Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

Minuteman Ballroom A/B
Reserve Officers Association of the United States
One Constitution Avenue, NE
Washington, D.C. 20002

Thursday, November 15, 2012
10:16 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
DONNA CHECKETT, MPA, MSW
BURTON L. EDELSTEIN, DDS, MPH
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NORMA MARTINEZ ROGERS, PhD, RN, FAAN
JUDITH MOORE
TRISH RILEY, MS
SARA ROSENBAUM, JD

Anne Schwartz, PH.D, Acting Executive Director

AGENDA PAGE

Session 1: Health care delivery system challenges and opportunities for Medicaid beneficiaries with disabilities

Staff contact: Christie Peters, Principal Analyst

Session 2: Update on Medicaid primary care physician payment increase

Session 3: Options related to Medicaid, CHIP, and exchange interactions

Session 4: Medicaid capitation payments to PACE and D-SNPs

Session 5: Overview of the Medicaid/Medicare dually eligible population

Session 6: State Medicaid Payment Policies for Medicare Cost Sharing

P R O C E E D I N G S [10:16 a.m.]

CHAIR ROWLAND: If we could convene, please. It is my pleasure to bring to order this session of the Medicaid and CHIP Payment and Access Commission for our November meeting, and I'm pleased that today we are going to have a number of sessions that really deal with many of the challenges facing low-income populations, the Medicaid and CHIP programs as we look at delivery system reform, as we look at care of the dual eligibles, and as we try to develop in greater detail MACPAC's overall agenda, the research findings, and the preparation for our reports to be issued in the coming year.

I want to start the session by once again thanking the staff for the great work that they put together. Jim, you don't have to look back. I'm talking to you. And I would like to do something unusual. I would like everyone to know who the wonderful staff of MACPAC is, so I'm going to ask, starting with Anne Schwartz, to just go around, first the staff around the table, and just introduce yourselves and tell people what issues you work on, and then we're going to turn to our first panel.

ACTING EXECUTIVE DIRECTOR SCHWARTZ: I'm Anne Schwartz, Acting Executive Director, and my issue is keeping the trains running on time.

MR. PETERSON: Chris Peterson. Eligibility, enrollment, and benefits.

DR. SOMMERS: Anna Sommers. Access and quality.

MS. STAHLMAN: Mary Ellen Stahlman, and I handle a variety of issues [off microphone].

MS. SIMON: Lois Simon, and I handle managed care issues.

MS. McGINN-SHAPIRO: Molly McGinn-Shapiro, and I work on long-term services [off microphone].

DR. BERNSTEIN: Amy Bernstein. I'm a senior advisor for research.

MR. FINDER: I'm Ben Finder. This is my first month here at MACPAC, and I'll be working on payment policy and eligibility policy

MS. HEBERT: I'm Lindsay Hebert. I'm interning for the year, and I'm working mostly on eligibility and benefits.

MS. GRADY: I'm April Grady. I'm the Director of Data Development & Analysis.

MR. TEISL: I'm Jim Teisl, and I'm focused on payment policy and financing.

DR. O'BRIEN: I'm Ellen O'Brien. I'm focused on long-term services and supports and dual eligibles.

MR. PARK: I'm Chris Park, and I work a lot with data analysis, managed care payment, and drug policy.

CHAIR ROWLAND: And you can say who you are, too.

[No audible response.]

MS. PETERS: I'll press this one. And I'm Christie Peters. I work on individuals with disabilities.

CHAIR ROWLAND: Thank you. And now I'm going to turn to Christie Peters and ask her to open our first panel, but I wanted to both thank the staff for all their great work and have you know who some of the faces behind the papers are.

Christie?

HEALTH CARE DELIVERY SYSTEM CHALLENGES AND OPPORTUNITIES FOR MEDICAID BENEFICIARIES WITH DISABILITIES

* MS. PETERS: Thank you. Thank you, Diane, and good morning.

The Commission initiated its work on individuals with disabilities last year and included a chapter on Medicaid and persons with disabilities in its March report to Congress. The chapter addressed several

foundational issues, including Medicaid eligibility and population characteristics, Medicaid service use and spending, and quality measurement.

Some of the key takeaways presented in the chapter include: the fact that Medicaid enrollees with disabilities are a heterogeneous group with a wide range of disabilities, clinical characteristics, health care and other supportive service needs, and socioeconomic and demographic characteristics. Many have multiple chronic conditions and co-occurring behavioral health and physical health conditions. Medicaid enrollees with disabilities are the fastest-growing eligibility group in Medicaid, and over 60 percent of the enrollees who qualify for Medicaid on the basis of a disability rely on Medicaid as their only source of health care coverage. And, finally, Medicaid spends more in total and on a per person basis on these Medicaid-only enrollees with disabilities than any other population in Medicaid.

The Commission made recommendations to the Secretary to accelerate the development of program innovations and to update and improve quality assessment for Medicaid enrollees with disabilities. Staff are building on this work to date by continuing to develop the population profile we've started on this eligibility group, with a focus on Medicaid-only enrollees with disabilities. We are also examining access to care issues and quality measures appropriate for these types of enrollees. And we have begun examining state managed care enrollment practices and policies for high-need/high-cost populations. Staff will present on this work in future Commission meetings, and we anticipate a chapter in the June 2013 report.

We are also starting to look at the organization and delivery of health care services for Medicaid enrollees with disabilities. The purpose of today's panel is to begin the discussion on the challenges and opportunities within the current health care delivery system for providing appropriate access to appropriate health care and support services in appropriate settings for Medicaid enrollees with disabilities.

Today's panel represents perspectives from beneficiaries, states, and providers, and their presentations and discussion are to inform the Commission's work on promising models of care, payment,

and access for Medicaid enrollees with disabilities.

Joining us today are Ms. Barbara Otto, the chief executive officer of Health & Disability Advocates; Ms. Elena Nicolella, Medicaid Director from the State of Rhode Island; and Mr. John Mathewson, the executive vice president for strategy and operations at The HSC Foundation.

We're going to start with Barbara.

CHAIR ROWLAND: We apologize to the Commission members who are sitting at this table because the only screens are behind you, so you might want to decide between looking at the speaker and looking at the slides, or angle.

* MS. OTTO: I won't be offended if you turn your back to me.

Health & Disability Advocates has a unique perspective because we work not only on behalf of beneficiaries, but we also work with providers and we also do some work with states. So we get a bird's-eye view of what's happening with Medicaid across the country. As a matter of fact, I just flew back from Oregon. I was in Oregon all day yesterday working with them as they move forward and thinking more strategically about how they are building their delivery system to best serve all Oregonians, but especially Oregonians with chronic conditions and with disabilities.

HDA has been working for 20 years sort of focusing at the intersection of health and economic security for people with special health care needs. We do this through the capacity building with community-based organizations because, as we well know, 75 percent of the health outcome is non-medical-related, and we spend a lot of time working with state systems and with the social sector to be wrapping appropriate services and supports around people with chronic conditions and disabilities. We do a lot of technical policy work and training. We have worked for the past 15 years with states as they looked at Medicaid-funded infrastructure for working people with disabilities. And, finally, in our state, in the State of Illinois, and some states around the country, we've been helping build medical-legal

partnerships, working with individuals and families at the point of disability and connecting those medical-legal components. So let me get started.

I give you this map to show that nearly half of the states have or are planning Medicaid managed long-term-care programs, and I actually would put Oregon in the green as well as it gets closer maybe, I guess, to 2014. This one only went out to 2013. But we have many states not only looking at how do they maybe consolidate some of their programs and services under the new authority under the ACA, the 1915(k). I know Arizona has gone one pending. And other states are increasingly looking at it. But then we also have -- and Oregon has a (k) pending. We also have a lot of states looking to do some --

CHAIR ROWLAND: Would you explain for the Commission what the (k) allows states to do?

MS. OTTO: Oh, I'm sorry. 1915(k), under the Affordable Care Act it allows you to bring many of the home and community-based services under the state plan, and it provides a nice foundation for states to begin building a foundation of home and community-based services and long-term-care services and supports and then allows them to use other fiscal options like the 1915(c)'s and even demonstration authority to provide services beyond the state plan for specific populations.

So nationally, you know, 50 percent of Medicaid enrollees are in risk-based managed care, but people with disabilities have traditionally been carved out. But that is really about to change. More than 30 states are moving forward with Medicaid managed care for people with disabilities; 12 states have long-term-care services and supports in managed care; 11 states are moving toward implementation in 2012 and 2013; and 15 states have been or are already looking for home and community-based service waiver consolidation for administrative and programmatic purposes.

So this creates a perfect storm from my perspective of someone who works with beneficiaries, states, and the providers. In many cases we're seeing the push toward managed care to be focused less on providing better care for people and more on trying to fix some deeply seated, long-term budget challenges

states are facing. And the fact is that state Medicaid agencies are not driving the push towards managed care. State legislators are pushing towards managed care. So it's not that we're moving towards managed care from a perspective of providing quality care coordination. I can say from direct experience of working in different state legislatures it's a push to try to find cost savings and to squeeze blood from a stone, as far as I'm concerned.

However, you know, in every crisis there is an opportunity, and I'll be moving forward with some of those thoughts. So we have this budgetary lens that many states are looking at as they're reconstructing or reimagining, as they like to say, their managed care. And since there is this notion in many state legislatures right now that government can't do anything right, there is in some states wholesale outsourcing of the delivery system to managed care. And in some states that is going to work well because we have incredible staffing cuts, we have limited state capacity, and between the staffing cuts and attrition, there is an incredible lack of bandwidth at the state level to be thinking about innovation and to be looking at Medicaid fiscal authorities and implementing them creatively. There is also, because of the economic downturn, increasing enrollment at the state level, and that continues to be a huge problem.

I think the biggest issue we have, though, as we transition to managed care is an expectation on the part of leadership in states -- and, again, using the budgetary lens -- that we're going to see a lot of savings in Medicaid costs. And I simply don't think that's going to turn out the way many state legislatures have hoped.

So what is Medicaid managed care? What are the challenges when we're trying to serve people with disabilities? I already went through the elusive savings. You know, people with disabilities are medically complex. They require specialty care and intensive care management. We have not seen to date a lot of this -- we don't have a lot of data to date showing that you can see significant savings when you're doing care coordination well, especially when you're doing person-centered care management. Evidence has also

shown us that there are significant unmet needs in fee-for-service Medicaid for people with disabilities, so fee-for-service utilization is not really going to provide us a sound basis for setting capitation rates when we look at Medicaid managed care. And there just really isn't enough data, much less technical support from the Feds, on how to best set rates out there.

So you combine that with the fact -- and I live in a state that has extremely low fee-for-service payment rates. If you look at how they're setting capitation rates and they're setting them on the already low fee-for-service rates, I think that there's not a lot of room to extract cost savings. And so I worry that without a lot of guidance and technical support, state Medicaid agencies are going to get caught between the budget lens and the demand for quick results, and we're going to need a lot more beneficiary engagement and beneficiary appeals processes and supports.

I think we have a huge issue with network capacity. Everything we've seen not only in the data preparing for the implementation of the Affordable Care Act but in looking at the numbers of people with disabilities and the unmet needs, we're looking at behavioral health issues, and we're seeing a lack of capacity, whether it's in a fee-for-service system or a managed care system, around behavioral health. And we simply don't have metrics and quality assurance mechanisms under managed care. We don't have a lot of data in this area, and at the end I provide some recommendations.

You know, the quality measurement in managed care relies on the current metrics, and since we don't have a whole lot of individuals with disabilities that are medically complex and have co-morbid conditions in managed care, it's really hard to be coming up with the quality standards. I think NCQA has been doing some interesting work in this area, and I would encourage you to continue looking at that.

So what are the opportunities, now that I've kind of been a big downer in talking about the challenges? There is an opportunity in looking at Medicaid managed care for this population, and some states are actually being quite bold in taking the most difficult to serve populations, people with disabilities,

and putting them in managed care first. I'll say the State of Illinois, which is the last bastion of fee-for-service, has a mandate that 50 percent of the Medicaid population must be in managed care by 2015. And they're having to do this all at the time that they're building their exchange, all during the time they're implementing the Affordable Care Act. And it turns out that moving towards a Medicaid managed care program for people with disabilities and moving long-term-care services and supports in a managed care environment is really going to help them with some of these issues around churn.

As we look at the insurance products that are being built for the newly eligible Medicaid adult group and for those who will be eligible for a subsidy, we're working with the same health plans that will also be providing managed care for people with disabilities in the state and looking at how do we build networks adequately, and that could potentially help Illinois with churn between systems. As we know, people are human and their economic situations change, and they don't stay in one program over a period of years.

I think there's an opportunity for more home and community-based services as we move towards Medicaid managed care. The value proposition has really changed in health care in general, and by moving towards blended rates in Medicaid managed long-term-care services and supports and in consistent rates, you're able to reinforce the states' goal to rebalance systems if you're providing the same incentives for people to be staying in the community as you see the same incentive for nursing facilities. So you see more states being able to move towards that goal of rebalancing.

You see more person-centered care. As you see more states looking towards the 1915(k) to balance out and using a Medicaid managed care platform to do that, you see more person-centered care and more of an opportunity to have people with disabilities much more engaged in their care planning.

And, finally, you see more of an opportunity to be looking at some of the social determinants of health that we have been always trying to work on with this population, like employment. You have states like Wisconsin, Minnesota, Arizona, and Oregon really looking at how do you fold employment services and

supports into whatever they're doing with Medicaid managed long-term-care services and supports and having employment as a benchmark in these programs. And that's something that CMS has strongly encouraged as well.

I have four minutes, so I need to get moving.

So I've basically said this already. You can see Medicaid managed care helping states achieve their goals. However, the state fiscal and staffing challenges make them less able to manage these delivery system improvements and provide adequate oversight to MCO contracts. And I think that it is really important that we get some stronger federal guidance and some stronger administrative and technical support to states as they move forward.

It's very hard for states to be strategic and think about best practice when they can't even get their payment cycle in line because of some of the budgetary issues they're facing.

So here are some best practices that we've seen, and I really like what has been done around the dual eligibles and CMS requiring that beneficiaries be a strong part of any kind of Medicaid managed care program. I think that recommendations like that could be moving forward. We need much more transparent processes with meaningful and defined beneficiary engagement as states move towards Medicaid managed care for people with disabilities. We need specific protections and requirements for network adequacy. We need effective functional assessments for long-term-care services and supports. We have a patchwork of assessment tools across the states. They're not effective. They're usually looking at a snapshot in time. We have different functional assessments for different disability types. It makes it very difficult to coordinate services and to look at the whole person.

We need flexible services packages that are more person-centered. We need care coordination teams with expertise in public benefits programs. As I said earlier, we know that 75 percent of a successful health outcome is non-medical, yet we still have very medical model-focused care coordination, and we need

to be changing that and have much more engagement with community-based organizations providing the range of public benefits programs people need to be successful in living and staying in the community. And then, of course, blended rates that incentivize community-based services.

I would be remiss if I didn't talk about where things are within the ACA that can help move things forward. There is, of course, Section 2703, and my colleague from Rhode Island is going to talk a little bit about what they've been doing there. There's money follows the person and the balancing incentive payment programs. More and more states are taking this up. And then, of course, the dual-eligible grants.

But here is where guidance is really needed. I can't say enough about the requirement of a standard functional assessment tool of some kind, some kind of foundational tool that states could be using. And I know that CMS has been also working on a taxonomy of home and community-based services definitions. As states begin moving towards Medicaid managed long-term-care services and supports, it would be so helpful to have a national foundation or a standard for what is a definition of a service and what is a qualified service provider of that service. I'd like to see them move on that since many states are getting out there, getting approval on their definitions of community-based settings, when we don't even have a final reg on that. And many states are moving forward with 1915(k) and these 1115 demonstration waivers, yet we don't have standard definitions.

I mentioned the strong standards for consumer satisfaction and engagement must be done by a third party. I think we need to be supporting more quality measures work. The NCQA Duals Measurement Advisory Committee is doing that. We need robust requirements for data collection. And then there are fiscal levers that can be used by states that look at MLR limits and medical inflation rates. However, that would require and make sure that we see care coordination efforts for people with chronic and complex conditions be considered more of a medical expense and less as an administrative expense.

So thank you very much. I think I've gone over my time.

* MS. NICOLELLA: Good morning. Thank you very much for inviting me to speak to you today.

I thought what I would do is talk a little bit about the history of the State of Rhode Island and its approach to this population, adults with disabilities; some of the opportunities in the Affordable Care Act that we're taking advantage of; and then the challenges that we face in compiling or putting together a responsive system of care for adults with disabilities.

So just as background, the state has been working since the late 1980s, early 1990s, to really develop a vision of long-term-care services and supports and coordinated care. We were one of the -- I think we took advantage of the home and community-based waivers relatively early on. We had nine of them. We adopted PACE as one of our programs in Rhode Island, and then in 2007 and 2008, we created a Medicaid managed care program for adults with disabilities. It was a pretty narrow scope in that it was for Medicaid-only eligible adults, and it was also only for their primary, acute, and specialty care services. So the management of care was limited to those services, did not include any long-term services and supports. We called that program our Rhody Health Partners Program. It was very much modeled on our experience with children in managed care.

What we found with that -- and I want to talk a little bit about it because we've talked about a focus of adults with Medicaid only, and sort of putting together interventions, targeted interventions for that population. What we found with Rhody Health Partners was over half of the adults enrolled in that program eventually became Medicare-eligible, and the way that we had designed it caused us to lose those folks once they attained Medicare eligibility. So we're trying to address that now with our new model, but I do want to reflect to the Commission that for many of these adults, being eligible for Medicaid only is really a temporary phase, so in retrospect, we probably should have pushed harder to at least include long-term services and supports in that package of services.

Some of the other things that we found with our Rhody Health experience -- and we had an accompanying managed fee-for-service model at the same time, which is much smaller, but what we discovered was that for some of these individuals, access to care wasn't necessarily a problem. It was that care was being accessed at very, very high rates. So not just emergency department utilization, but if we found a cohort of people that had four-plus ED visits in a year, we found that they were also seeing multiple behavioral health providers, they had multiple hospitalizations. They just spent a lot of time in the medical service delivery. And when we spoke to them, that was the way they needed to get their services.

We met with one woman who carried around her folders of medical services just because she kept going from provider to provider. And it wasn't that it was -- it was certainly inappropriate utilization, but this was what she needed to do because there was actually no one else assisting her. So it was a real lesson for us in terms of the isolation that many people, elderly or adults with disabilities, experience.

We also found that pain was a real contributor to their health care-seeking behavior, and so we have instituted a pain management program with some alternative services to try to address that. The initial results of our evaluation have been that we have been successful in reducing emergency department utilization, hospitalizations, and prescription drug-seeking behavior.

