. Whole classes of benefits that are
10 missing, like a personal attendant, or services in greater amount, duration, and scope than what you're going
11 to get under a standard plan because of limits, just treatment limits that are built into plan design.
12 We're going to need, just like Medicare beneficiaries need Medicaid as a supplement, the under-65
13 population with a lot of kids who are not going to be duals, so it's not that group, but it's people in the
14 two-year wait for Medicare potentially who are in exchanges, it's families with children who are over the
15 cutoff, are going to need two sources of coverage. And I'm afraid what we're going to end up with
16 because of this exclusivity issue that's been introduced is a lot of families with children with disabilities and
17 working-age adults with disabilities who are able to go onto the exchange but don't get Medicaid as a
18 supplement, or if the state keeps Medicaid as a more generous coverage for people with disabilities, they
19 won't be able to go into the exchange. And I don't think we want to be there as a matter of disability
20 policy. I mean, that's why we have risk adjustment and the coverage arrangements. So --
21 MR. PETERSON: Just one quick clarifying --
22 COMMISSIONER ROSENBAUM: -- this interaction I think is important.
23 MR. PETERSON: One quick clarifying question. So when you think about that option, who

1 would you want in your world to be eligible?

2 COMMISSIONER ROSENBAUM: For that option? I would want to give a state the flexibility

3 to build a supplemental plan design for any individual who is covered through an exchange but who has

4 needs that extend beyond a standard exchange design. And it's going to be a lot of things, home and

5 community-based care services, things that -- I don't care how generous plans are with, you know, what's

6 called the "habilitation option," which we haven't talked about, which I think will boil down to 15 speech

7 therapy visits. I mean, that's what it will be, and that's fine, that's good. But it's not going to be what

8 Medicaid is for this population. And what we've done is set up, I think, a very serious set of downstream

9 triggers, and so I would at least give states the option of going there and supplementing what's available in

10 the exchange.

11 COMMISSIONER COHEN: Boy, my comment is not going to be worthy of following up on

12 Sara. Lots of great, great points.

13 Much more concretely -- and great presentation, Chris. Thanks very much. I think, well, it may

14 be more in the -- it may be more a question than a comment, but you'll see where I'm sort of headed. I

15 like very much that you lay out the sort of policy issue and the problem. In looking at these problems,

16 churning, TMA, where you don't exactly lay out the problem, but I think we all understand what the

17 problem was, churning and split family coverage, I am familiar with lots of literature about the harms

18 associated with churning. I may be out of date, but I'm somewhat aware of what it is, and I would love to

19 be updated by you, you know, kind of what that is.

20 I'm less familiar with literature about the harms associated with split family coverage, and I know

21 that a lot of people very much raise it as a concern all the time. I'm just sort of less certain that I

22 understand what the real harms are there. So if that literature exists and you can illuminate, you know, in

23 this setting or another, I think that's great. If not, I just want to sort of put a marker that sometimes I

1 think the first thing we need to do is just be crystal clear about the problem. So I'm not crystal clear about
2 the problem. I sort of get the potential. But in reality, I'd really like some evidence that that is as serious
3 a problem as I understand, again, churning to be, although I know in whatever kind of recommendation or
4 analysis that we're going to do, I'm sure there will be a lot of discussion about the literature out there on
5 these various things.
6 MR. PETERSON: The only thing I'd say is that the old literature on churning had to do with the
7 idea of people going from Medicaid and CHIP to nothing. And so this is a little bit different context, so
8 even that literature may not be valuable, as valuable to us moving forward, unfortunately.
9 Also in the CHIP context, there is some literature when states were given the flexibility to cover
10 parents in CHIP and the idea was let's not have them be in different plans with different provider networks,
11 so that will be some of the literature that we can look at again. But I don't know if since then there's been
12 much, honestly.
13 COMMISSIONER ROSENBAUM: Well, and even for children in separately administered CHIP
14 programs there's literature, because as their income fluctuated a little bit, they moved between these two
15 markets. And I do remember a whole series of studies about both falling off and the problems of
16 transitioning between the two markets.
17 COMMISSIONER COHEN: But can I just follow up on that?
18 CHAIR ROWLAND: Why don't we let Sharon -- [off microphone].
19 COMMISSIONER COHEN: Go ahead.
20 COMMISSIONER CARTE: Yeah, as a follow-up, I just wanted to say I'm really concerned about
21 the income volatility also which contributes, and now, as Chris was saying, you know, we used to be
22 concerned with CHIP, Medicaid, and nothing. But I'm sort of concerned with CHIP, Medicaid, exchange,
23 and the exchange -- and complicated by the way the income is counted now for the households and families'

1 inability to predict their income. I can see them getting discouraged either through the inadequacy of
2 coverage in the exchange for a disabled child -- and I know in our own CHIP program a couple of years
3 ago, we were looking at the issue of managed care because our program was strictly fee-for-service, and we
4 compared West Virginia's CHIP to our Medicaid children, absent the SSI kids, and to our public employees
5 kids, and the CHIP children on a risk-adjustment basis were sicker.