What we did was we did sort of a combination of incentives as well as utilization controls, so in Medicaid, Medicaid state agencies are allowed to lock in people to specific pharmacies or providers if they have a history of seeking multiple providers. And we did that. We tried to do it in a non-punitive way, but really build more of a care management model around that. And we also provided incentives, such as gift cards, the same incentives that you see generally in employee wellness programs, but you don't often see applied to the adults with disabilities population. And we're finding that to be very promising.

So we've been working on our managed care program for adults with disabilities. And then in 2009 we were approved for an 1115 waiver, and in that wavier we looked really hard at our long-term services and

supports system and tried to address the, what we saw, gaps in that area. So we used the 1115 waiver authority to collapse all of our existing 1915(c) waivers, and that has been just a big help to us in terms of administration. I think in 2009, we had 11 1915(c) waivers, all targeted to a specific disability or a specific setting, and we had to report on an annual basis on each of those. We had to manage finances for each of those waivers separately. And it really kept us from viewing the population from their functional needs.

Instead, we were addressing people in terms of the institution from which we were trying to divert them from. So we set up services for people to keep them out of ICF/MRs or hospitals or nursing homes. But what we really wanted to do was -- essentially a lot of the services are the same. It's personal care services, attendant services in the home.

There are differences in terms of -- so, for example, a younger population is very interested in employment and we would try to provide services to address that need. And then there's more safety and protection issues when you're dealing with an elderly population. But, in general, the continuum of care, the long-term services and supports, they vary based on the functional need and sort of a social need as opposed to the setting that we're trying to keep folks out of.

So we also use the 1115 to include preventive services. One of the areas that we saw needed improvement in our long-term care system is that we were just getting to people too late. So in order for a person to be eligible for Medicaid-funded long-term care services, a person needs to meet both a clinical eligibility standard as well as a financial standard. The clinical eligibility standards prior to our waiver were, again, based on an institutional level of care, and we changed those so that they were much more functional and we tiered folks, so that if you were at the highest -- you needed the highest level of care, you could access nursing homes or you could access a community-based alternative. If you were not at that institutional level of care, if you were at a high level of care, we would still fund home and community-based services for you, but we won't fund nursing home services.

And then we had a third level which we called a preventive services level and that allows us to provide a limited number of home care hours to people long before they ever meet that -- the sort of institutional level of care that had been in place before, because it's really -- what we are trying to do is halt the migration of people from the community to the nursing home and to divert that nursing home stay or hospital stay as much as possible.

The 1115 waiver also allowed us to offer new services, such as shared living. We increased our self-directed program. And we started a nursing home transition program.

The Affordable Care Act provided us some opportunities to build on what we had started to do with the 1115 wavier through grants, such as the money follows the person, which very much supplemented and enhanced our nursing home transition model.

Barbara mentioned our health homes model. We have two. One is for people with serious and persistent mental illness, and that's really focused on building a community mental health organization as a health home and integrating physical care.

So it's still early. I mean, it's only a two-year model, two year with the 90 percent Federal funding. Because of the difficulty we have in data, it's a little early for us to really say whether or not that model has been successful. And I think we have some concerns about the way that the health homes program is set up with the 90 percent financing for care services or care management services alone. It drives a State to define care management services pretty broadly. Maybe the answer to the issue isn't necessarily more care management. Maybe for some populations the issue is more services, or as Barbara alluded to, maybe more behavioral health services or substance abuse services. So we've been talking to the researchers and the evaluators about that structure.

I'm going to just switch to -- so this is a slide, it's a little bit busy, but -- oh, four minutes. We've been -- because we are trying to pursue an integrated care initiative -- that's what we're calling our duals and

adults with disabilities managed care model -- we think of everyone as whether or not they're Medicaid eligible or not. This chart is not so much to show you the numbers but really to show you the complexity of the programs that we have in place.

So the duals in the purple, we have in very different places. We have some PACE enrollees. We have a lot of dually-eligible people who are living in the community. They're eligible for Medicaid. But they're not receiving any long-term care services. They're just sort of fine. And those are the folks that we want to reach through our integrated care initiative so that we're able to do some care coordination very early on, sort of an early intervention for dually eligibles.

And then you'll see in the green, those are the Medicaid-only and they're in our Rhody Health Partners or Connect Care Choice.

So in the short time that I have, I'll show you -- I know in one of your previous hearings, you talked about the desire to look at different PMPM costs for the people in the different subsets, so these different PMPM costs reflect the introduction of Medicare, but then also reflect the utilization of services.

So what we're doing with our integrated care initiative is in 2013, really just integrating Medicaid-funded services and we're not including intensive behavioral health services or services for -- long-term services and supports for individuals with developmental disabilities. We are hoping in 2014 to include those services as well as the Medicare services.

And I just want to talk a little bit about -- this brings me to some of the challenges that we face, which is there's a lack of integration at both the State and Federal level around services for adults with disabilities, and at the State level, we have, I think because of historic funding paths or streams, we have separate agencies with responsibility to serve different populations. And so we have an agency that is a sister agency to us but is responsible for individuals with developmental disabilities. And we try to work very collaboratively with that agency, but the truth is that the Medicaid agency and the agency for adults

with developmental disabilities have very different cultures, very different missions. And while many of the services that are funded in that other agency are funded with Medicaid dollars, it's a very social model. It's not a medical model.

And trying to bridge the communication as much as we want to -- and again, it's a very friendly, cooperative relationship -- there isn't a lot of push at the Federal level to coordinate. In fact, I think some of the silos exist at the Federal level, as well. So it would be helpful to get some pressure around more coordination for individuals with developmental disabilities as well as individuals with severe and persistent mental illness. It would be nice to have a model at the Federal level that we could follow.

Okay. So I just really quickly want to talk about some of the other challenges we face. We are moving to a managed care model for this population because we really believe for Rhode Island that it is a tool and a delivery system that is the most responsive that we can use at this time. We at the State just don't have the flexibility and the capacity that managed care organizations have to build systems.

And what we recognize with our Medicaid managed care effort is that we're not buying a system that exists today. We have to work in partnership with the managed care organizations to build the system that we really need. So we need more capacity for specific services. We need more focus on the family, for example. We need support for family caregivers. And we can't get there quickly enough from a fee-for-service perspective. We really do need the ability of the managed care organizations to move that way. And we're looking at very specific subpopulations -- former prisoners, people living with HIV/AIDS, and the homeless population.

And I'll just echo, in closing -- it's amazing how quickly ten minutes goes when you're talking about this -- but I do just want to reiterate one of Barbara's comments, which is that States are certainly feeling the difficulty and challenge of responding to the needs of these new opportunities and the needs to build these very complicated systems of care with existing State resources. So I know that the National Association of

Medicaid Directors just issued their survey of Medicaid agency operations and I've spoken to Trish about the need to look at capacity of States to have high-performing systems. So that would be a really good area for us to get resources and help in.

So I'll close with that. Thank you.

* MR. MATHEWSON: Good morning, everyone. I am going to change the flavor just a little bit in that I'll be talking to you about care coordination for pediatric populations and young adults. And so the HSC Healthcare System is actually based here in Washington, D.C. We're a nonprofit, kind of a nice gem tucked away in different parts of the city. Most people used to know us primarily as a hospital for sick children and we've stepped well beyond those doors in the last several years.

At any rate, it's an integrated pediatric and special needs health care system. I sometimes, as an elevator spiel to get people who've never heard of us before, to think of us as a Kaiser Permanente for special needs kids. There's a hospital. There's a foundation. There's a health plan. There's home care. There's a consulting group. And there is a National Youth Transition center which has just opened about a year ago on GW's campus.

I am going to talk from the chart just to tell you what each one is and then we'll keep rolling. Think of that as a clock. The HSC foundation is the parent and less so as a foundation and a philanthropic organization. It's a management company. Health services for children with special needs is the care coordination plan, where I'll spend the bulk of my comments this morning. The HSC Pediatric Center is the former Hospital for Sick Children. HSC Home Care is just that.

All of these entities are nonprofit, and I'll talk about how they collaborate together to serve the population. Special Needs Consulting Services is actually a national consulting concern as opposed to here locally. It works with States, governments, providers and health plans to look at this population. And then the National Youth Transition Center is a collaboration. It's a physical building where the foundation

is housed, but it's actually a collaboration of 45 like-minded organizations who all focus on the issues of youth transition from age 14 to 26. It also includes the National Veterans Center.

You saw that -- the one thing, on direct services, you can think about direct services in many ways as the laboratory. So we serve about 6,000 people in direct services. Then the other entities have a broader reach. And then when you include our research partners, and the research partners vary -- it's Harvard, Georgetown, GW, AAP. We just signed an MOU with NICHD at NIH with Alan Guttmacher and Yvonne Maddox and we're looking forward to, with them, a net force considerably.

Health services for children with special needs, it's care coordination. We do not have an insurance license. And we started as a demonstration project almost 20 years ago with some innovative people at then HCFA as well as in the District and also people from the hospital who said, we need to do something beyond what we were doing before. The net is right now you have an experiment that is sitting there as a real gem with 20 years of longitudinal data. It probably doesn't exist in many places in the country that you can find it, but it is sitting right here. And so that's one of the things that the folks at NIH were really excited about and they said, we can't wait to get that effort going.

There are about 5,400 members served in the plan, but you have to use a multiplier when you think about this in the light of TANF, probably somewhere between a seven to nine multiplier in terms of the cost. So 5,400 members, but pretty expensive. There are no carve-outs, so it is social, it is medical, it is behavioral, it is dental, it is long-term care, pharmacy, all of it is in there.

About 60 percent of the eligibles in the District who are eligible for this program actually are enrolled, and it's a voluntary program. And so that contrasts about 20 percent nationally is what you would typically see for a voluntary program, so it does work.

We have seen a lot of different financing arrangements. We've been at risk. We've been not at risk. And we have risk share. Of course, we much prefer not risk.

And that last statistic there is just looking at the relative load of special needs populations versus the national average in the District.

Organization approach -- we combine our care management focus with social care management and with the goal of moving the family to the highest level of independence, and that's across all of our different entities. That is the end goal. And again, I expressed that it's a complete model that includes behavioral health.

The network also is more community focused than what you typically see under a typical TANF. So we work with a number of community-based organizations, but it also means working with schools very diligently. It means working with other government agencies very diligently.

All members receive care management, and then we have something called outreach, but it's a bit of a misnomer. We've been struggling with a good word or a way to describe it to the outside world. But the official name of the department is Family and Community Development, but it's well beyond anything you've seen in typical outreach. It's outreach on a great deal of steroids. From the minute they touch us, we are working with them very, very diligently to make sure they're getting the services they need, whether medical or not.

One of the things that we think really makes this go is that we are actually linked to a delivery system as opposed to just an insurance approach, and that makes a fundamental difference. We actually have what's called a System Quality Council. The System Quality Council is composed of all of the entities. And the things that you get qualitatively do not show up on claims data, and I'll give you one of my great examples, and that is coming from home care. They're physically in the home, so they're seeing the kinds of things that go on. They call it the two-hour golden window after discharge planning. So once there's a discharge and once they get home, there's two hours. If you're not there within two hours, things start to happen. Medicine gets lost. Instructions get lost. The parent gets nervous, gets concerned. Back to

the ER. So we know that as a discipline. That's what we do. But again, it won't show up on claim forms anywhere. It is because we have this integrated approach in talking about cases and how we approach the population.

What this leads to is a belief that there has to be a granularity in the approach of looking at the population. It includes the family assessment, as I was explaining earlier about what we do with outreach. What we know is from the social determinant spectrum, there are four things that are big, big factors for us: Housing, finance, nutrition, and the health of the caregiver. And so when they have grand rounds, they'll spend maybe ten minutes on their high-cost cases talking about the issues that are medical. The rest of the time is how do you address these other things.

It's not uncommon for a young mother to call care managers, usually Friday close to five o'clock, and they're calling from somewhere, bus stop, homeless shelter. They've had a discharge and they have nowhere to go. And so everyone has to go scrambling and we have to find -- usually, it's a hotel over the weekend, but hooking up with the different agencies to make sure that they do have some type of support.

There's a special male caregivers support program that has been very effective. It's been around quite some time and the members there tend to be very, very stable.

Sixty-seven percent of the employees in the health plan actually have direct contact with the members, so it's a very active, very engaged population that we work with and they know the members that we're trying to serve. Peer-to-peer support is very, very effective with us. We've found that there have been significant increases in compliance and quality measures.

I'll put this one slide here on behavioral health just to underscore. Almost 63 percent of our members have some behavioral health diagnoses in addition to whatever else is there. But it's fundamentally a part of almost everything that we try to touch.

And it doesn't matter about age. It really is pretty evenly spread across the different age groups.

Of course, over age 13 is much more challenging. We have far less control and the caregiver has far less control in terms of how you're able to affect that.

Which brings me to the caregivers. Under the current CASA program with the District, caregivers are not covered under the benefit. That's a gap. We are talking with the District about it. But that is an issue as we look in particular with behavioral health cases. You really need more family therapy, we find. If the other family members aren't covered, that leads to a hole. So certainly one of the recommendations we have is that you need to cover the whole family to have a really solid approach underneath what you have. This is just a few of the parameters that we're looking at.

We actually partner with a number of different organizations outside. There's something called Sister-to-Sister Circle that was actually intended for caregivers above age 40, and what we found is 20 percent or 25 percent of our caregivers are younger than that and there needed to be something different for them and they're in the middle of crafting and developing something for that now. I think the youngest grandmother we've actually encountered was 24. So it creates a lot of challenges for us.

Foster care is the controller for two percent of the members, which is interesting from a data perspective. Foster care here does not track data by health status, disease status. they use a different system, much like workers' comp tracks by body part. And so when we're trying to compare data, there's some disconnect in terms of the synching and things they're trying to do.

Outcomes -- the outcomes. The first bullet there has actually been studied independently outside of us, that we have improved access to primary care and specialty care relative to fee-for-service. We were able to increase dental access. No secret there. We increased the rates. That was pretty fundamental. There's a managed dental program that's available to us, but the rates -- it just made a lot of sense.

The next two are probably bullets are probably important to you, and that is what has happened to a longitudinal basis in terms of cost. So when we -- and this is fairly recent. We did an assessment looking

at our rate increases compared to commercial health insurance for the years 1996 to 2009 -- 55 percent lower. Big difference.

And the next is we said, okay, let's look more recently, 2003 to 2008, what has happened. And so we looked at the SSI costs across the country, both in the District and the fee-for-service world, and where we were. It was 23 percent in the District, 21 percent nationally. We were at 17 percent, and that's with an all-in cost. It's fully loaded, all the admin, all the machinery, everything. And so when you go over time, you do begin to build those savings, so it has been cost effective.

The last two bullets are just decrease of residential use. I didn't want anyone to think that we're taking away care and we're not giving individuals something. That's not what's occurring. It was actually a good thing. There was a big push to move individuals back to the District, and in particular from out-of-State facilities. It was a big concern for families.

These are some additional findings. I'll lump the first two together. The main thing here is in 2008 to 2010, we looked at 2,600 continuous members, and that was 76 percent of our membership. Their cost increase was only 2.5 percent annually. So again, we see that it's working, especially with continuously enrolled populations, which is the large amount of the membership there.

The last two things we thought were interesting showed up as an artifact, but I thought it would be important just to highlight, and that is a very small panel and a very large panel tend to have similar results, middle of the road, in terms of quality. The sweet spot is 35 to 50 patients in a given physician panel. And this wasn't just with EPSDT. So this is one of the things we want to look deeper at when we start a collaboration with NIH, to see, okay, what does this mean here? What do we need to do differently? We know there's just some practical things, is that the physician and the practice is able to give fewer patients more time. They are complex cases. They have issues. Depending on how much of this is behavioral health, how much of that gets affected, but this is all primary care.

That's just a chart highlighting, again, what we were able to do, really, over a year's period. In terms of residential treatment utilization, it dropped by over 50 percent.

Quality factors, we're pretty proud of this. We reported on 46 of 90 measures for a compass, and we were exceeding national standards and benchmarks in about 36 of the measures, almost 80 percent, whether you were comparing nationally or to other ACAP plans, which are other like-minded, nonprofit, community-based plans.

Okay, the lessons learned. You've heard the social determinant intervention issue before, and I just want to stand up, jump up and down on my head, anything I can do to say this is it, this is where you go, this is where it is, this is where the action is. This makes a difference. We know it does. We live it, we see it, we breathe it. But right behind that you have to look at -- as you do that, you have to make sure that the community-based organizations have the rigor that you're going to need, and I think from that perspective, managed care has developed a good regimen and discipline. You have to make sure they have the data reporting and focus on the outcomes. You don't want to just say, hey, here's the money. That is not good enough for us. And so we are going through this process now with certain nonprofits that we're working with, and we've actually found it to be very interesting when some people from the managed care industry have actually joined these nonprofits. We've had some really great results, very, very exciting, but that rigor is absolutely needed as you do it.

The next thing I would say is the stimulation of real provider systems rather than just an insurance approach, and I know insurance is the game that we're in, but this is a granular need. And so anything you can do or anything that can be done, be it federal or state level, to help stimulate the provider systems -- and that's more than just clinically based systems -- would be very important. We're a big fan of -- next is ASO arrangements, if at all possible. It's a volatile population. That's all we can say. It's a very volatile population. It's very difficult to get actuarially sound rates from year to year.

The other thing that you should think about as you're thinking about the rating piece is removing risk requirements that are beyond the control of plans. I'll give you two examples. One is court-ordered services. The plan doesn't control that. The next is individuals with severe disabilities, that are in long-term care, that you simply aren't going to change the arc very much. And that's a sad statement, but that is true.

Building granular best practices, and by this I mean -- this is one of the things that came from our System Quality Council. If an individual has ADHD and they're in therapy, they can get help only so far working with PT-OT-speech, and at some point, it becomes behavioral. Well, what's the best practice for that handoff? And do they get lost if you're not in an integrated system? We find that they can get lost. In fact, one of the things that we're considering now is developing our own behavioral health approach, and it's very important, these granular things that really can create leakage for you and really have a huge impact on the population.

Define structures for engaging the family, providers, and schools. I have to underscore schools. That's where the kids are most of the time. In the District, interestingly enough, they're getting ready to combine their two special education schools into one, so this is going to be pretty fascinating. We hope to collaborate with them on that.

This other one is very important. We've been around for 20 years. If you asked two years ago -- not even that long ago -- 18 months ago our 140 employees to define care coordination, I guarantee you you'd get 300 different definitions. Well, imagine what it was like in the communities. So we set out to give a definition to care coordination that everyone knew, to families, to providers, to schools. This is our role, this is your role. It's making a significant difference. I know it sounds small, but it is very, very important that everyone understands what their individual role is.

I talked earlier about covering the individual member, and last but not least, especially since we have

an advocate here on the panel, which I'm so excited to see, is engage individuals with disabilities in the discussion. I think their mantra is, "Nothing about us without us."

Thank you very much.

CHAIR ROWLAND: Thank you very much. This has clearly been an excellent continuation of our discussion on population with disabilities that depends on and is covered by the Medicaid program. I think this is one of the central areas in which the Commission is trying to both lay out the issues as well as look at some of the opportunities, and you've given us a lot of very helpful information.

I'm going to open it up for questions from the Commission, and then we'll continue our discussion.

COMMISSIONER ROSENBAUM: This is very helpful. John, you mentioned that you've gone through several different payment mechanisms, and putting your remarks together with Barbara's remarks, it seems to me the issue is how to structure the financing to bring pieces of the delivery system together, but without creating a level of financial risk that sort of backfires.

Can you describe a little bit more what lessons you draw from the different kinds of payment mechanisms you've been under? What were the pluses, what were the downsides?

MR. MATHEWSON: Sure. There have been three. When we initially started, we were at risk, and the population was simply too small. There was just too much variability and volatility to be able to do that. We lost a lot of money in trying to get it off the ground, so we said that's not the way to go.

So we went through a period --

COMMISSIONER ROSENBAUM: All right. So where was the volatility? How small was your group? And did you operate with some sort of a stop loss or the District just came in and gave you extra money?

MR. MATHEWSON: It was full risk in the early years and was less than a thousand members. It was very, very volatile. There was not a stop loss.

We did go through a period where we had reinsurance, but there are no takers at this point given the volatility that we have in the population.

We then went through a period where we went to administrative services only, which was comfortable. There was still a cap, and so there was a guess, there was an actuarial assessment on the population to see where we should be. And usually every year we were within plus or minus 1 percent. The rules of the game changed, and the state, in working with CMS, decided they needed to go back to an at-risk approach, but they knew that that was very problematic for us, and so we went to a risk share with quarter.

It has worked better. However, the issue still becomes where do you peg the rate at the end of the -- in the actuarial range, and one of the challenges and debates we always have is you can't always set the rates at the lowest end of the range and expect it to work. You want to make sure that your infrastructure for the population remains stable, and they're hearing this. We're working together a lot. I think we'll come out with something meaningful as a result, probably some risk share arrangement, and where we have really highlighted a lot are those things where we really don't have any control, such as court-ordered services. And so backing those things out to the degree they can -- and we understand the state wants predictability. Absolutely, we recognize that. It's just a very volatile population. That's why we think it's more important to spend more time around what is the actual provider system of care going to be, and we think that will help to stabilize it a great deal.

COMMISSIONER MOORE: It strikes me in listening to John, but I'd also be interested in Elena's and Barbara's reactions, that while you serve children in your system, special needs kids, there are a lot of parallels, maybe almost all parallel, to serving adults with disabilities. Can you comment on that, and particularly the behavioral health needs, which might be a little different, particularly given the unavailability of services to children, maybe to adults as well? But I'd be interested in your and others' comments, too, as

to, since we've only heard from you about a model of care delivery that's coordinated, what differences you might see with the adult population?

MR. MATHEWSON: Barbara, I'll comment, and then go ahead and take it.

Remember, we do go up to age 26, so we have young adults. What we see is that the DD, or developmental disability, population changes the rules of the game from the pediatric population in general, especially once they're emancipated. And so the steps that we have to go through, you know, you don't necessarily have a caregiver in place to help control things. And right now we're in the middle of talking with the District about going up to an even higher age, and so this population in particular is a big concern to us. We think we're going to have to change our infrastructure to be able to handle it well. So we don't pretend to have a perfect model for that. Largely, we found the over-age-21 population still relatively small, a couple hundred, that are well known to us, they were members for a long time. So we have a grasp on it. But if we were to get a larger influx, we think we'd have to change the rules of the game a little bit. And, also, you got to make sure you have a provider complement that's able to serve this population as well, and that also starts to be a challenge. I mean, the District has a population of, what, 600,000. But the minute you step outside of the District of Columbia, you're in Maryland or Virginia. It's just a confounder.

CHAIR ROWLAND: Barbara?

MS. OTTO: Just a little off topic. I think youth in transition is a huge issue that maybe this body might want to take a look at and consider. There's really a fragmented approach across the states, much less a fragmented approach even across the different delivery systems within a state.

Having said that, a lot of issues we're seeing around network capacity with behavioral health is people being able to operate at the top of their license and payment rates really set much more on a clinical model and a medical model and less so on what we know works. We've got a lot of evidence-based

practice out there on different interventions and mental health prevention even strategies that could be used that we're still not funding because states and our provider networks are confounded on how do we develop a rate around that.

I wish I had something more intelligent to say than that.

COMMISSIONER RILEY: I agree this was a fascinating conversation, and I'm struck with the differentials. I, of course, was attracted to blood from a stone, because those of us who have been on the state side think there's plenty of money within this system. And I still feel that's the case, but the disconnect is -- and it's interesting with your discussions. And Elena talked about the silos. If we build -- the system that we have has been created very ad hoc. It's largely created by providers that are Medicaid-only and experts in one piece of disability or the other. They're very much entrenched in that as the appropriate way to do service. I don't think we know that. I mean, where's the data about what works?

So if we build a system on the status quo, I think we're doomed to fail. If we build a system that's more centered on the people we're serving, like John talks about, and say we really need -- the hell with the silos, we really need to restructure what it is we deliver care, it seems to me then managed care has great promise. The challenge is a political one because you've got a whole entity of providers and advocates in the world who go to court and get the court orders, and we reinvent the same old way of doing services, without, I think -- you talked about data, which I totally agree with -- without the evidence and data about what works.

So it strikes me that we've got to come to some agreement across silos to see the world differently and take some risks, and if we just keep going on can't do it, can't get blood from a stone, I don't see how we ever move this agenda. So I saw a real disconnect between you and John.

MS. NICOLELLA: Can I just make one comment? It's sort of related to the earlier question,

and then also -- the silos -- the point that I was trying to make is certainly some of that is driven by the provider system and by the advocacy groups. But from where I sit, there isn't pressure from the federal government or the state government to change that. So it's very -- it's a very difficult cultural norm to have folks come to the table. And we talk a lot about person-centered care, but even when we talk about person-centered care, it's limited by the services that we're each funding. So it's only person-centered care to the extent it's convenient for the payers.

So I would just urge that the state and federal governments think about how do we as policymakers change that and really do look at the individual and the family.

MS. OTTO: Back to the blood from a stone, I mean, when you're -- let's talk about a state like Illinois where they just cut $2.7 billion out of the Medicaid budget. Basically what they did then is eliminate behavioral health. So while there might be money and we might want to say there's enough money in the system, the problem is that structurally we aren't perhaps funding or establishing -- building provider systems of care. We have definitions of services, and we have agencies that deliver services, and short of blowing the system up and trying to start over, which, you know, I actually think there might be some opportunity in some states to do if they're taking up the Affordable Care Act, I don't see that happening, which is why I gave the recommendation if we had some pressure to have a common set of definitions of what a service is and what a qualified service provider is, we could get focused more on building the provider and the delivery system and less focused on the funding stream for that system.

It's compelling, I think, that we keep hearing the notion of IDD coming up, and it is an area where I think we do have a lot of money in the system, and it's an extremely heterogenous population. However, we don't have a whole lot of data supporting what we're funding, and so perhaps looking at how do we use data and quality-of-life measures more in those high-cost populations would make sense. And it becomes an even bigger issue when you get into youth transition.

So, you know, I guess that's my comment back to you. I mean, if we had some more federal guidance and more infrastructure to support states, it would make it a lot easier to get at some of these silo issues. And it is a political issue, Trish. You know that.

COMMISSIONER GABOW: This was fascinating and informative, so thank you. I have several questions. Can I just run through them?

CHAIR ROWLAND: Of course.

VICE CHAIR SUNDWALL: I do, too, so [off microphone].

COMMISSIONER GABOW: So don't take forever, is what you're saying.

I do think the issue is that there is -- when you realize that we're spending twice as much as every other developed country on health care, it's hard not to believe that there's money to be saved. And I think that what Elena and John put out is what I believe, is that if you create the integrated delivery model and you link it timely to the finance model, and I'm a fan of capitation, if it's done right, because it lets you have the flexibility of moving money to where the need is. So my first question is: What do other countries do to facilitate that? What do we know about how this works in other countries that are spending less and generally have better quality measures than we do?

The second sort of part of that is: Given that we know that if you have standard work for definitions and integrated delivery models, what federal levers would you like to see pulled to facilitate what you have see as useful? I mean, you've alluded to some of it, but I think that would be helpful. So that's my first question, if you would deal with that.

CHAIR ROWLAND: Elena, do you want to start?

MS. NICOLELLA: Sure. I'm going to try to answer what I think I heard as two questions. On the issue about what --

CHAIR ROWLAND: She'll come back with three more.

[Laughter.]

MS. NICOLELLA: On the issue about what do other countries do, my knowledge of international health care financing and policy is limited, but in preparation for today, I was thinking quite a bit about the long-term-care system and Medicaid's role in the long-term-care system, and this notion that we are the primary payer for the majority of people in custodial long-term care. So the length of time that somebody is in, say, a nursing facility will almost guarantee that Medicaid will play a role.

So what we've got is a single-payer system, but it's interesting when you look at what states such as Vermont are doing in trying to pursue a single-payer system for acute care, acute and primary care, that somehow on that end is seen as sort of a value and can bring benefits, but on the long-term care side, it's really not a great thing to be the single payer, and primarily because people come to the system without us being able to impact them at all. So the number of people who enter into a nursing facility without Medicaid eligibility and then because of spend-down eventually do become Medicaid-eligible, there is nothing today that I as a Medicaid Director can do to impact that. That is the way that the system has been set up.

So to lead into answering your second question about what are the federal levers that can be pulled, we're very committed to pursuing an integrated care model for the dually eligible beneficiaries. But that integrated care model doesn't impact the issue that I just talked about. We're still going to have Medicare beneficiaries spend down into Medicaid. And, really, for a portion of adults with disabilities and for the elderly, that is where our spending is, that we are spending the majority of our long-term dollars in nursing homes. So it's not enough to look at the dual eligibles. We really need to have a very -- a much broader look at the entire system, including people who are Medicare-only.

And then in addition to that, I would say this issue of individuals with intellectual disabilities and developmental disabilities, again, the -- I used to work at CMS, and I have to say that that is not a

population that we talked often about. And even on the Medicare side, there doesn't seem to be a whole lot of ownership of that population as a Medicare population either. And yet the impact on cost and the ability of states to design responsive systems of care is really hampered by that sort of lack of attention to the population at the federal financing entities. I don't know if you would agree with that, but -- so I think that needs to be addressed.

MR. MATHEWSON: I can't speak to the international piece very well. That's something that we want to look at more. We actually met with some people over at the State Department to start talking about it. Our initial conversation, what it netted out is that the U.S. has a very different approach to disability than the rest of the world, and so it would be something very different for us to move forward looking at that.

But on the federal levers, the thing that hits me is the definition of medical necessity and how that can be adjusted so that you're able to engage in the activities of social determinant interventions and have it reimbursed.

COMMISSIONER GABOW: So I think since I said it, I think you have both demonstrated in the delivery part of it that integration of care is helpful. Why has the PACE program really not grown? And why is it so expensive if John could show this tremendous savings with improved quality? I'm still confused about that program.

MS. NICOLELLA: So I'll just speak from Rhode Island's experience, and we are a state that's very committed to the PACE model. But what we found is it's not very scalable, for one thing, so we've had the PACE program in for several years, and we have 200-plus enrollees. I think the model is based on a physical site, an adult day center, so that brings with it its own limitations. The notion that a person needs to give up their primary care physician in order to participate in PACE is an area that I know CMS is looking at and I think may already allow programs to waive.

One of the issues that we found is because of the size, the program can't negotiate rates very well with hospitals or even with nursing home providers. They just don't have a negotiating power. And the last issue that we've got with the model is we don't require the PACE organization in Rhode Island to contract with all of the nursing homes. So if a nursing home is not in the PACE network but the person or the family would like admission into a non-network nursing home, that is automatic disenrollment from the PACE program. So from the financing perspective, that's a real issue for us because we've been paying the PACE rate the whole time to divert the institutional stay, and then it's -- and I'm not alluding that our PACE organization does this deliberately, but it's just not a great structural component of PACE. But I think it's the scalability that's the biggest issue.

COMMISSIONER GABOW: So it's the restrictions, it sounds like, that make it not sellable in one geographic spot. No primary care rather than it being integrated is not the problem.

VICE CHAIR SUNDWALL: I'll be brief. I have one question for each of you, and thank you for your presentation. It's obvious to me why this is such a focal point and concern on the Hill and others, the costs and the challenges here.

Barbara, I just share your skepticism about the potential for managed care savings. I admire Trish and Patty for their understanding we have too much health in the system, but, my goodness, the faith -- I call it faith-based policy, having come from Utah where we just had a revision of Medicaid where we're going to require everyone go into risk-based managed care. The extrapolated savings are a mystery to me. You know, hundreds of millions of dollars are going to be saved, they think. And so I think that we're -- while we do have half of our population now in risk-based managed care, I'd like to think that we're going to have to be very alert to better document if the savings accrue. And while it's a policy that's popular and has been adopted, it is troubling.

Are you aware, Patty [sic], with your advocacy, of any bright spots in managed care for the disabled?

Are there some things you could tell us that maybe give us hope?

MS. OTTO: Bright spots -- well, I think that for every bright spot you have someone saying it's a dark stain, so there's no real consensus. But I believe in Wisconsin, outside of the IDD community, people with disabilities were very -- I wouldn't say enthralled, but they were more engaged in a transparent process of determining what services and supports would be made available as they transitioned into Medicaid managed long-term-care services and supports, and by creating their single point of entry for people with disabilities through their aging and disability resource centers and having a five- to ten-year process -- which states really don't have now, but a five- to ten-year process of going county by county, and talking with people about here's how much money we have, so let's talk about what services are critical for you to remain in the community, and by having a third party come in and do customer satisfaction surveys and to have a strong appeals process, I think that has worked well.

Now, if you talk, though, to the IDD community, they didn't feel it worked as well because the facilities, which had a much larger lock on the Medicaid and how the dollars flowed there than other disability populations, weren't as happy.

VICE CHAIR SUNDWALL: Well, any of us who have dealt with the advocacy groups or the disabled, as I did when I was responsible for the Medicaid program in Utah, we know that we have to have more realistic expectations.

MS. OTTO: Right.

VICE CHAIR SUNDWALL: And more is never enough.

Elena, I've got a question for you. I was intrigued with your consolidating your waivers. That's one thing we've heard over and over about how troublesome and complicated and complex and costly it is to do this. Did you really go from 11 to one? This is very impressive to me if you were able to do that?

MS. NICOLELLA: Yes, we did, and we did it through the 1115 waiver authority, which brings

with it its own complexities, primarily having to meet a budget neutrality test. But it was a benefit for us to combine all of the waivers for two reasons. One was the administrative burden was just incredibly decreased for us. But, more importantly, it really forced us to change the way we thought about the home and community-based services and, again, less about the specific program. So, for example, we had an assisted living waiver, which, in retrospect, seems really nonsensical that you would just set up a specific authority to allow people to access assisted living. And if you were a person who had, say, a developmental disability but you're also elderly, you needed to choose which waiver you were going to -- and there's no reason why you can't provide assisted living services to a person with -- an elderly person who happens to have a developmental disability. So it was helpful for everyone to just change the way they thought about the services.

VICE CHAIR SUNDWALL: I'd like to learn more. It sounds like a real model.

John, one last question. First of all, your enthusiasm and positive attitude is really amazing. This is a hard topic, but you seem to really like what you're doing and are proud of what you've accomplished. The one question I have policy-wise is: You say cover the family so freely. I don't know quite what you mean by that, but the data I'm aware of is if you were to pay family caregivers the minimum wage for a 40-hour work week, I think a dated estimate puts that at about $28 billion nationally. How would you possibly achieve that in this economic climate and this era? Do you really think that's a defensible policy position to -- if I understand you, by covering the family, you mean pay for the services that family caregivers provide.

MR. MATHEWSON: Let me say first that my enthusiasm comes from my mission and serving. That's it, plain and simple. So if you can't champion for the disabled, then, you know, your DNA must be --

VICE CHAIR SUNDWALL: That's pretty commendable.

MR. MATHEWSON: There's something going on.

Anyway, here's the issue. Cover the family was just simply coverage. It wasn't paying caregivers, although that is something that we are considering. In the District, under the CASA program, if you are on Medicaid, typically the mother will go into a TANF plan, but if the child has a disability, they enroll the child in our program. So they're disconnected in terms of what plan they're in. So we might not have coverage for them. And what we think is a better approach is to put the whole family together so that we're able to approach it as a family unit. Does that make sense?

VICE CHAIR SUNDWALL: [off microphone] services coverage then?

MR. MATHEWSON: I'm sorry?

VICE CHAIR SUNDWALL: You mean Medicaid coverage?

MR. MATHEWSON: Yes, yes.

VICE CHAIR SUNDWALL: Okay, okay.

COMMISSIONER ROSENBAUM: D.C., just to clarify, there'd be really nobody -- very few people who are totally uninsured.

MR. MATHEWSON: Right.

COMMISSIONER ROSENBAUM: But I think what John is alluding to is that the parents and the children are in different plans.

VICE CHAIR SUNDWALL: I see. Okay [off microphone].

CHAIR ROWLAND: Let me ask one follow-up, and then I know we have to move on. We do have the Affordable Care Act coming in, and we know that even within the traditional Medicaid program, there are people with disabilities who are there by nature of going that pathway, but many others, especially with behavioral health needs, who are not in there.

What should we be thinking about as we look at going forward on these policies with regard to the

implementation of the Affordable Care Act? And are you especially thinking you're going to end up with a lot of additional people who may be putting pressure on these services?

MS. OTTO: Well, from a structural perspective, I'm -- we know that 37 percent of the uninsured -- we know this through the data -- have been diagnosed with some kind of chronic condition. So what are our essential health benefits looking like that will be a part of the benefits this population will now have a path to? And will they be adequate I think is a big issue.

I think that we did not get a lot of strong guidance from our federal partners on what those packages should look like for the newly eligible. And I think it would be a really good idea to be thinking about what that guidance should look like and providing some definition around there, especially around habilitation and mental health.

Finally, what are the triggers within this new eligibility system that are being built that will help the exchanges and the states identify whether somebody needs that deeper diver and indeed should be in either a Medicaid-optional program or in a different program, because right now, when they're brought in, they may be brought in under the modified adjusted gross income and put in a category. What's a trigger to get them out if their service needs are not being met? Right now, safety net providers are meeting those needs, and that money's going away, too. So that's my two cents.