6 And so there's that, and then you have that structural difficulty about the advance tax credit being
7 employee only. So I have real concerns about what's going to happen to the CHIP families, particularly
8 the ones that need to go into the exchange. So there's a lot to dig into there.

9 VICE CHAIR SUNDWALL: Yes, that's going to be [off microphone].

10 COMMISSIONER COHEN: I'll be really quick. I think maybe, you know, like the stream here
11 is that maybe we want to go a little more -- changes may be more worrisome than difference. You know,
12 the volatility of moving around is more worrisome than difference. And then I think we also have to look
13 at what are the factors that are in issue. Really, it's provider networks, right? I mean, if you can go to the
14 same doc all the time, regardless of your coverage, I just -- it's the next level of going deep on, you know,
15 and not just sort of on what the real problem is because it may not be a problem everywhere. You may
16 have the same network. It doesn't really matter so much what your coverage is.

17 CHAIR ROWLAND: Patty.

18 COMMISSIONER GABOW: So I have one clarification and then two comments. What I
19 wasn't clear about, Chris, is is 12-month continuous eligibility actually a legal option now or not?

20 MR. PETERSON: It is legally.

21 COMMISSIONER GABOW: It is, so even with loss of exclusion criteria, with the -- we can still
22 do --

23 MR. PETERSON: No. Then it goes away.

1 COMMISSIONER GABOW: So that's my question, is how can we have a discussion about

2 12-month continuous eligibility if legally it's not going to be permitted going forward?

3 MR. PETERSON: I think the context would be it would be a potential option for the

4 Commission to say, Congress, a statutory change --

5 COMMISSIONER GABOW: Fix this, okay. So that was what I wanted clarification on. Right.

6 So the two other points I want to raise about the churning issue between Medicaid, CHIP, and the

7 exchange, is as my understanding, which may be inadequate, so correct me if I'm wrong, the lowest level of

8 plan in the exchange has a -- it doesn't cover 100 percent of the cost. It's not 100 percent of the actuarial

9 value. So people are going to have to pay either a high deductible or a large something --

10 VICE CHAIR SUNDWALL: Copay.

11 COMMISSIONER GABOW: -- copay to play there, which they don't have to that degree in either

12 CHIP or Medicaid. So part of the problem of the churning is going to be the financial burden on the

13 family or the person as they move into the exchange, isn't that correct?

14 MR. PETERSON: It is correct --

15 COMMISSIONER GABOW: And that -- and I'm worried about that also from a provider point

16 of view, because we know that when people have high deductibles or high copays and they come to the

17 safety net, they just don't pay them, which ties back to the DSH discussion, is that you can be insured under

18 the exchange, but if the actuarial value of your plan is 60 percent or 70 percent of the cost, then what's

19 happening to that other 30 to 40 percent? It becomes bad debt, as I follow the train of logic.

20 So if that is true, then we need to raise that, because I personally think that's a big issue about the

21 people going into the plan, the exchange, who are poor. They're going to pick the cheapest plan and then

22 they're not going to have the money to pay this other piece, as I understand it. So that's one issue about

23 churning.

1 The second has been pointed out about the networks being different, but why that's a problem, in
2 part, is the flow of information. So as you -- one of the reasons that Denver Health has been able to
3 achieve the kind of, you know, 90 percent of kids being immunized and 70 percent of people having their
4 blood pressure maintained is they're in the same doctor with the same medical record number, whether
5 they're uninsured, Medicaid, CHIP. It doesn't really matter.
6 But as you flow between networks and data doesn't flow, then you don't know who's immunized.
7 You don't know who's had X, Y, or Z. You don't know what tests have happened. So you immediately
8 not only create problems for the family, but you create quality issues and either duplication of something
9 that has already happened or not doing something that should have happened.
10 And so that has costs to it that we have to think about, about when networks aren't the same, unless
11 we guarantee information flow, which I don't know anything in the law that facilitates the flow of
12 information across networks. Since we're not giving people a card with a magnetic strip with all their data
13 on it, it's a problem.
14 MR. PETERSON: Two points. On your first, with respect to cost sharing, just to be aware that
15 for individuals who are below 150 percent of poverty who qualify for exchange subsidies, their actuarial
16 value, including the cost sharing subsidies, will be about 94 percent. So once you take that into account, it
17 does change that calculus some.
18 And then with respect to network adequacy and --
19 COMMISSIONER GABOW: So what about between 150 and 200 percent?
20 MR. PETERSON: Eighty-seven percent.
21 And then --
22 COMMISSIONER GABOW: [Off microphone.]
23 MR. PETERSON: That's why I carry this everywhere I go.