MS. NICOLELLA: So just quickly, we're doing a couple of things to try to prepare for the expansion, and our integrated care initiative is really one of the ways that we're looking at the system and trying to ensure that it's ready for the new eligibles, many of whom we think will have unmet need for behavioral health services, substance abuse services, et cetera. And, again, we're looking at people leaving prisons and ensuring that our system is -- we're one of the states that we would like to ensure people have access to Medicaid coverage the day they are discharged from prison and, when necessary, have a follow-up appointment shortly with a community-based provider that they know.

Rhode Island -- and this is subject to our General Assembly approval, but our secretary does not intend to have a limited benefit package for the expanded Medicaid-eligible folks. I know states have the opportunity to use a benchmark plan. From our perspective, we don't see a whole lot of value in pursuing a benchmark plan. We think some of those support services that we've talked about -- transportation, for example -- are really necessary to allow people access to services.

MR. MATHEWSON: Our approach going to the future is really looking at trying to develop lower-cost models of support and family empowerment. At the end of the day, these are community resources, and so knowing that the community does have limited resources, how do you prepare for the future? For us, that means thinking about care coordination probably for the template of something through home care, which is lower cost, more effective in getting out, but it's an empowerment model, for example, and with home care we require that the family sign a contract delineating here are your responsibilities, here are your accountabilities, and this is ending in 30 days. So it's a very aggressive approach that we think can bear greater fruit over on the care coordination side.

CHAIR ROWLAND: Great. Well, I want to thank you all. This has been a very helpful discussion. I know it's just the beginning of many more discussions we hope to have with you, and we hope you'll continue to work with us. And we wish you all success in the work you're doing, which I think is really inspiring and really helps give us some guidance for where we should be moving forward. So thank you very much.

MR. MATHEWSON: Thank you.

CHAIR ROWLAND: And now we're going to shift gears a little bit as we go to look at another aspect of the Affordable Care Act and the regulations that are coming out with the Medicaid primary care physician payment increase. Obviously, as the Commission on Medicaid and CHIP Access and Payment, we are very interested in looking at not only the payment levels within the Medicaid program, but the impact

that these payment policies may have on access to care for the beneficiaries.

So I welcome our staff person, Jim Teisl, to give us some guidance.

UPDATE ON MEDICAID PRIMARY CARE PHYSICIAN PAYMENT INCREASE

* MR. TEISL: Thank you very much.

VICE CHAIR SUNDWALL: Donna has shown up. It's good to have you here.

MR. TEISL: And so I'll try to move along. I have the session right before lunch, and then I also have the session right before we adjourn, so --

[Laughter.]

MR. TEISL: So as Diane mentioned, we wanted to provide you an update on the final regulations which were recently issued to implement the requirement from the Affordable Care Act for increased payment to certain primary care physicians for primary care services.

So the purpose of this session is threefold: Again, to review the statutory requirements, provide an overview of the final rule implementing the requirements, and incorporating many of the 171 comments that CMS received on the proposed rule, and then highlight some of the key differences.

Just a quick note. The final rule also implements an update to the maximum amount that providers can charge for vaccine administration under the VFC program. We're really going to focus on the primary care payment increase.

So a quick statutory background. As you'll recall, in 2013 and 2014, States must pay at least 100 percent of the Medicare rate for primary care services by a physician with a primary specialty of family medicine, general internal medicine, or pediatric medicine. This applies to both fee-for-service and managed care. Primary care services are defined specifically as evaluation and management procedure codes as well as services related to immunization administration, and States are able to obtain 100 percent Federal financing for the increase over the rates that they paid in their Medicaid program as of July 1, 2009.

This last provision was to prevent States from reducing their payment rates for these services after the bill was enacted in order to attempt a benefit when the required payment increase went into effect.

So a quick walk-through of the regulations in the final rule. This includes services, again, furnished by or under the personal supervision of a physician that self-attests to a specialty of family medicine, general internal medicine, or pediatric medicine. And in the regulation it says, and/or that 60 percent of the Medicaid billing for that provider is for these eligible E&M codes and vaccine administration. This includes sub-specialists, for example, neonatologists, but the authority -- and CMS says this in the preamble to the final regulation -- the authority from the statute does not exist to extend this payment increase to other categories of physicians, most notably probably OB/GYN.

It does include non-physician advanced practitioners working under the personal supervision of an eligible physician. So it would include, for example, nurse practitioners or certified nurse midwives. The final rule removes the proposed requirement that the services would have to be billed under the supervised physician's billing number in deference to the fact that States have different billing requirements for these providers. But it is clear that if in 2009 the State paid these non-physician practitioners at a percentage of what it paid physicians for these services, that practice has to continue under this rule.

VICE CHAIR SUNDWALL: Jim, could I just ask a quick question? Nurse practitioners often practice independently whereas PAs do not. Do nurse practitioners, to get paid this enhanced rate, have to also be under the supervision of a primary care doctor?

MR. TEISL: Yes, and that's the last point I was just going to make. They are clear that the increased payment -- I'm sorry -- is that it has to be under the personal supervision of an eligible physician, and independently practicing advanced practitioners are not eligible for the increase.

They're also clear that the increased payment is for the physician's services benefit under Medicaid, so it wouldn't include services provided by a physician under other benefits, for example, community health

centers or nursing facilities.

VICE CHAIR SUNDWALL: [Off microphone.]

MR. TEISL: Yeah, sure. So what they wanted, they made clear that the increased payment was for these specific E&M codes under the physician benefit for eligible physicians, and to the extent that physicians are providing services under benefits that are paid on the basis of an encounter rate, for example, to a community health center or a per diem, for example, to a nursing facility, those services would not be eligible for the payment increase.

COMMISSIONER ROGERS: What happens to nurse practitioners who are working independently because they're in a rural community where there aren't physicians?

MR. TEISL: Yeah. I mean, under the provisions of this regulation --

COMMISSIONER ROSENBAUM: -- physician services --

MR. TEISL: I'm sorry. Go ahead.

COMMISSIONER ROSENBAUM: The statute is clear. It's just for physician services, certain procedures furnished by physicians. So there is no coverage in the statute for independent practitioners.

MR. TEISL: Correct.

COMMISSIONER GABOW: So I want to be clear about this. So any of these physicians practicing in an FQHC are not eligible for this because they're in encounter rate costs. Okay.

MR. TEISL: Correct.

A couple of new requirements, or a new twist, I guess, in the final rule as opposed to the proposed, is that States may use the Medicaid rate for the specific site of service, where the services are provided, or the State may opt to just use the office setting rate across all settings.

Also, States may choose to apply Medicare's regional adjustment if it has multiple Medicare regions, or can apply the average rate over all the counties. This was in response to a lot of comments about State

payment systems not necessarily being set up to account for paying different amounts for different sites of service or different regions within the State.

States may make the payment as add-ons to the existing rates, so they can increase the rate that they pay on a claim, or they can make lump-sum payments to account for the increase. If lump sums, it should be no less often than quarterly. Payments can be made retroactively to account for the increase once the required State plan amendment has been approved. And they're also clear that the increase has to go to the eligible provider regardless of whether that provider is paid under a salary, some sort of a sub-capitation arrangement, or fee-for-service.

So State plan requirements. States are required to submit a State plan to implement the payment increase. They need to identify all the eligible codes that it will pay at the increased Medicare rates in 2013 and 2014, and also must identify all codes that weren't reimbursed by Medicaid as of July 1, 2009. That's because it appears that for newly added codes since 2009, the State will be able to get 100 percent Federal match for the difference between zero and the Medicare rate, but CMS has stated they don't intend for States to be adding codes simply to maximize reimbursement. So they're going to need to include both the codes that they will pay under the increase as well as codes that weren't reimbursed as of 2009. And then, obviously, they'll need to specify whether they're going to adjust payment for site of service and region.

CMS has also committed to providing a template to States to use for submitting their State plan amendments.

Again, 100 percent of the amount by which the required payment exceeds the amount that would have been paid as of 7/1/2009 is -- that's eligible for 100 percent matching funds. When determining what was paid for the eligible services in 2009, States are to exclude any incentive payments or bonus payments or other performance-based supplemental payments, but are required to include supplemental payments that are linked to volume, such as those that we've talked about in past sessions that are made to physicians

employed by State university medical centers. So States will actually need to figure out how to allocate the extent to which those supplemental payments apply to these eligible codes and eligible physicians.

Let's see. CMS will issue reporting requirements by the end of the first calendar quarter in 2013. They're clear that non-claims-related costs, such as increased admin expenses, are not eligible for the 100 percent matching funds. But they also are clear in the final rule that the increase in the amount of Medicare cost sharing that States will pay will be eligible for 100 percent matching funds. We're going to talk more this afternoon about State policies for payment of deductibles and coinsurance for dual-eligible individuals to the extent that this payment increase results in increased payment of cost sharing. That is eligible for 100 percent match.

Quickly, managed care requirements. Contracts must require the plans to make the payments to the specified physicians, again, whether that's directly or through sub-capitation arrangements. Plans must provide documentation sufficient for States and CMS to ensure that the payments are increased.

And for managed care contracts, the State needs to submit two methodologies to their regional offices for approval, the first to identify the payments to the managed care plans for the specified primary care services as of 2009, and then their methodology for identifying the differential from 2009 to the required payment in 2013 and 2014. States have until March 31, 2013, to submit these methodologies for approval. That's actually a three-month extension over the December 31 requirement that was in the proposed rule.

CMS has also awarded a technical assistance contract to a firm with actuarial experience that's going to be developing a framework for States to use, and they anticipate providing written guidance and holding informational calls before 2013.

So here on your slide is just a table with some of the significant changes, for example, whether or not -- States are no longer required to apply the site of service and regional adjustments. Now, it's an

option. It expanded the specialty boards under which the eligible physicians may be certified. It is, again, self-attestation of eligibility by physicians now and States will be required to audit a statistically valid sample each year rather than verifying the eligibility of all physicians.

Just as a reminder, we have initiated a project to work with a number of States to better understand that the decisions they're making around implementation of this requirement, what the potential implications of the decisions are, for example, what are the potential effects that they see in their State, how do they plan to do any sort of evaluation, and what aspects of the policy might they seek to retain or change.

We actually started some of our structured interviews with States prior to the issuing of the final rules, and so, naturally, we heard a lot of, "We're waiting for the final rules." So now that those are out, we're hoping to be able to discuss a little bit further what decisions they're going to be making to implement.

Again, we're conducting the structured interviews and we're talking with State Medicaid policy officials, technical MMIS staff, provider representatives, as well as representatives of Medicaid managed care plans in the States.

So a number of issues for the Commission's consideration, and obviously for States and plans. Will States implement the rate changes? For example, will States implement the changes in the Medicare rates that may occur throughout the year? They also have the option of just locking in the rate at the beginning of the year and paying it throughout. Will they choose to adjust for site of service and regional adjustment? To what extent do States do that now, or might they choose to change the policy that they currently have in place? How will they allocate those lump sums across specific services? There are obviously program integrity issues to be considered, evaluation issues. And really, those last two are probably key. How will CMS and the States evaluate the effect of the increase on access, particularly considering all of the other things that are going on at the same time. And then, obviously, what happens when the temporary increase ends in 2015?

CHAIR ROWLAND: Jim, obviously, one of the changes from the proposed to the final rule was the requirement that States submit data on service utilization and physician participation. Is there any guidance on, one, how they -- will they have a uniform way of reporting that?

MR. TEISL: Yeah. I didn't -- I, at one point, think I had written or highlighted, but it basically says in the form that CMS requires at such time as they require it, or something along those lines. So guidance is still ultimately pending on sort of what the specific data, on what the format is going to be. But that is an important change.

CHAIR ROWLAND: Because since one of our challenges is obviously to evaluate what the effect physician payment rates have been and will be on participation, perhaps that's an area where we would want to be sure we're aware or maybe make some suggestions about what that reporting could be like and how simple it could be in comparison to what data we think we would need.

Okay. I see Mark and then Patty and then Donna.

COMMISSIONER HOYT: I had a couple of questions. Maybe this is going to be covered in what you mentioned about methodology. They relate to managed care plans or managed care contracting.

How would the additional payment be calculated? This is sort of flavored by some of my experience negotiating rates with plans where -- this is a little bit dated now, but I would suspect it's still true in some States -- where they said, we just can't put a network together of your rates so we have to pay more for primary care than you pay. So would the delta be calculated off of what the plan's physician reimbursement is or would it be the Medicaid fee-for-service schedule, if lower?

MR. TEISL: So the delta or the difference eligible for the 100 percent FMAP is the delta between what the State paid plans for these services and physicians in 2009 and what the State will pay in order to implement the required increase. So it's the increase in capitation payments of a plan.

COMMISSIONER HOYT: I guess that would depend, then, on how they're going to -- it seems

kind of circular to me. In most States, if you were trying to pull apart a capitation rate and figure out how much was for specific -- especially like ICD-10 codes or something -- in a primary care line, that would be kind of like a silly joke. So I'll be interested to see how they do that.

And then you'd have a question of, are you going to do it the same for every plan or would it vary by plan? So you'd want to pull all the plans apart and analyze them separately.

And then, lastly, on the utilization, at least for managed care plans, in my mind, you'd use the encounter data rather than have them come up with some additional set of reporting requirements. Just use the encounter data that are already submitted.

But what about the plan question? Would it vary by plan, or --

MR. TEISL: I can't recall a specific statement about variation by plan. I think, if my understanding is correct, that States are required to submit a methodology that they will use to calculate the increase within their managed care plans. So I don't know that it's specific that that methodology has to be sort of standard across plans, but I think that that may be an approach that States would take. But it's something we can look into and see if --

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: I think we should use this as a dramatic poster child example for what's wrong with our current system. I mean, this is -- I mean, it's like a nightmare, a bad dream, that something that was intended to do good -- you know, let's help with primary care -- and how in the current payment and delivery model, wanting to do a good thing becomes so complex and so construed in thousands of rules that it ends up probably being something that people won't like at the end and we won't even be able probably to know because of all the other things that are going on.

I'm not joking about saying that this is an example of why we need more fundamental changes in our payment models and our delivery models if we're really going to get to high-value, low-cost, high-quality

care for America, because as we try to do these on-the-edges fix for something that is inherently broken, we simply add more complexity and are unable to have the clarity of what it did in the end.

So I'm serious about using this as an example of why we need major payment reform.

CHAIR ROWLAND: Donna.

COMMISSIONER CHECKETT: You know -- well, actually, I'm going to respond to -- hey, if you knew what I went through to be here, I'm very glad to be here. Thank you.

Actually, I want to follow up on Patty's comment first because you stated it so well and there may even be a broader opportunity for us to just do education on, really, what defines primary care. I don't know. I remember a number of years ago, there was some reporting -- I can't even quite remember what it was -- on physician increases, and yet it completely left out osteopaths. Well, if you really know anything about people who really serve a lot of the nation's poor, they're osteopathic physicians who are also physicians. They just didn't happen to go to a certain type of an allopathic medical school.

And I look at this and this reminds me of that in that it's left out OB, it's left out advanced nurse practitioners. We need to help people inside the Beltway understand who's really providing primary care to Medicaid beneficiaries and in what settings.

So, again, I think a really good intentioned, well intentioned effort, you wonder if it's going to get to the mark or not.

And then specifically to Jim, I do wonder, has there been discussion about the fact that many managed care plans and, indeed, some States are already paying at Medicare for these services, and so how do the managed care plans pass this increase on, then? If, say here would be the example, the State's at 50 percent of Medicare or 75 percent of Medicare but the plans are paying at Medicare, then are you supposed to pass those additional funds on? Could you clarify? Thank you.

MR. TEISL: Let me see if I understand the question. So you're saying under fee-for-service, the

payment rates are 50 percent of Medicare, but the plans already were paying at Medicare levels?

COMMISSIONER CHECKETT: Some plans will be paying that or close to, just as part of negotiations or to build a primary care network.

MR. TEISL: Yeah, so --

COMMISSIONER CHECKETT: So are the doctors going to get, like, a double-bump, which wouldn't be bad, but --

MR. TEISL: No. To the extent the plans were already paying at Medicare levels, there is sort of no increase.

COMMISSIONER ROSENBAUM: But I don't know how -- and this goes to Mark's question -- the States' stated fee schedule -- the question is, does the reg key off the fee schedule as it stood on July 2009, which is my understanding. It can't possibly -- I don't know how anybody could possibly do the variable adjustments to figure out for what proportion of the population that fee schedule actually wasn't even in effect, so --

MR. TEISL: Yeah. And one thing I'd mention about the final rule that was different from the proposed rule is -- and you see this in a lot of the commentary throughout the preamble -- is CMS is sort of saying, we're asking the States how you're going to do this calculation and now requiring you to submit these two methodologies. You know, they hired somebody to help in providing a framework, but they really are sort of turning back to the States to say, tell us how you're going to do this, for our approval, ultimately.

COMMISSIONER RILEY: I agree with everything that's been said, but we do have this thing. It's moving forward. So it strikes me as the craziness of the two-year-ness. There will be those who will want to make conclusions about access based on this two-year temporary thing. So it strikes me in our case studies, that I think are great and the questions you've raised here, I would really hone in on really drilling down on the questions with both physicians and States about what do they really think about this

two-year thing. Is it just -- you know, I would think for most -- I would think, practically, you'd think it's a bonus. It's two years of bonus that's going to go away. Why should we expect it to change behavior? So I'd like to get a better baseline of what their expectations are for their own behavior for a two-year bump.

CHAIR ROWLAND: I'd also like to see us do a case study in a State that's already been paying at the Medicaid rate, just so that we have a comparison there of, you know –

COMMISSIONER GABOW: To that point, we know this with the community health centers. When you have the FQH bump, you end up at the Medicaid rate. So I'm not sure that we don't already know what paying at that rate does to access and quality or whatever else you want, and --

CHAIR ROWLAND: We don't know what it does to participation outside of this, and --

COMMISSIONER GABOW: Well, but --

CHAIR ROWLAND: -- but we would if we looked at a State.

COMMISSIONER GABOW: But if you looked at a State that -- presumably, every State has FQHCs where they're paying the rate to the non-FQHCs and the FQHC wants the distribution of the Medicaid population, and I think it wouldn't be --

COMMISSIONER ROSENBAUM: I'm just thinking that we're going to have to be very, very careful about where we go for these cases because you want parts of States where there's no organized managed care that's negotiated higher rates, where you don't have clinical providers that actually -- to the extent that they're using contract doctors, not just their employed doctors but contractual doctors whom they've negotiated separate rates with -- an FQHC and its encounter rate can negotiate, if it needs to negotiate a different rate with a doctor -- where you sort of have a lot of physicians in independent practice who were directly billing the Medicaid program. And that's really kind of the pure look at this issue.

And so it would be, I would think, more, ironically, more general internal medicine for older adults with disabilities. It's not going to be pediatrics. They're, by and large, in managed care arrangements.

It's not going to be people who are cared for at clinical providers paid in an alternative fashion. So it's really sort of a very narrowly conceived intervention, which you have to be careful about how we structure it.

VICE CHAIR SUNDWALL: As a primary care doc, let me just speak up and say that I believe there are -- it's not an insignificant number of non-participating physicians in Medicaid, and I think the intent of this is clear. It's not those in FQHCs or those who are paid in other ways. It's to see if the degree of participation in Medicaid will improve if they're paid better, and if they are, that's going to be a compelling argument to increase the rate in two years. But that's the audience. It's not -- maybe not quite as -- I mean, the process is unbearably complicated, but the intent is quite care to me. See if we can improve access to health care for the poor by getting more primary care doctors who aren't currently participating in Medicaid to sign up.

COMMISSIONER GABOW: But you have set up an experimental system that is impossible to evaluate, so you will not be able to answer that question. So I think that that was my point. The intent was well meaning and admirable, but the design will make it impossible to answer the question that was being posed.

CHAIR ROWLAND: Okay. Denise.

COMMISSIONER HENNING: And by leaving out nurse practitioners and nurse midwives, who basically -- that is what we do, is primary care -- by doing that, you're eliminating the opportunity for that whole provider group to be involved in this thing. And it's also just another way that we get forgotten about.

When people look to hire a nurse practitioner, and in particular a nurse midwife, the State of Florida pays me $180 less to deliver a baby than they pay an OB. It's the same amount of work. In fact, it's probably more work for me to deliver a baby than it is for a doctor. So when they're looking at it dollars

and cents -- and it's not even so much the delivering of the baby, it's at the office. You know, if I'm seeing 20 patients in the office and they have to take a 20 percent hit every time I see a patient, then it makes me less attractive for them to hire, because although they pay me less money, they don't pay me enough less money to take that 20 percent hit on each patient that I see.

So, again, the primary care piece of this whole thing, if you're leaving out a whole class of providers, and there are a lot of States where nurse practitioners are independent providers of care, so they don't need physicians to sign anything for them to provide care to people, and yet by these rules, they're saying you have to provide that service under a physician, you're now narrowing the scope of practice for a lot of nurse practitioners who are providing care in rural areas that are the very people that we're trying to reach with the expansion of Medicaid and expanding insurance across the board.

CHAIR ROWLAND: But let's be clear here. This regulation is based on statutory language that has many restrictions, and I think our response is, first, to say this is our comments on this regulation and on the policy that it embodies from the statute. But we really need to look broader at how should payment be reformed under the Medicaid program and is this a baby step that went awry with good intentions, but how could it have been better improved. And so with that --

VICE CHAIR SUNDWALL: Are we commenting? Excuse me. Are we commenting on this? It's a final rule.

CHAIR ROWLAND: No.

VICE CHAIR SUNDWALL: Okay.

CHAIR ROWLAND: But we will, obviously, in our work on physician payment, this becomes a piece of our body of work, these studies. We'll look at it. We may well want to comment on what HHS is going to ask of the States in terms of their reporting so that we know whether the data will be useful, not useful, or whatever. And we will just keep Jim on the hot spot for a long time working on these issues

because this is clearly only the tip of an iceberg to the broader payment issues that we have to take on, and that's where I think scope of practice, who's really doing what -- and as we've talked about before, one of the big issues in Medicaid is not access necessarily to primary care services where the community health centers and others have been on the front lines. It's really some of the specialty and sub-specialty care that this regulation and this policy doesn't touch at all. So I think what we need to come back with is kind of an agenda for payment analysis and reform that goes beyond the scope of just this particular provision of the ACA.

So thank you, and Jim, we'll look forward to hearing you later.

VICE CHAIR SUNDWALL: Jim, be assured, we don't blame you for this --

[Laughter.]

CHAIR ROWLAND: And with that, we're going to take a break for lunch and we'll convene as close as possible to one o'clock. Thank you.

[Whereupon, at 12:18 p.m., the meeting was recessed, to reconvene at 1:00 p.m., this same day.]

AFTERNOON SESSION [1:09 p.m.]

CHAIR ROWLAND: If we could start to reassemble, that would be great.

We started the session before lunch with a simple description of the final rule on the primary care bump-up, and now we'll go to another simple description of the interaction between Medicaid, CHIP, and the exchanges. And so Chris Peterson is going to guide us through this discussion and through some of the issues that as a Commission we need to really begin to take on and develop some evidence and some recommendations on how this can proceed more simply and smoothly than might otherwise happen.

Chris?

OPTIONS RELATED TO MEDICAID, CHIP AND EXCHANGE INTERACTIONS

* MR. PETERSON: Thank you, Diane.

Yes, so this session continues the discussion on options related to Medicaid, CHIP, and exchange interactions. Slide 2, for those of you who have your back to the screen. In this session I want to review the proposed schedule to get to a chapter on the ACA in our March report, and then I'll review once more the four issues that we have discussed for some time now on churning, TMA, limitations on Medicaid and CHIP to wrap around other coverage, and differing benefits among low-income adults.

Previously, we've discussed some options to address these four issues, and the paper that the Commissioners have received lays out a number of potential options and the pros and cons of each. And then we'll close with a review of next steps and additional time for discussion.

Our primary goal here today is to get from you your feedback on which options we can rule out. So although the paper you have discusses the broad policy implications of the various options, our next step will be to reach out to CBO to work on cost estimates for the options, so we want to be judicious with their time and the additional analysis that staff will have to do for the next meeting. So ruling out options would be extremely helpful today.

Slide 3, in terms of the proposed schedule --

CHAIR ROWLAND: Chris, just to be clear, this is then for our presentation for our January meeting?

MR. PETERSON: Correct, right. So for our schedule, in terms of content, for March we are proposing to look at eligibility, enrollment, and benefits, and then for a possible June ACA chapter, we could focus on differing cost sharing in Medicaid, CHIP, and exchanges, differing plan requirements for Medicaid, CHIP, and exchanges. Then as Diane mentioned, for January 2013, that's when we would have

real consideration of potential recommendations and review of the draft chapter at that point, and then the February meeting would be final consideration of recommendations and any last review of the chapter.

A slide on churning --

COMMISSIONER GABOW: Regarding this timeline, do we have any sense of when states will have to have decided these issues in order to be up and rolling for January 2014?

MR. PETERSON: I would say less so on the Medicaid side. I think on the exchange side of the house there have been some pretty hard deadlines that have been set. But I have not seen that similar level of requirements. So I can't speak to that specifically.

COMMISSIONER GABOW: But functionally.

COMMISSIONER ROSENBAUM: Medicaid, when the Medicaid changes would have to be made?

COMMISSIONER GABOW: When, if the state is going to have their exchanges up and running by 2014, and we're talking about some issues related to that, are we out of sync with the timing when we put this in for when they are going to have to make decisions?

COMMISSIONER ROSENBAUM: I don't think so, because I think that there are tremendous timelines around the exchanges, of course, but it is already clear, if only because of the Supreme Court's decision in June, that states have a lot of flexibility around when they're going to start their Medicaid reform. So I think we will be timely. I mean, ideally, the state would be trying to deal with both markets at the same time, but there may be many states that won't.

CHAIR ROWLAND: I think a more critical issue is that some of these things that Chris is going to talk about may require statutory change.

COMMISSIONER ROSENBAUM: Yeah, exactly.

CHAIR ROWLAND: And the timing on that is obviously to at least begin to talk to Congress

about it. So the timing is as best we can do it, but I think we really need to focus in January and February on getting anything that needs to be into the congressional mix.

COMMISSIONER MOORE: I was just going to say it would be useful to know -- to have talked to some states about this, which you guys may have already done. I think it's too late for us to hear from states, although I'd love to do that. But I just think on these kinds of things, the more we can hear from some states about their experience, their expectation, their problems, their challenges, the better off we are. And I just don't know whether we've got time to build that into this or not. But just keeping that in mind.

MR. PETERSON: Yeah. No, that's a good point, and we have done that at a staff level, reached out to states and talked to various states about these, and CMS, just kind of to make sure we're not missing something.

So now the next slide on churning, and we want to revisit that. And thanks to Lindsay Hebert for doing the research on this paper and for writing it.

So in 2014, millions of individuals may move between Medicaid, CHIP, and exchange coverage as their eligibility changes over the course of the year. The issue paper that you have gives numerous examples of cases where churn occurs, its effects, and state tools to minimize churn, including 12-month continuous eligibility, which -- so, again, continuous eligibility means it is not necessary for a family to report changes in their income within their 12-month window, and more than half the states do this for children in Medicaid and CHIP, and we've noted in the past that 12-month continuous eligibility for children in Medicaid is a statutory option that's explicitly in the statute. And although it is not an explicit statutory option for adults in Medicaid, states currently accomplish it by using their flexibility in how they count income to say, okay, adults, we are simply going to disregard any changes in your income for the next 12 months. However, once the new income counting standard, modified adjusted gross income, MAGI, goes into effect, for many populations in Medicaid this state flexibility will be gone, and with it the ability to do

12-month continuous eligibility for adults in Medicaid.

I also want to point out something particularly important. There is, in fact, no statutory provision for 12-month continuous eligibility in CHIP. In CHIP, 12-month continuous eligibility is also implemented through states' income counting flexibility, and currently 33 states offer 12-month continuous eligibility for children in CHIP. Thus, because of MAGI, in 2014 the state plan option in CHIP to do 12-month continuous eligibility also appears to go away.

So the options that we have laid out are, one, to provide CHIP state plan option for 12-month continuous eligibility; two is to provide Medicaid state plan option for 12-month continuous eligibility for adults; and then there is to require states to implement 12-month continuous eligibility.

So the first two are to provide states with options that they already have but that go away in 2014. As I said, if the Commission is interested in pursuing these options further, we would work with CBO to get estimates of the federal costs. Again, the first two would be doing this at state option. Some of the federal costs could be offset by people not going into subsidized exchange coverage since CBO projects that subsidized exchange coverage is more expensive than Medicaid.

The third option here is whether to recommend Congress require states to do 12-month continuous eligibility, and while this would be quite costly, it would reduce churning. And then --

VICE CHAIR SUNDWALL: Just so I'm clear [off microphone].

CHAIR ROWLAND: Microphone.

VICE CHAIR SUNDWALL: Just so I'm clear, the options you're laying out would be for our consideration of recommendations to make in our report.

MR. PETERSON: That's right, and what I would like to know is which of these should we strike and no longer consider so that when we come back in January we've narrowed down the list somewhat.

VICE CHAIR SUNDWALL: Strike the require -- [off microphone].

CHAIR ROWLAND: I would question whether the fourth option, maintain the status quo, is accurate since it's not the current status quo. It's the new provisions that come in under the ACA. So I think that at least has to be clarified.

COMMISSIONER EDELSTEIN: Before we get to the options, Chris, there's a request I'd like to make in the drafting of the work with regard to the first bullet. Within pediatric services, I don't believe there is any service that varies more between Medicaid, CHIP, and exchange coverage than dental. They are completely different levels of coverage, and so here churning makes a tremendous difference in the continuity of care, whereas I don't think that's true for any other pediatric service. So it would be a terrific citation in your chapter as an example of why churning can really mess with benefits.

COMMISSIONER ROSENBAUM: Well, actually, just to add on, though, it would matter for children with serious and chronic health conditions who get the depth of coverage in Medicaid that they're probably not going to get under essential benefits. But I agree with you that in terms of primary treatments, dental is a terrific example.

CHAIR ROWLAND: Let me do this. Let me have Chris actually go through the four issues.

COMMISSIONER ROSENBAUM: And then go back, right.

CHAIR ROWLAND: So that we can come back and have a discussion based on all four of them and are able to see where we want to focus our attention.

MR. PETERSON: All right. So the next issue is TMA, transitional medical assistance. Again, TMA prevent uninsurance primarily among low-income parents by requiring states to provide six months of Medicaid coverage when the family's income has risen about a state's eligibility level. So current eligibility levels for parents vary widely by state, from 17 percent of poverty in Arkansas, which for a family of three is $3,245 in annual income, to 133 percent of poverty or more in several states.

So in Arkansas, for example, as a Medicaid-enrolled parent's income rises from $3,000 a year to

$4,000 a year, they would then be ineligible, except that TMA provides another six months or more of coverage. Although their children would also get TMA, TMA is not as critical to prevent uninsurance for children because there are other pathways into Medicaid and CHIP for children higher up the income scale, pathways that don't exist for parents.

Six-month TMA has been in place since 1988 with the state option to cover more months. But Congress has to perennially extend its funding, so that's what makes TMA different than many other Medicaid provisions.

Currently, funding for six-month TMA ends December 31st. If allowed to expire, TMA would revert to its four-month duration. That is permanently in the statute. So if past is prologue, one might expect legislation soon to include TMA in the extenders we might be seeing over the next couple of months.

Assuming it is extended through 2013, the issue for our March report pertains to TMA in 2014. In 2014, in states that go to 138 percent of poverty, with subsidized exchange coverage going up to 400 percent of poverty, will TMA actually create more confusion and administrative burden than it's worth? And, of course, the tradeoff is that TMA provides more comprehensive coverage and less cost sharing than, for example, if individuals were to move into exchange coverage. And so the options we put up here is to extend six-month TMA, as has been done for the past several years and/or, to allow states to opt out of TMA if they implement the expansion to 138 percent of poverty, thinking that now coverage exists these individuals won't be uninsured.

The third option is kind of what Diane alluded to before as a quasi-status quo, and that is, if Congress takes no action, that has an effect of six-month TMA expiring and it reverting to four months of coverage. So that is the TMA option.

Issue number three has to do with limitations on Medicaid and CHIP to wrap around other

coverage. Although Medicaid has historically played a role in supplementing private insurance, this is not permitted for subsidized exchange coverage. The ACA says that in 2014 individuals can only be in one what the ACA calls state health subsidy programs, and those are Medicaid, CHIP, subsidized exchange coverage, and the basic health program.

So the options are to allow states to supplement coverage with Medicaid based on criteria established by the states. The second option is merely the first one but limited to a particular subpopulation. For example, children have been a particular priority to the Congress with respect to Medicaid and CHIP, so limiting to a subpopulation could reduce the potential cost of this option, which, again, would be at state option. And then maintain the status quo.

The final option, number four, differing benefits among low-income adults, and thanks to our new analyst Ben Finder for helping to put these options together. The new adult group will receive essential health benefits, and that includes things like preventive benefits, chronic disease management, substance abuse treatment, and some of these may be benefits that are not required for existing eligibility groups such as low-income parents under Section 1931. So as I said, that means that these higher-income parents who will come into the new adult group may have benefits that the lower-income parents under 1931 do not have. So there's inequity for people who appear similar, and so options to address this:

One is to allow states that implement the expansion to 138 percent of poverty to enroll all parents in this new adult group.

Another way to go about it is to say, well, in addition to what you currently cover in your regular Medicaid benefit, require traditional Medicaid to cover, also cover essential health benefits. And then there's the status quo.

So, in conclusion, we would like to hear which, if any, of these options merit bringing back to you in our next meeting, which ones we can rule out, and are there other analyses or state approaches that we

should examine. And I'll turn it back over to you and look forward to your feedback and thoughts.

CHAIR ROWLAND: Or are there other more creative options that the Commission members want to come up with?

COMMISSIONER MOORE: Can I just ask for a clarification? I think I'm being slow today. The limits on the wrap-around, can you back through that? Give me an example. I don't know --

MR. PETERSON: So let's think about the current world. If you are, let's say, a child who has special health care needs and your parents have employer-sponsored coverage, if your income is low enough to qualify for Medicaid, then Medicaid is the secondary payer, that is to say, the employer-sponsored coverage pays first, but what the employer-sponsored coverage does not cover, that child can get their needs met through the Medicaid program.

So what happens under the ACA is the ACA says if you are eligible for subsidized exchange coverage, you cannot get Medicaid. One or the other, regardless. So the option then is to allow states the flexibility, if you want to, state, cover certain individuals through Medicaid, notwithstanding subsidized exchange coverage, to permit that.

CHAIR ROWLAND: And to receive federal matching funds for that.

[Inaudible comments off microphone.]

COMMISSIONER ROSENBAUM: I mean, I think the issue is that right now states have the option -- a lot of different options to set more liberal eligibility standards for various subcategories, including people with disabilities. You want to make it possible for a state to continue to be able to exercise that option without costing the individual and family potentially, in the case where they're above the exchange threshold, without costing them the exchange enrollment for two reasons: one is because it offsets costs to the state, and the second, because I think a lot of families, especially for family coverage, if you imagine, you know, a couple of parents and three kids, one of whom is very disabled, the family might

want to go buy a family plan in the exchange, have everybody in the family plan, and then have Medicaid as a secondary payer for the child with the disability. And we saw this very case a couple of weeks ago. I was saying to Chris before, in the Medicaid partnership briefing in which they brought in a child with cystic fibrosis who's a member of a working family with employer coverage, the family all has employer coverage, the child has Medicaid as a secondary payer. And if it weren't for Medicaid, the limits of the employer coverage are so -- you know, they're very limited. The child would have no coverage.

So the family was extremely -- was there, you know, to give testimonial to Medicaid, but it was a family with employer coverage, and that's what, ironically, under the Affordable Care Act we no longer allow, if that family, instead of getting employer coverage, gets exchange coverage. So this is -- and, you know, if it's not permitted, one of my big concerns is that a lot of states will be incentivized to drop their disability coverage because they don't want -- you know, you want to have the primary exchange coverage. This, it seems to me, is a way to incentivize states to hold onto the disability coverage, which is not a mandatory coverage item, but giving them the offset of the primary insurance.

CHAIR ROWLAND: Because Medicaid would remain a second payer.

COMMISSIONER CHECKETT: A question. Chris, help me recall and understand the relationship of the option -- I think it's called premium assistance, where states purchase and make a payment to someone's employer, in other words, paying for the premium, and then providing a wrap-around. How does that affect it? I think it's not quite the same thing as what we're talking about here.

MR. PETERSON: Right, because what we're talking about here has to do with the subsidized exchange coverage, which is really not group coverage.

COMMISSIONER CHECKETT: Okay.

MR. PETERSON: Premium assistance, by and large, is employer --

COMMISSIONER CHECKETT: All right. That's helpful.

MR. PETERSON: -- sponsored, and so that's where the Medicaid program says, okay, employer, you're kicking in a certain amount, we will kick in the Medicaid enrollee's share of that.

COMMISSIONER CHECKETT: Right. And so this prohibition does not affect that --

MR. PETERSON: Correct.

COMMISSIONER CHECKETT: I think that's what I was really driving at.

MR. PETERSON: Yeah. That's right.

COMMISSIONER CHECKETT: So that still stands--

MR. PETERSON: That still stands.