1 VICE CHAIR SUNDWALL: Glad you asked.

2 MR. PETERSON: On the second issue, that's a great point, and I think that's why plans are --
3 States are considering in their contract language to ensure that handoffs take place, that if a person is
4 undergoing a particular treatment, course of care for a chronic condition, that the contract language says,
5 this has to continue, even if your providers are going to change. If they have a provider, that provider is
6 going to continue for at least 90 days, something like that. So those are some of the options in response to
7 that issue.

8 CHAIR ROWLAND: David.

9 VICE CHAIR SUNDWALL: Chris, this is really good and I appreciate your making this list for
10 us. I recall at our previous meeting, we agreed to do, I think, a MAC research or some report titled
11 something like, "Problems Identified, Challenges With Implementing the ACA." All of these things come
12 under that, but they're not everything else, so we've identified. Have we abandoned that, because, again, I
13 put myself in the place of a Hill staffer. Nothing would be more welcome to me than if I had a concise list
14 of things that needed their attention, and we could suggest either regulatory or statutory change. I
15 understand -- maybe Sara knows this -- but there's going to be great reluctance to open up the law for fear
16 of whatever happens, but there are so many things that need tweaking. I think the MACPAC -- did I
17 misunderstand what we talked about?

18 EXECUTIVE DIRECTOR ZAWISTOWICH: Yes. Yes, you did. This is really our first
19 discussion as a Commission identifying the issues in the data. So we will be addressing this as we move
20 forward, but we have not heretofore had a contract or anything to address these issues. So yes.

21 VICE CHAIR SUNDWALL: Well, sorry --

22 EXECUTIVE DIRECTOR ZAWISTOWICH: It's a good idea.

23 VICE CHAIR SUNDWALL: -- but we did have a discussion on the list of challenges of

1 implementation of the ACA and these are part of those.

2 EXECUTIVE DIRECTOR ZAWISTOWICH: Yes, we did talk about the -- around the eligibility

3 section, yes. But we haven't -- this is really our first discussion of it as a Commission moving forward. And

4 Chris will be working on it, but we haven't yet done anything, so --

5 CHAIR ROWLAND: Which doesn't mean we can't.

6 VICE CHAIR SUNDWALL: Yes. I mean, it's just a no brainer. This is what the Hill needs

7 and wants. They've got to -- the things that we as a Commission have identified repeatedly that are

8 challenges for States and for implementing these provisions, if we all understand we need to move forward

9 with this, I think they'd like to hear what we as a group and advise them are going to be challenges that

10 they're going to need to pay attention to from a policy standpoint. And these are very good ones.

11 CHAIR ROWLAND: It seems to me there's an additional layer that we ought to think about if

12 we're really looking at the glitches and what works and what doesn't, which is what the difference is and

13 what happens in the State that elects not to take up the Medicaid expansion versus what happens in States

14 that do, because our discussion here is kind of premised on having that seamless network and it might just

15 be useful to also have as an analytic unit what happens when there's a State that has decided to not go

16 forward.

17 Judy. I'm sorry.

18 COMMISSIONER MOORE: That's one thing I was going to say. The other is, I really haven't

19 talked to States -- I don't know much about what States are thinking about a Medicaid benchmark, and I

20 don't know to the extent to which anybody does. I think it would be really useful -- maybe we could have

21 a panel of Medicaid directors or maybe you could look at that a bit, because it seems to me that's a bit

22 unknown and not as visible an issue and certainly something that's incredibly important.

23 VICE CHAIR SUNDWALL: Just to follow up, we just set ours in Utah -- very, very parsimonious

1 and, you know --

2 MR. PETERSON: But that's probably for the exchange coverage, not for the Medicaid --

3 VICE CHAIR SUNDWALL: Well, it's the essential benefit package.

4 COMMISSIONER ROSENBAUM: Right, but that is not the Medicaid benchmark.

5 VICE CHAIR SUNDWALL: That's different. Okay. No --

6 COMMISSIONER MOORE: I'm talking about the Medicaid.

7 COMMISSIONER ROSENBAUM: There are about five States that do benchmark plans and they

8 generally do their own design, and so getting a better fix on what they're doing in their design. And, of

9 course, there are requirements, right. The EPSDT is in the benchmark. Family planning is in the

10 benchmark. So --

11 COMMISSIONER MOORE: I'd just like to see us do a little bit more education of ourselves and

12 the world on --

13 MR. PETERSON: And I have reached out and States, they're not making that choice at this point.

14 I mean, I think for the exchange coverage, this is something they're required to do now. For Medicaid

15 benchmarks, it's not something they're required to do, I guess even before -- well, I don't know exactly

16 when they'll be required to. Nothing as of yet.