COMMISSIONER CHECKETT: -- if states are interested in that, and we can provide the wrap-around there. We can't provide a wrap-around --

CHAIR ROWLAND: That's the paradox.

COMMISSIONER CHECKETT: Got it, got it. Yeah, and it should be another point to call out in a report.

COMMISSIONER ROSENBAUM: Yes.

COMMISSIONER RILEY: I think that's right, because actually when you think about the Medicaid wrap, you think about administrative complexity. But it does invite the question of we know the subsidies won't be adequate for people at the break point. So it does invite the notion of a premium assistance-like effort to supplement the subsidies rather than the whole wrap of services, although you might want to do that for disability only.

COMMISSIONER ROSENBAUM: I mean, if you think -- where it really is going to matter, I would say -- and it sort of all rolls up into one big ball because then we also get to this question of whether you give states the option of altering benefit design for the low-income population. But at some point

where the rubber really hits the road on this one is for children and adults who clearly under a more liberal disability program in Medicaid would get a deeper coverage both in terms of classes of benefits and amount, duration, and scope. And I think we might incentivize some states to hold onto that if they did not have to be the primary insurer for everything.

Now, there are, I assume -- there must have been some -- and we'll talk about this -- some assumptions made about people with disabilities remaining outside the exchange and in the expanded Medicaid pool -- in the expanded Medicaid program, and I don't know how that affects premium subsidy costs and other things.

COMMISSIONER RILEY: But then we create a new class of dual eligibles.

COMMISSIONER ROSENBAUM: Yes, we do. But they exist today. That's the premium assistance group.

COMMISSIONER RILEY: But another option -- it may not be realistic, but another option to this and to churning would be to do some mandates about health plans in the exchange, and that health plans in the exchange must do A, B, and C. It's probably more regulatory than we want to be, but it seems to me it's a legitimate option to consider.

COMMISSIONER ROSENBAUM: Yes.

CHAIR ROWLAND: So add it to the list.

COMMISSIONER ROSENBAUM: And I do want to argue for leaving on the list the mandatory approach. I know David would like to see it off the list. The reason I want to leave the mandatory approach on the list for Option 1, Issue 1, is because I think the way a lot of states would think about it -- I would if I were a state -- is why would I want to guarantee enrollment because if the family qualifies for the subsidy, once my federal contribution starts to drop down, I'm essentially inviting exposure for myself. And I'm not sure that's the right way to think about it, and it might show up in a cost estimate once we see

the assumptions, that actually it seems like it's going to cost you more money, but for a bunch of other reasons, it would not, to stabilize enrollment. So I would say it's worth in terms of thinking about how the different options would play out, what they would cost, is to leave the option on the list. And then if we see that it's, you know, a huge cost to state Medicaid programs to do this, we can --

COMMISSIONER RILEY: But the issue there, it seems to me, is who pays. It isn't whether or not one should have continued -- so you really should look at a - those of us who do --

COMMISSIONER ROSENBAUM: They do match.

COMMISSIONER RILEY: -- disregards to make people eligible did so so that they wouldn't become uninsured. But now this is the exchange, so it seems to me it takes away the argument for disregards or for continuous eligibility unless the exchange pays for it. It's paid for from the subsidy pool and not the Medicaid pool. And I don't know how doable that would be.

CHAIR ROWLAND: But that's where you get into the issue of but then are they changing plans or are they in the same plan. So it's more complicated. Patty just rolled her eyes.

I also want to ask a question whether the policy for CHIP needs to be considered separately from what we're talking about with regard to Medicaid. So if we were requiring states to implement 12-month continuous eligibility, would you be doing that within both the CHIP program or just in the Medicaid program and leaving the CHIP issue as a state plan option?

MR. PETERSON: Well, on that one, Medicaid covers children with 12-month continuous eligibility, so that option is already there.

CHAIR ROWLAND: It's an option.

MR. PETERSON: So Option 1 really is about the CHIP.

CHAIR ROWLAND: Do we need -- these options are not mutually exclusive.

MR. PETERSON: Correct.

CHAIR ROWLAND: You might want to do the CHIP option as a --

MR. PETERSON: Right.

CHAIR ROWLAND: -- provide state plan option within CHIP and then do a require mandatory --

MR. PETERSON: Oh, I see what you're saying. You're talking about the third. Okay.

CHAIR ROWLAND: To just clarify that we're not picking one of the three or four. We're picking for what our combination option would be.

VICE CHAIR SUNDWALL: Could I ask Sara, just to follow up, could I ask you -- and I could be supportive of a mandate or a requirement if it is in the spirit of simplification. It seems to me like it would really simplify and be less costs of churning. But, I mean, I guess the support of something that's a mandate or a requirement would be how it's costed out by the CBO.

COMMISSIONER ROSENBAUM: I think it's also a matter of how -- yes, it's a matter of how we frame it. If what we're trying to say is move to 12-month enrollment periods, 12-month enrollment periods if you're in the exchange or in Medicaid, just to make life easier to align these two markets --

VICE CHAIR SUNDWALL: The spirit of [off microphone].

COMMISSIONER ROSENBAUM: -- make it a 12-month enrollment period, and then as Trish points out, we can worry about how we're going to finance 12-month enrollment. But I think that just like an employer benefits -- I mean, you can lose your employer coverage if you don't pay your premium or if you drop out of the workforce. But the assumption going forward is that people -- you're eligible for a plan year. You're covered for a plan year. And there is no such assumption in Medicaid, of course. There's a hope that you would do this, but we've taken away the state flexibility to budget for a plan year now. And so if we want to make life easier for everybody who's having to run one of these programs -- and Massachusetts' experience with churning, for example, they're the one state we really have to look at.

And their numbers are terrible, and they freely admit that they've just not been able to and have not had sort of the political will to deal with the alignment.

COMMISSIONER RILEY: But Sara I think articulated what my concern was, which is it shouldn't be provide Medicaid 12-month continuous eligibility, but on both sides.

COMMISSIONER ROSENBAUM: Right.

COMMISSIONER RILEY: And then the states might think it's a reasonable tradeoff because if I'm a Medicaid-eligible for 12 months in the exchange, I stay there.

VICE CHAIR SUNDWALL: Or the exchange [off microphone].

COMMISSIONER ROSENBAUM: Yes.

COMMISSIONER RILEY: And that's a simple tradeoff, but the numbers will have to show us.

COMMISSIONER GABOW: As we go through a number of these, Chris, you talk about how it's the administrative burden for the states. And a couple places you mentioned the providers, but it is for the providers as well. If you knew that people were on for a plan year, you wouldn't have to -- I know at Denver Health you have to screen everybody every time they come in to make sure they're still in whatever they are, and if we could get to -- I mean, the dream would be that the plan years would be the same for everyone, you know, that all plan years would start October 1st for commercial Medicaid, CHIP, whatever, and that goes for a year, whatever it is. And that would be, I think, a different message than mandate but would create simplification for everyone -- patients, providers, the state. And so synchronize across all payers the plan year.

And I think one of the things we've talked about in this group is to not think about things that are just Medicaid as if they don't exist within the overall marketplace of health care. And so I think making that --

VICE CHAIR SUNDWALL: That's a [off microphone] just don't call it mandate or a

requirement.

CHAIR ROWLAND: Well, one of the complexities there is that there's not a single open enrollment period for these programs so that the year --

COMMISSIONER GABOW: I see.

COMMISSIONER ROSENBAUM: Your plan year [off microphone].

CHAIR ROWLAND: Your plan year could change but--

COMMISSIONER GABOW: Would it have to? I mean, if you said whatever you're in on January 1, you're in for the year.

CHAIR ROWLAND: Until October or --

COMMISSIONER GABOW: Yeah. I mean, it wouldn't -- it isn't necessarily true what you said, is it?

CHAIR ROWLAND: There's no open enrollment period.

COMMISSIONER GABOW: Well, I mean, you could make it that, couldn't you? If you say wherever you are, you stay for a year, starting in --

CHAIR ROWLAND: Yeah, but then everybody wouldn't end on October 1st. That's all I'm saying. You could either say everybody rolls on October 1st if that's how you're aligning up everything. Or you could say you're in for one year from whenever you become eligible.

COMMISSIONER GABOW: Right. I'm saying why don't we go for the first option, for the --

CHAIR ROWLAND: Right.

COMMISSIONER GABOW: -- everything, and it would create -- I mean, that simplification for providers and families would be, I think, incredible. But maybe I'm wrong.

CHAIR ROWLAND: But that, I'm trying to think through -- that would not be 12 months of continuous eligibility. That would be eligibility throughout whatever the plan year is that you're in. It's a

different option.

COMMISSIONER GABOW: Well, if you -- maybe I'm not thinking this clearly, and anything that involves numbers, I do not --

[Laughter.]

COMMISSIONER CARTE: Chris, you did a really nice job of discussing churning in this paper, and I'm really grateful that I'm in a state that does have continuous 12-month eligibility for CHIP. And I know that it still presents -- even with 12 months continuous eligibility, you still have a lot of administrative burden from the churning that does occur. And I think Sara had a paper in Health Affairs that I believe pointed out that the churning in states with non-continuous eligibility is almost double that of states -- 30 to 16 percent, if I recall it correctly. And I just wonder if there are any studies out there or plan studies that would help states see the cost of that administrative burden, because I can just, you know, hear them saying in the current budget environment, well, yeah, but to have that 12-month eligibility will be a pretty high cost, but there would be some offset as well.

MR. PETERSON: And I think that's definitely what we want to do going to the next level as we think about the budget implications specifically.

CHAIR ROWLAND: Let me ask how you think Issue 1 may interact with or could create additional or different options for traditional medical assistance. I think these two have interactive effects, so if we recommended 12-month continuous eligibility, then do we recommend that TMA may not even need to be there and that would be a very different administrative savings?

COMMISSIONER CHECKETT: Chris, are you aware of any research on churning within either the individual insurance market, like people having coverage, dropping coverage, that they're purchasing themselves, or moving from employer-sponsored insurance back and forth? Because, you know, I think we need to continue to stretch our brains a little bit and think about, okay, I know we're Medicaid and

CHIP, but our beneficiaries are now in this whole new exchange world, too, and so I don't know -- somebody told me, I have no idea if they're right and I don't know where they got this, but that they thought that the amount of churn in the individual insurance market was -- and they may have just been kind of guessing -- probably as closest to what we see in some Medicaid populations. I'm just curious.

MR. PETERSON: And are you talking about people moving from individual market coverage to Medicaid or individual market coverage to uninsurance, or whatever the case may be?

COMMISSIONER CHECKETT: I think all of those.

MR. PETERSON: Right, right.

COMMISSIONER CHECKETT: I just don't know if there has been research or maybe other Commissioners know if there's been research on it. It would be an interesting -- it would just be an interesting thing to look at, as I think we're looking at people moving among these various programs.

MR. PETERSON: Yes, there has been research on that and -- I mean, there are -- yeah, Medical Expenditure Panel Survey, many of these longitudinal panel surveys where you can track people and how their coverage changes. So we can get you some of that information.

COMMISSIONER CHECKETT: It would be interesting to see if there are any lessons in that that would help us make maybe broader and more informed decisions in some of these issues. I think particularly on the churning and, you know, to recommend 12-month continuous eligibility for Medicaid I think seems easy because we're all familiar with it. But 12-month eligibility for exchange, I don't know. I mean, I'm not saying I have a personal opinion. I'm just trying to think what would that feel like or look like to that world and population.

COMMISSIONER RILEY: But I guess I'd question the research, it seems to me -- maybe I -- wouldn't you need to only look at states that already had guaranteed issue? Because if you looked at churning without GI in an exchange environment, you really wouldn't have comparable findings, I don't

think.

COMMISSIONER CHECKETT: I don't know. I'm just thinking about it.

CHAIR ROWLAND: Okay. Other comments? Donna -- I mean Denise.

COMMISSIONER HENNING: You keep trying to rename me.

CHAIR ROWLAND: Well, you're Donna and Denise next to each other today. That's even more --

[Laughter.]

COMMISSIONER HENNING: That actually kind of brought up a thought of mine, which was: What about the people that are in exchange coverage that change to employer-sponsored insurance? So if we did the 12-month continuous eligibility, that would allow them to stay on their exchange coverage, because most employers, at least, you know, that I've been involved with, they don't actually start your health care coverage until you've been working for them for three months or so. So you could actually have coverage through the exchange up until your employer starts covering you. So that might be a benefit for people at the upper end of the income scale.

VICE CHAIR SUNDWALL: Let me just ask you a question, Denise. I think, if I understood the exchange right, or the subsidies, it would still be employer-sponsored insurance, but they'd be getting a subsidy to buy that. So it isn't necessarily you're not going to have exchange -- an exchange is a facilitator for getting insurance. The subsidy is to help them pay for it. Is that not correct?

COMMISSIONER CHECKETT: You're mixing -- there's two kinds of exchanges. There's an individual exchange that just a person is going to get on their own, and that's, I think, where most of the Medicaid beneficiaries would move in between. And then the small SHOP exchange, as it's referred to, is where you would get subsidy through your employer. I don't know if I've clarified, but I think people don't realize there are two different exchanges.

CHAIR ROWLAND: Or if you're working -- or if you have employer-sponsored coverage and you can't -- it's a higher share of your income, then you go into the exchange, too. So there's a lot of movement that goes around in the whole system. We're looking at the lower-income side of it, but there's other churning that they're worried about with the exchange as well.

COMMISSIONER ROSENBAUM: You'd really -- I mean, what we really are ending up with, if you think about it, are five distinct markets. Right? An exchange, Medicaid, CHIP, employer-sponsored, and Medicare. And so the population is dynamic until you qualify for Medicare, and then you're really, you know, relatively stable. And I think that what you'd have to accommodate it is for certain special enrollment periods. So, for example, you could make a policy decision that if somebody qualifies for employer coverage during a period of exchange or Medicaid eligibility, you would enroll in your employer plan, your government-financed enrollment would cease at that point, just like in COBRA we have special qualifying periods. But I think that -- and I think Diane's point before was exactly correct, which is we want to couch our recommendations about the low-income population in the context of the dynamics of movement. You know, when you used to just fall out of things or whatever, it was bad for people, but you didn't have to think about it systemically. Now we have to think systemically, and we as MACPAC are focusing on, you know, certain aspects of the systemic problem.

But when we did the study -- when I did the study with Ben Sommers and Ann Hwang on churning, if you introduced a basic health plan, which is yet another variation on this theme, it doesn't do away with churn -- it does away with churn a little bit, but what it does is it pushes the churn point up to a level where typically what you're doing is going into an employer plan. You know, it gets you high enough up the income schedule -- scale. So we have to -- in developing this chapter, I mean, I think we have to talk about churn, churn is a problem, different kinds of churn, and where we see, if anything, you know, some openings to introduce some sensible limits on churn.

COMMISSIONER CHECKETT: Right, and even to -- and this really is a fascinating policy discussion, but, you know, is there -- you know how there's like a rate of unemployment that's acceptable? Well, is there a rate of churn that's acceptable? I mean, some of it, you're just going to have churn. And then, you know, even to benchmark toward that over time would be another thing to think about at some point.

VICE CHAIR SUNDWALL: Just got to live with a certain amount of churn.

CHAIR ROWLAND: You have family changes, you have a lot of other changes in addition to just income change as well. Aging, over 26, divorce. Anyway, I don't think we're going to solve all those problems at the same time.

So let's go back to each of these issues for a minute to give Chris some additional guidance. On Issue 1, on churning, it's clear we're interested in this. We're interested in looking at the options that you put there and in seeing whether we can also move beyond these to look at some of the exchange side that would make things potentially simpler.

VICE CHAIR SUNDWALL: A comment. Can we have a menu for them to consider as recommendations? Or did you want to be very specific and say we support the idea of 12-month enrollment? Or the CHIP one or the Medicaid one option as well? What's the sense of the Commission? Do you want to be very specific and have one recommendation or give them -- or, you know, say it's the sense of the Commission that we would like to recommend 12-month enrollment periods? Absent that, do the CHIP for 12 months or Medicaid for 12 months?

COMMISSIONER GABOW: Can I ask a question that relates to what you were alluding to, Diane? If we say we support for all federally subsidized program that there be 12-month eligibility, just create simplification, and then does that, along with the states that go to 138 percent of poverty eliminate the need at all for transitional Medicaid? Because I think if we can link these two, we're offering a further

simplification of a complex thing. And I think that would be -- if those two can actually link up, as you were suggesting, I think that's a powerful argument to go that way.

CHAIR ROWLAND: I think actually that Issue 1 and 2 can go together because TMA is all about churning, too. So that it's the current fix on churning versus looking at a broader thing, and so I think it's really about changes in eligibility and maybe merging -- you know, I think there are two discussions within perhaps one set of options.

COMMISSIONER GABOW: I'll ask one other question. How many states have 12-month continuous eligibility right now for CHIP and Medicaid? Do we know?

MR. PETERSON: I think it's 33 for CHIP, and I want to say 23 for kids in Medicaid, and we don't know yet how many do it for adults, but I think the Kaiser survey that's coming out in January will get at this for the first time. So that will be good information to have, which will be available then for our March report.

COMMISSIONER RILEY: But we have got to remember, the policy environment has changed. You do continuous eligibility because you don't want people to become uninsured. Now they go into an exchange, so that's why --

COMMISSIONER GABOW: But one of the things, our mantra has to be simplification as well, and I do think this -- it's an even stronger argument to say 12-month eligibility because it's 12-month eligibility wherever you land so that it's not, again, well, they're going to fall off into something. They're going to be being paid for -- the lower-income people are going to be paid for in some pot. So let's make -- let's make it clear which pot they're in so that you're not moving pots, which may change your network, may change your provider, a whole variety of issues. I think we should look at this as an opportunity to make simplification even a more attractive goal.

CHAIR ROWLAND: But let's also be clear on what the problem is, the issue that we're dealing

with. Current law allows -- or current law pre-ACA allows states the option to do these things. That is taken away, so that unless there is a change, the option of doing 12-month continuous eligibility under CHIP goes away; the option of doing it for adults under Medicaid goes away.

MR. PETERSON: And, of course, one could always say they could do waivers, but aside from that --

CHAIR ROWLAND: Right.

VICE CHAIR SUNDWALL: That's what we want, more waivers [off microphone].

[Laughter.]

CHAIR ROWLAND: And then on TMA, which goes along with it, it stays at four months under Medicaid, unless Congress extends it to six months or unless we change it. So I think it's very important to lay out sort of here's the situation today in terms of the way these things can be provided, here's how, because of the ACA changes, these options change or go away, and here's our recommendation about how to make the system more simple, more fair, and more easily administered, and then look at the options with those criteria.

MR. PETERSON: And back to David's question, that will be the fun part of doing a cost estimate of if we're going to do both of these in combinations and you have to match all of these up and you come up with a lot. But it could be the case that what we're looking at are just orders of magnitude for cost estimates, so we'll see how that goes.

CHAIR ROWLAND: Okay. And then so that looks at Issues 1 and 2. Issue 3 is the wrap-around issue, which, again, is the same thing. What you can do now may not be feasible in the future and how do you change it. So I think that option is fairly nicely laid out in the issue brief.

VICE CHAIR SUNDWALL: Could I just go back to the -- before we go there, do I understand correctly that if we do 1 as we've discussed, which is recommending the 12-month enrollment, whether we

do the other options as a menu, does that eliminate the need for transitional Medicaid assistance altogether?

CHAIR ROWLAND: I think you could make -- we can make that argument. We could look at it.

VICE CHAIR SUNDWALL: Because I like what, you know, you said. In the spirit of simplification that would be a great constructive recommendation.

CHAIR ROWLAND: We'd have to have Chris come back and tell us what we're doing.

VICE CHAIR SUNDWALL: See if you could make that happen [off microphone].

COMMISSIONER CHECKETT: Could you repeat that again? A plan year -- I'm sorry. Is that what you were saying, David?

VICE CHAIR SUNDWALL: Yeah, what I was saying is that I think we have some sense of agreement that we would recommend that there be 12-month, you know, enrollment --

COMMISSIONER CHECKETT: Right.

VICE CHAIR SUNDWALL: -- regardless. I mean, we can have it for all or we can have it for CHIP or for Medicaid. But the thing is I just wanted to make clear that if we did that, then we wouldn't really need to have transitional Medicaid assistance.

COMMISSIONER CHECKETT: Yes, I think when you pointed at Patty, I thought you were referring to the plan year discussion, and I just wanted to -- okay, because there would be huge implications if that was going to apply to private insurance and would be -- we would need to really think it through before we made that recommendation. My misunderstanding. Thank you.

MR. PETERSON: Okay, so I gave the blank stare because I was trying to come up with an example of where that wouldn't be the case, and I came up with one. So let's say that --

CHAIR ROWLAND: Don't tell us. We like our dream.

[Laughter.]

MR. PETERSON: Let's say that you have a family come in and their income changes six months -- actually let's say a month later their income changes, goes up. Maybe that's -- no, let's go to the 11th month. Okay. So the 11th month their income changes, right? So 12-month continuous eligibility, what that would say is don't bother telling us. But when you come back in in the 12th month, you're going to be redetermined as eligible.

CHAIR ROWLAND: Or ineligible.

MR. PETERSON: Or ineligible, that's right.

CHAIR ROWLAND: And then you go --

COMMISSIONER ROSENBAUM: A snapshot once a year [off microphone]. We don't care what kind of stuff happened to you in Month 11. We want to know on the first day of the 13th month, basically, where you are. Okay?

Now, the issue, of course, there are other issues which I don't think we can grapple with right now, but the way open enrollment works, you're actually taking the snapshot a couple of months before, right? So really what we're talking about is just a rolling annual period. The mechanics of it are that your plan year may be January to January, but it's in October of that year that someone's assessing your eligibility for the next year. And wherever you're going to be at that point is where you are.

MR. PETERSON: Yeah, I guess in my example, what would happen is if you're then determined ineligible after the end of your 12 months, TMA would say, okay, now you get Medicaid, versus without TMA you may go into exchange coverage.

COMMISSIONER ROSENBAUM: This is why Issue 4 also feeds into this, which is what are we going to do in terms of benefit design. I mean, in theory, for families whose eligibility for assistance is income driven, you know, there's nothing going on in the family other than they need some direct assistance to make the coverage affordable, I think we have to think long and hard. This has been, I find, the most

difficult issue for me, which is Issue 4. Is it time to recognize that for families whose basis for subsidization is that they went through an income test and, you know, they need a subsidy -- there's no disability test involved. Isn't it time to maybe come up with a common benefit framework, especially given the way benchmark benefits are laid out in 1937 now?

So I think that some of these other issues like TMA is not only an issue on the eligibility --

CHAIR ROWLAND: Eligibility side.

COMMISSIONER ROSENBAUM: -- but it's benefit design. And so I think in some respects we need to think about 4 as well.

COMMISSIONER RILEY: And I'd argue that 3 and 4, just as we mushed 1 and 2, 3 and 4 mush as well, because it's the same issue of what the benefit is. So if you're income eligible, what's your benefit eligibility?

COMMISSIONER ROSENBAUM: Yes.

CHAIR ROWLAND: Okay. So we're doing --

COMMISSIONER ROSENBAUM: The issue of supplementations --

CHAIR ROWLAND: -- eligibility and we're doing benefits, the two tiers, and we have A's and B's. We have a 1-A, B, 2-A, B as our issues.

MR. PETERSON: Right. And so I think technically these still remain the levers, but there are interactions, and so we put them together in different combinations.

CHAIR ROWLAND: Right.

MR. PETERSON: In other words, I'm not going to come back in January and say here's our one issue with all these options. Right?

CHAIR ROWLAND: Right.

COMMISSIONER GABOW: I do think, to your point, Chris, about trying to find an exception, I

mean, I think we need to look at this as an incremental movement to a better health system for America, and that if we sit here and try to figure out the perfect system, we wouldn't even be talking about most of this stuff. And so I think that we need to be careful about, to go with the old saying, don't let the perfect be the enemy of the good. We all know that the ACA isn't the ultimate fix for American health care.

VICE CHAIR SUNDWALL: I'll say.

COMMISSIONER GABOW: I mean, right? I mean, nobody thinks that, do they? And so I think what we want to do is to say given where we are, there are some really big sort of issues hanging out, let's try to create what is the most rational of this, realizing that we're not going to solve every variable at this point in time. And I think if we have that view, we'll come up with a different approach that if we say, well, if we can find an exception to this thing, we shouldn't do it because -- then we'll never move off this dime.

CHAIR ROWLAND: But we're also -- I agree totally. I think what we're looking at is how do you make the ACA, as it has been crafted, work better. So where are some of the glitches that we're trying to overcome, not how to make the ACA perfect.

COMMISSIONER GABOW: I agree with that, but that's why I'm saying if we can find one exception, we shouldn't say, well, then, we shouldn't go there.

COMMISSIONER RILEY: I also think it's our worldview. We have to get out of the blindness of this is how Medicaid always worked. So we have to take it from the ACA.

CHAIR ROWLAND: Right.

COMMISSIONER RILEY: And I think we haven't done that quite yet. In this discussion you sort of have to say the ACA requires A, B, and C; Medicaid used to have X, but it's not a Medicaid world anymore. So we have to sort of restructure how we think.

COMMISSIONER ROSENBAUM: Well, this is where Chief Justice Roberts was so correct. I

mean, he said Medicaid went from being a program for, as he said, "the neediest among us" -- he was a little limited in who he described as the neediest among us -- to a component of a national health plan. And that's what we're grappling with, and I think that's the right thing for us to grapple with.

COMMISSIONER RILEY: Because the issue is we don't need continuous -- we need continuous eligibility for poor people --

COMMISSIONER ROSENBAUM: Somewhere, right [off microphone].

COMMISSIONER RILEY: And we need continuous -- and continuous eligibility means both eligibility for the card and eligibility for the same set of services.

COMMISSIONER CHECKETT: And that's a great segue, Trish, into this very last issue that I'd like to touch on, which is this really interesting notion of requiring states to make the essential health benefits available to people on Medicaid. You know, we always think of the fact that people on Medicaid, it may not be deep coverage, but it's very, very broad coverage, and the concept that now they actually have less. But I challenge that, and I did just go back, Chris, and you're right, it was very good explaining it's the smoking cessation and disease management programs that are required under essential health benefit that certainly isn't required under Medicaid. I still think the traditional Medicaid benefit is much broader than what you're going to get on essential health benefits. You've got the social supports. You have transportation. You have all those long-term supports and services. None of that is going to be in the essential health benefit.

So I think we need to think that one through and talk more about it. My initial reaction is I would be reluctant to make that recommendation.

MR. PETERSON: And to clarify --

COMMISSIONER RILEY: It could take you in the wrong direction pretty easily.

COMMISSIONER ROSENBAUM: I actually think the opposite. I think for people whose

Medicaid eligibility is based on disability, there is no question they need the service classes that only Medicaid recognizes, they need the amount, duration, and scope, you know, the greater amount, duration, and scope that Medicaid provides. They actually need a medical necessity definition, going to the point that John was making before, that's different from a commercial medical necessity standard that has a maintenance standard in it or, you know, a standard that doesn't necessarily require restoration or improvement, all the things that Medicaid is great for, for children and adults with a lot of needs.

But I sat for hours -- hours -- with the statute open, with the essential benefit design as we see it in the December 2011 guidelines, as well as the statute itself -- and I think it was Elicia Herz did a CRS analysis of this as well. If you go class by class, and you think about people who fall within the non-disability sort of standard users of Medicaid, I think essential benefits actually is right up there with what you'd get in Medicaid, and especially if you look at the essential health benefit statute in Medicaid -- which is not the same as the essential health benefit statute. It's a different statute. There are certain rules that apply. I mean, family planning is expressly named, so there are certain things that are expressly named. And so I think for populations with disabilities, there's no contest. But I think for populations who are just looking for a subsidized coverage plan, it's very hard to see why you couldn't align the coverage design.

Now, cost sharing would change, obviously, depending, you know, on your income. But to me it's a much better benefit design than CHIP, which has been touted for its benefit design. The essential health benefit statute is a good, basic statute. And there will be a lot of variability in how states implement it, but there's a heck of a lot of variability in Medicaid today. And we shouldn't think that that listing of 27 service classes is, you know, sort of everything that's within the classes is what's covered.

So I think we have to do some real drilldown on this issue and known what -- be able to say to Congress what the tradeoffs are: You will get a full range of preventive benefits which aren't guaranteed to you if you're an adult. You won't have X, you won't have adult dental, but you don't get adult dental in

Medicaid anyway, except as an option. And you can imagine having states continue to have the option of doing a vision and dental supplement on top of, you know, the essential health benefit statute.

So I think this is probably going to be the hardest of the issues we deal with.

MR. PETERSON: And for clarification purposes, I just want to point out on Issue 4, Option 2, what we're talking about is Medicaid is going to cover more than -- it's going to cover more benefits than what's in essential health benefits, writ large. But there are some exceptions where current state Medicaid programs don't cover things that are in essential health benefits. So the proposal isn't to say roll back Medicaid to some essential health benefits. It's just that where essential health benefits happens to be a minimum that is greater than what is currently in Medicaid --

COMMISSIONER ROSENBAUM: Exactly and bring [off microphone].

MR. PETERSON: -- and bring it up to that level.

COMMISSIONER ROSENBAUM: And that design, premium support [off microphone].

CHAIR ROWLAND: Thank you. All right. I think you've got a lot of work to do, but I think that this is really an important piece of what we need to move forward.

COMMISSIONER MARTINEZ ROGERS: Just a final comment. You know, all the discussion that we have, and I'm sitting here thinking, I'm wondering how each state is really going to implement this, because as I look at Texas, having the most uninsured both of elder adults, adults, and children, and I'm just wondering what we're going to do -- unless we leave the United States, of course.

[Laughter.]

COMMISSIONER GABOW: I just want clarity. Did we decide on Issue 3? Because I have a sense that we went from 1 and 2 together to 4.

COMMISSIONER ROSENBAUM: Trish made the point that on 3 you're sort of dealing -- it's a subset, almost, of 4; that once you decide how the benefits align together, it starts to become clear that what

a state -- what we're really talking about is moving at some degree the benefit design of Medicaid to a new design, but with full state ability to continue to offer benefits and service classes that are beyond the design, and then this question of secondary payer sort of becomes an answer. Well, once you do that, then it becomes clear why you're giving states that expansive option. Then we come back around to the secondary payer question.

MR. PETERSON: So can I take off the list Issue 2, Option 1, to extend six-month TMA?

CHAIR ROWLAND: Yes.

COMMISSIONER ROSENBAUM: Yeah, yeah.

MR. PETERSON: Is there anything else that can --

CHAIR ROWLAND: You are trying to narrow this down?

[Laughter.]

COMMISSIONER ROSENBAUM: Number 3.

CHAIR ROWLAND: Number 3.

COMMISSIONER ROSENBAUM: Why can't you just do Option 1 under TMA? Do we need it still? Depending on how you answer, I mean, the only reason you get to 2 and 3 on number 3 is if Congress --

MR. PETERSON: Just to be clear, 1 is to extend six-month continuous eligibility.

COMMISSIONER ROSENBAUM: Yes.

MR. PETERSON: I mean, continue TMA. I'm getting all mixed up.

CHAIR ROWLAND: We're talking about really adding to Issue 1, the churning issue.

COMMISSIONER ROSENBAUM: Yes.

CHAIR ROWLAND: Do we need TMA?

COMMISSIONER ROSENBAUM: TMA.

MR. PETERSON: Right.

CHAIR ROWLAND: And then how will TMA interact with -- so we're really almost eliminating --

COMMISSIONER ROSENBAUM: Yeah, as a separate --

CHAIR ROWLAND: -- 2 as a separate issue and just making it one of the considerations under how we design our options for Option 1.

[Comment off microphone.]

CHAIR ROWLAND: No.

[Comment off microphone].

CHAIR ROWLAND: Okay. Thank you. And so we will turn to the next Chris.

Thank you, Chris.

And we heard this morning some discussion from our first panel about the PACE program, and we also obviously have the special needs plans that have been created, and so we've asked Chris Park to join us to brief us here on what's going on with dual eligibles in terms of the payment patterns and the capitation assistance in these two types of plans that some of our Medicaid beneficiaries are in, along with other Medicare benefits. Chris?

MEDICAID CAPITATION PAYMENTS TO PACE AND D-SNPs

* MR. PARK: Thank you. Today's session provides an overview of the Medicaid capitation rate-setting methodologies that states use for two types of fully integrated dual-eligible plans. Those are dual-eligible special needs plans and PACE plans.

The material highlights some key Medicaid rate-setting elements, particularly around how states capitate the long-term services and supports as the majority of Medicaid spending on dual eligibles are for these services. This material is presented in anticipation of becoming a chapter in the March 2013 report.

This overview of Medicaid PACE and D-SNP payments not only sets the foundation of our understanding of those two programs, but can also lead to insights on how states might set the payment for the Medicaid portion of the benefit in the dual demonstration plans as a lot of these states have some experience with PACE and D-SNP and they will likely build upon some of the elements they've used for those programs.

I also only focused on the Medicaid portion of the payment. A lot of the acute care services are paid through Medicare, and they receive a payment from Medicare which goes through the Medicare Advantage bid process, and I won't be discussing any of that.

Also, you know, as we heard this morning from some of the speakers, there is some concern about how rates are set for Medicaid-only disabled plans, and while a lot of this discussion is kind of through the lens of dual eligibles, a lot of it is also applicable to how states would set rates for a Medicaid-only plan that covers long-term services and supports.

So to give a brief background on these two plans, D-SNPs are a type of Medicare Advantage special needs plan that focus on dual eligibles. These plans can contract with states to integrate the Medicaid benefit. Those plans are commonly called fully integrated D-SNPs.

The state can choose to enroll only certain subsets of dual eligibles, so they may focus only on the elderly 65 and older population and not put the under-65 population that's disabled into the plan. There's no requirement to be nursing home certifiable, so you may have a mix of people who need a lot of long-term services and supports and some who really only need acute care services.

Also, enrollment can be voluntary or mandatory, kind of depending on how the states has built up its entire Medicaid program to deliver LTSS.

On the PACE side, PACEs can be a Medicaid state plan option for individuals age -- yes?

VICE CHAIR SUNDWALL: The acronym one more time [off microphone]?

MR. PARK: Oh, sure. PACE is --

CHAIR ROWLAND: You mean the LTSS?

VICE CHAIR SUNDWALL: No, no. I can never remember PACE. What does it stand for?

MR. PARK: PACE is the Program for All-Inclusive Care for the Elderly.

VICE CHAIR SUNDWALL: Okay.

MR. PARK: This program focuses on individuals age 55 and older who are nursing home certifiable, meaning they meet the state's level of care criteria for nursing home services. They don't have to be dual eligibles. They could be Medicare-only, Medicaid-only, or even neither, but overall about 90 percent of the enrollment are dual eligibles. The enrollment is voluntary so, you know, there are no mandatory enrollment PACE programs.

Just to kind of set the stage for the overall goals of Medicaid capitation rate setting, the goal is to kind of have an appropriate rate that is neither too low that plans avoid enrolling those high-cost individuals or, you know, not to limit any access to needed services, but you don't want to make the rate too high that it kind of reflects inefficient delivery of services. You also want the payment system to reflect the relative risk of providing appropriate care to the enrolled population so that plans, you know, get paid a little bit higher if they have a higher acuity population, and they don't have as much incentive to try to avoid those higher cost people and, you know, try to cherry-pick the lower-cost population.

Some of the differences in the rate-setting methodologies between these two programs are kind of determined by the federal requirements around rate setting for these programs. For the D-SNP program, like other Medicaid managed care plans, they are required to have actuarially sound rates, meaning that the rates are set following generally acceptable actuarial principles and are certified by an actuary.

The states have some flexibility in determining what services are covered within the contract, so some states can carve out certain services, maybe like behavioral health or nursing home services. They

can also put some of the services at partial risk, so some states have limited nursing home coverage under the plan's responsibility to like 180 days, and after that the benefit goes back to fee-for-service.

On the other hand, PACE follows a slightly different criteria. They are held to an upper payment level which basically means what the program would have paid if these enrollees were not in PACE. And so this is kind of the old standard that used to be used for Medicaid managed care plans, and it still holds for PACE.

Even though the rates don't have to be actuarially sound, I think most states generally follow the same principles and use actuaries to help develop the PACE rates.

In the PACE program, the plan is at full risk for all Medicaid services, so there are no carve outs. And also the rates must take into account the comparative frailty of the enrolled population, and also there's a requirement that the payment remains a fixed amount, regardless of changes in health status throughout the payment year.

CHAIR ROWLAND: So it's 12-month continuous payment.

MR. PARK: Yes. In general, you know, there is kind of a general outline that most states follow when setting rates. You know, first you start off with a baseline experience, usually one to two years, of either fee-for-service or managed care experience that, you know, contains the eligible population and whatever services are included in the contract.

Based on that historical experience, you make adjustments to the payment period to account for claims completion, you know, to cover claims that have been incurred but not reported in the data, any policy or programmatic changes that may occur between the historical experience and the payment period, price and utilization trends, managed care efficiency, and particularly fee-for-service data is used. If managed care experience was used, you might not adjust for any managed care efficiencies because those are already in the data. Additionally, administrative costs such as care management.

Also, states can put in place certain incentives or risk arrangements such as stop loss or risk corridors to help manage the risk that the plans face.