17 But I do think it is the case, just something to keep in mind, that just to make things easier for

18 themselves, States are considering doing full Medicaid coverage as part of their benchmark, which would be

19 permitted under Secretary approved. So on the one hand, it could be a cost issue relative to what you

20 might otherwise be able to obtain in benchmark, but it also means there's administrative simplification

21 issues where, like, you're not having to figure out who's in which bucket. So those are some of the

22 trade-offs associated with that choice.

23 CHAIR ROWLAND: Patty.

1 COMMISSIONER GABOW: To David's comment, I do think sort of a list of things that need to
2 be thought about, and as you pointed out, where the trade-offs -- you started to say, here's the trade-off
3 between this and that -- would be very useful to both States and the Hill, I think, because I'm not sure --
4 Sara, probably, and maybe Lu and Diane have read through every page of this, but most people, I would
5 guess, have not spent this as their evening reading. And so it would be --
6 [Laughter.]
7 COMMISSIONER GABOW: It would be --
8 COMMISSIONER ROSENBAUM: Every night.
9 COMMISSIONER GABOW: Well, I know you do, Sara, along with global health, but --
10 [Laughter.]
11 COMMISSIONER GABOW: But I think that would have utility as something from the
12 Commission.
13 EXECUTIVE DIRECTOR ZAWISTOWICH: And, Patty, that is on our to do list. The list of
14 issues is on our list. And I know Chris has been thinking about it for a while. So as we develop our
15 research agenda on it, we will be bringing this to you over the next couple of months.
16 CHAIR ROWLAND: Well, I think it also has to be on our list, because as these regs are rolled out
17 from the Department, we have to decide whether to weigh in and how to weigh in, and so also just having
18 some benchmarks of our own for how we're looking at these issues would be useful, and I know, Chris,
19 you've started on that.
20 MR. PETERSON: I guess what I would want to know from the Commission is there are a lot of
21 organizations that are putting out laundry lists of problems, and I'm not sure the extent to which we would
22 have a value add coming up with a laundry list of problems versus is our approach rather to say, well, there
23 are problems and here are ones that statutorily we think as this Commission need to be addressed, so --

1 VICE CHAIR SUNDWALL: [Off microphone.] Yes. That would be fine.

2 CHAIR ROWLAND: Sara.

3 COMMISSIONER ROSENBAUM: I think that we best encapsulate this issue as a problem of
4 market alignment for people who are going to get directly subsidized by a government -- a government, I
5 don't care if it's Federal-State, I don't care if it's Federal -- but their subsidies don't come through a tax
6 exclusion. Their subsidies come through a direct subsidy. And that this population has both very fluid
7 income. It has often family members whose needs continue to be beyond the needs of a standard benefit
8 plan. They have relationships with a health care system that need to be sort of established in the most
9 progressive way possible.

10 And if we, rather than worrying about just sort of the laundry list, if we get a -- I mean, that's where
11 you're going with your work. You've got this overarching thematic problem of market alignment. I also
12 think it's a way of explaining it that gets people to think in terms of government interventions that relate to
13 market solutions, which may be a stronger way of framing the problem than simply, you know, individual
14 issues.

15 So I'm concerned both about identifying the issues and identifying the issues in a way that lets policy
16 makers at the high level sort of sort out this -- the 2010 amendments to Medicaid, which just sort of
17 superimpose things on top of this underlying very complicated statute while also creating a whole new
18 market over here, and now we're just beginning to pick through it all. I think if MACPAC can come out
19 with a way to explain this to people, then we will have done a huge service.

20 CHAIR ROWLAND: Other comments? Clearly, this is an area that bears a lot of work in the
21 future, but I think it's critical to get it onto our agenda and I think, Chris, you have as much ambition on
22 your plate as Jim had on his, and so thank you and good luck trying to put all this together for us.

23 Out of today and yesterday, I think we've come up with two new words for the Commission to have

1 as its themes. One is "simplification" and the other is "buckets." So we're going to put everything into
2 buckets so we can simplify the issues that we're working on. But I think we've got a really good start on
3 our agenda for the coming year and I know it'll have some bumps in the road, just like the primary care
4 bump, and I know that it'll also have some simplification efforts to it.
5 If there are any comments the public would like to offer at this point, please do come forward and
6 state your name and organization and share with us whatever comments you have.
7 [No response.]
8 CHAIR ROWLAND: Seeing none, hearing none --
9 CHAIR ROWLAND: Great. Any other comments from Commission members or the public?
10 #### **PUBLIC COMMENT**
11 * [No response.]
12 CHAIR ROWLAND: Not hearing any, we will adjourn and our next full meeting will be in
13 November, so we will see you then but talk to you much before then. Thank you.
14 Adjourned.
15 [Whereupon, at 11:47 a.m., the meeting was adjourned.]