Where you start seeing some more variation in design elements is how states handle managing the risk of payment to the plans. Kind of the first step in managing risk is through the development of rate cells. Rate cells are how states split the overall eligible population into distinct groups, like a certain rate cell will have similar cost characteristics, but each rate cell will have kind of a different cost pattern than the other rate cells. And so this allows -- the state pays more to a plan if they have a different demographic mix than another plan.

On the D-SNP side, common rate cells -- well, for both D-SNP and PACE, common rate cells include eligibility category, age, and geography. Where they kind of diverge is in the use of other characteristics. So D-SNPs can use health status, frailty, or site of care, which means that separate rates for nursing facility users and community-based users can be set in D-SNPs. So that would be one way to manage the risk. You could pay higher if the person goes into a nursing facility, and you could pay lower if they remain in the community.

On the PACE side, I mentioned before that the payment has to remain a fixed amount throughout the year, and so the site-of-care rate cells are not allowed, and so the nursing facility and HCBS users are paid the same rate, which is usually set depending on a certain mix that the state anticipates will be enrolled in the program.

Another area for variation is how states handle the risk for LTSS. Because of the high cost of LTSS services and diversity of the population, the plans can face significant risk in responsibility for delivering of these services. On the D-SNP side, they can have partial risk, and where partial risk is most commonly used is on the nursing home side. So they could limit the risk that the plan faces in terms of covering nursing home services.

Alongside these partial risk arrangements, they often put together some type of incentive structure that encourages the plan to kind of keep the person in the community and utilize HCBS services more than nursing facility services. Additionally, as I mentioned before, they can have these separate rates for the institutional and community setting.

On the PACE side, the program is at full risk for LTSS services, and as I mentioned, you know, the rate if blended for nursing facility users and HCBS users. So the state usually looks at the historical experience and looking at the weighting between how many users are in HCBS and how many are in a nursing financial and kind of blend together a rate based on that weighting. Because this is kind of fixed throughout the payment year, it becomes a very important part of the rate and where the state kind of sets that weight between nursing facility and HCBS users. If the state believes that the population might be less frail, they might weight the HCBS users more heavily than the nursing home users. But if they think, you know, that frailty might be different, they could shift using that weighting.

To give kind of an example of how states have used rate cells and these partial risk arrangements, two states on the D-SNP side have kind of used different combinations of these features. The Massachusetts Senior Care Options Plan has created separate rate cells for different levels of nursing home levels of care and community rate cells. But to help kind of facilitate and encourage the plan to keep patients in the community, they use a transitional rate structure where, if a patient transitions from the community to the nursing home, the plan still gets paid at the lower community rate for 90 days, and vice versa, if a person goes from the nursing facility to the community, the plan gets the higher nursing facility rate for 90 days. So this creates some incentives for the plan to try to utilize and keep the person in the community more often.

For the Minnesota Senior Health Options Program, the plans are limited to 180 days of nursing home coverage. The state creates a nursing home add-on payment, kind of developed based on certain

assumptions on how many of the enrollees would go into nursing facility care for, you know, a certain length of stay and how much that would cost. And the plan gets paid this add-on amount while the enrollee is in the community. So essentially this add-on is pre-payment for the expected care that they will have to cover once a person goes into the nursing facility.

Once a person goes into the nursing home, then this add-on payment stops, and the plan covers the 180 days out of that prepayment they've already received. After 180 days, the benefit switches over to fee-for-service, but the enrollee still remains in the program, and the plan picks up any cost sharing that they might have on the acute care side.

So another feature that many managed care programs have used is risk adjustment. However, this experience is primarily limited to risk adjustment on the acute care side. The models that states have been using for acute care only take into account health status, diagnostic information, and are not necessarily good predictors of LTSS use and cost. In order to get better prediction of LTSS, the state would have to incorporate measures of frailty and functional status, such as, you know, activities of daily living or measurements of cognition.

Because there aren't very many of these LTSS models out there, some states have gone through the process of developing their own LTSS risk adjustment model. However, this could be a resource-intensive process because not only does the state have to run their own data and figure out kind of the regression cost model that they need to create to link certain characteristics of the population to their LTSS costs, they also need to ensure that appropriate collection processes are in place to capture these measurements of functional status and frailty, which, you know, usually requires a different process because all the diagnostic information comes off the claims, and so, you know, you would need to look at the care plans and other measurements.

I should also mention that two states that come to mind that have created these LTSS risk

adjustment models are New York and Wisconsin, and they have created these models and put them in place for both their PACE and D-SNP programs. So they've kind of leveraged this model to use for both programs that they have.

As I mentioned before, the goal is to kind of achieve this appropriate rate, and so where the challenges come in is how to set the payment that achieves kind of the right balance between institutional and community care while mitigating the substantial financial risk that the plans face for delivering these high-cost services. As I mentioned before, some plans in states have these partial risk arrangements that, you know, while are beneficial to the plans at reducing the risk, they also may reduce some of the incentives that are there to utilize community-based care over the nursing home. Full risk, you know, kind of maximizes some of these incentives, but, again, it kind of really puts the risk on the plan. You know, due to the diversity of the population, they could face substantial losses, as we heard John mention before, that, you know, it can be a challenge in covering services for this population.

Because there is a lack of experience with LTSS risk adjustment models, full risk can be problematic. Most states on the acute care side with a high-cost, diverse population use risk adjustment to account for these differences between plans and population. Because few states have these models, you know, it's still somewhat unproven as to how effective these risk adjustment models can be in predicting the LTSS use and cost, not only within the state but across states, because the benefit design might be different, so it might be hard to come up with a national kind of model that might be used across states. Also --

CHAIR ROWLAND: You don't think we should try?

MR. PARK: Well, I think it might be something to explore, but it will be a challenge, as not every state covers the same things under their HCBS waiver, how they pay nursing homes might be different, and, you know, what is a good predictor of costs in one state might not be a good predictor in another, and, you know, how do you standardize some of these measurements of frailty and functional status across states so

that they could all use a single model?

Another kind of interesting part of these dual-eligible plans are many of them use voluntary enrollment, which voluntary enrollment can magnify some of these challenges that I just mentioned because the population that actually enrolls in the plan may be significantly different than the population used to determine the rate. In mandatory programs, you know, you have pretty much everybody in at least one of the plans, and so the overall average rate that the state pays should be fairly close to what the overall involved population's cost will be. However, in voluntary, you know, you introduce some variability where you might have a much more acute or less acute population that actually enrolls, so the overall average might be off, not to mention any differences between plans. And so, you know, there really needs to be a good way to kind of account for these differences between the enrolled population and kind of the rate-setting-based period population and how do you use something like risk adjustment or other techniques to kind of, you know, adjust to take into account that the voluntary enrolled population may be different?

So we would appreciate any feedback the Commission has on the information presented in this presentation and if there are any thoughts for further analysis or exploration.

CHAIR ROWLAND: So the goal of this is to provide a descriptive chapter on how the capitation payment works for these types of plans. But I think as you've gone through, it would be nice to also add some of the areas where having more common definitions across states or a more common framework might help to be able to do more sharing of methodologies and impact. But other comments from the Commission members?

COMMISSIONER GABOW: I think it would be useful to me to know exactly what the goal is of this chapter. Or is there a specific question we're trying to answer? Because I don't -- I'm sure it's because I just don't understand this area very well, but --

CHAIR ROWLAND: I believe that because one of the issues within the main duals

demonstrations that are going forward is how you calculate payment and how you calculate savings, that to understand what we know about how the Medicaid piece is being put together for dual-eligible populations that are in capitated plans, whether they're D-SNPs or whether they're PACE programs, was just to try and begin to us what might be going on in the evaluation of savings under the dual-eligible demos.

COMMISSIONER GABOW: But there have been a lot of D-SNP plans around, and my understanding is there haven't been many failures. And I guess I would ask Donna and Mark, I mean, actuaries seem to have a pretty -- and insurance companies seem to have had a pretty good way of figuring this out over the years because we haven't seen lots of failures. I guess in that realm I'm having trouble exactly figuring out what it is we're searching for.

I also have a separate question about PACE programs. In your article --

CHAIR ROWLAND: Let's go first to the question you just posed.

COMMISSIONER GABOW: Okay.

ACTING EXECUTIVE DIRECTOR SCHWARTZ: I just wanted to add on to what Chris said. Right now there are about 120,000 dual eligibles who are in fully integrated D-SNP plans, and that's what our experience in doing the rate setting for the long-term -- for the Medicaid portion, which is the long-term services and supports. So our experience is based on this rather small group of individuals.

If you go in a direction where you're putting hundreds of more thousands, potentially millions of people in those plans, how are those individuals the same or different from the people who you're using now? How is the data going to predict variation in costs so that payment in a much more expanded managed care situation would be accurate and would ensure that there were the types of services that individuals need while also ensuring that they aren't failures? We could predict now that they haven't been failures because they picked the right people to enroll. It has met their model. I don't know that for a fact, but that's an example. So that's really the rationale behind this, to be able to explore and explain sort

of the state of the art as it is now.

And then I guess the thing that we would really use some help from you is sort of what other questions does that raise that we would want to be aware of, cautionary about, optimistic about, if we were to look for a much broader use of managed care in this population.

CHAIR ROWLAND: Okay. Part two?

COMMISSIONER GABOW: Well, part two is sort of the simplification issue again. I have a big "S" written on my head. I was astounded -- it's an area I don't know much about, but the PACE program, they have 25,000 enrollees total in 12 states -- in 29 states.

VICE CHAIR SUNDWALL: Yes.

CHAIR ROWLAND: Rhode Island has 200.

COMMISSIONER GABOW: So I guess I'd be really interested to see how they cluster. Are most of them in California where this program started and there are three in Wyoming or something like that? And then I guess it has been around for a long time, and it has not grown.

VICE CHAIR SUNDWALL: It has not caught on fire [off microphone].

COMMISSIONER GABOW: So I wonder if it's needed, if you go to managed care for -- if you really expand the D-SNPs -- and they already have six times as many people in them. What's this -- why does this chad keep hanging on, I guess?

[Laughter.]

COMMISSIONER GABOW: I mean, maybe that's not a train we want to go into, but it's curious to me that it's been around for a long time and there's hardly anybody in it, which seems that people have voted with their feet that this isn't --

CHAIR ROWLAND: Well, I think states have found that it's a very expensive and complicated model to put together, and I think as you heard from the Rhode Island experience today, it also requires an

adult day center. I mean, it has some pretty rigid requirements and is pretty rigid about who can get into it. So it may be that it's a model that has been too constrained and restrictive, but also too expensive.

I know Mark is up.

COMMISSIONER HOYT: My own take on PACE is it was put together for reasons other than saving money, and it kind of got special status in that it was the only kind of pre-approved way to merge or blend the two funding streams together and that it did have some specific requirements around it. And the initial rate setting was pretty loose. It was highly questionable in the actuarial sense, and maybe they fixed it now, but initially you would look at the fee-for-service data for the entire catchment area, and it might have -- of all the nursing facility eligible people, or whatever term you like, it could be 85 percent were in nursing homes, and they would take that same mix and then apply it to the PACE program, where it might be the flip-flop almost, could be 10 percent in a nursing home. So it was a gross overpayment for the people in PACE, but then that was explained away by -- for other reasons.

CHAIR ROWLAND: So perhaps one of the things we should be looking at is whether the PACE payment model is even one to keep on the table, which is a subset of the broader question of whether with other changes you need PACE as an option at all.

VICE CHAIR SUNDWALL: I'll just give you a little historical footnote. Maybe some of you know this, but it was Marie-Louise Ansak, a Danish woman living in San Francisco, who created this in the North Beach area of San Francisco for Chinese residents. They had a homogeneous culture. They were dealing with supportive families. And it was a wonderful model, and she was a great advocate and came back to Washington proposing this, and we all went out and visited and were awed. But it's almost a personality-driven thing, and it does --

CHAIR ROWLAND: It's called On Lok.

VICE CHAIR SUNDWALL: Yes, On Lok. It does the social determinants of health for sure,

but it requires a community of like-minded people for it to work.

COMMISSIONER HOYT: So in Arizona, which I'm most familiar with, although there have been other kind of deferral programs that might be cast in slightly different clothing, Oregon and Wisconsin, what drove all the savings was keeping people out of nursing homes and putting them in home and community-based services. So a data table that I think would be highly useful would be, if you can get this, what percentage of the long-term-care population is in a nursing facility, or the converse. And the way Arizona drove all the savings was kind of structured negotiations with contractors county by county or groupings of counties as to what was possible in terms of growing the percentage in HCBS. Now, a long time ago that was pretty high, 80, 85 percent, and they pushed it down around 50-50 now, but I think they're still trying to move that forward a little more

MR. PARK: Right. I think in Arizona, like you said, they do have some negotiations with the plan on kind of what an expected mix between nursing facility and HCBS users would be there. So that's, you know, how they're kind of using the rate-setting methodology to make that encouragement to HCBS.

COMMISSIONER HOYT: Another key area of risk adjustment, you could call it, was the use of risk corridors, there where you have HCBS networks or LTSS networks that aren't mature yet, especially in rural areas, how much improvement would be possible over the next contract period. And so we would monitor data by geography as to what the spend was per person in HCBS and then put some corridors around those figures.

COMMISSIONER MOORE: I kind of feel like we're into more detail here than maybe we could or should be. I wonder if at least in setting this up we need more introductory information about predictive efforts, what they mean, how risk setting has been done, the limitations of it. There are an awful lot of states doing managed long-term supports and services, just starting them, and they're not -- maybe they're pulling numbers out of the air, but maybe they've got some risk models that haven't been addressed,

that haven't been publicized, that aren't being discussed. And I am just feeling like focusing in on PACE and D-SNP, particularly given the discussion that we've had so far, is an inappropriate way to articulate sort of what our concerns are. And I guess I'm looking more for a more sort of philosophical approach with policy questions and maybe examples in it. But other people may have other ideas, but that's just what I seem to be thinking myself as I listen.

CHAIR ROWLAND: Too deep a dive before we set the context.

Donna.

COMMISSIONER CHECKETT: I'd like to address a couple of issues that have been raised, and start by saying I completely agree with Judy in the end. And we may even want to just take PACE off the table.

And Patty, to your question, and my perspective about PACE, granted the historical -- I think it was the first, and people enjoyed it. And if you've been to On Lok, it's extraordinary.

But the fact is that you have got to have a physical location for it. And that means you have to find an institution that is willing to give up the square footage and can make a business case for setting up this very unique program.

I think there was a time when hospitals and nursing homes were looking at it, especially hospitals with excess capacity, and literally set up PACE programs up to cover empty square footage. Well, you don't have that in hospitals anymore. You don't have hospitals running around looking to build a PACE site to have bodies covering some square footage.

And I think it's just a very limiting model, and I don't even know that, given that -- as terrific of a model as it is, it's a very limited model -- we should spend a lot of time on it.

I really like the idea -- there have been -- you know, whether they were not-for-profit plans or for-profit doesn't make any difference -- there have been people who got into D-SNP in 2006 and 2007

who lost money. There was a huge influx of plans -- what was it, the first year there were like 600 companies that applied for D-SNPs, and lots of them got in and had to do the full board of CMS compliance and had four enrollees. I mean, really, things went completely belly up. So I wouldn't assume that it's necessarily a profitable model.

I take from that, and really like I think where Judy got us, which is it's a really important issue. Let's not get so narrow on PACE and D-SNP. Let's talk about what are the components states should consider. Are there guidance about the decisions that you make when you create a capitated payment rate that includes all these long-term care and support services that maybe blends Medicaid and Medicare? I think that would probably be at a more appropriate level because there are some great lessons learned from PACE and D-SNP and we ought to call those out. But I wouldn't put them up as models.

CHAIR ROWLAND: Chris, both of these issues have also been, obviously, studied by MedPAC. And maybe it would be helpful at our next meeting to sort of have a review of where MedPAC has come out, not just on the payment issues but on the role of these two types of plans and to then coordinate some of work with them through that.

MR. PARK: Sure.

CHAIR ROWLAND: Trish?

COMMISSIONER RILEY: I completely agree with Judy and Donna. But I would say there is some lessons to be learned. Because people have made conclusions about D-SNPs.

What I would like -- and you mentioned them, Chris, in the paper. But I'd like to know more about the carve-outs. What's covered? Because as we move into this territory, one would hope that they'd cover everything.

So I'd like to know more about what were carved out for populations and services. And maybe that would also inform which D-SNPs were more successful than others.

COMMISSIONER CHECKETT: Yes, and too, you know, the whole issue of because it's voluntary enrollment, are there lessons we could learn from how people have successfully gotten people to choose a decent group to participate, too? That would be very helpful, I think.

CHAIR ROWLAND: Mark.

COMMISSIONER HOYT: Yes, I was just going to -- a couple of other things quick.

I think at a higher level, at least this has been true for a few years, consulting the states, there's a number of them looking to implement managed care principles into their long-term care programs. So at the higher altitude, that's what I think is going on. And maybe that's more where we start.

One other piece that I don't think is mentioned specifically yet in what you've done, Chris, is you do talk about ADLs and assessment and the need. Maybe this has gotten better, but we used to find the fox in the henhouse thing in a lot of states, where you don't have an independent analysis of what the ADLs are. The administration, the tool, is all over the map.

Maybe you could find some best practices in a couple of states or somehow cull that out. Because the ADLs do sort of make you think oh, that would be useful for risk adjustment. But I don't think anybody does it because of how problematic the data is.

MR. PARK: Right, yes. That is one of the challenges, I think, kind of creating a risk adjustment model for LTSS, how do you collect the necessary measures? Do it periodically. What measure should be collected? Who does the collection?

COMMISSIONER HOYT: Yes.

CHAIR ROWLAND: Judy.

COMMISSIONER MOORE: That goes back to what was mentioned this morning, which is the need for more standardization, uniformity, Federal guidance, in terms of functional status assessment and the use of all of these measures. That would fit with both of those agenda items, is more discussion of that

and what we know and what we don't know.

CHAIR ROWLAND: Okay. Well, I think this has been a helpful discussion. I think that we will continue to look at these issues. When we take a quick break, we will come back to deal more broadly with the dually eligible population, of which this is just one little sub-issue.

So thank you, Chris.

We will reconvene in 10 minutes, at three o'clock.

[Recess.]

CHAIR ROWLAND: If we could please reconvene.

We've talked a lot today about a lot of issues with regard to disability, with regard to payment, especially to integrated payment systems, for long-term care. But now we're going to turn to the topic that we have covered before and take a new, in-depth look at it, which is that of who the Medicare-Medicaid dual eligible population is, what they cost, and how we might begin to think about talking about the kind of services and changes that may be required in the program.

So we'll begin, I believe, with April Grady and then followed up with Ellen O'Brien, and we are now at Tab 5 of your notebooks.

OVERVIEW OF THE MEDICAID/MEDICARE DUALLY ELIGIBLE POPULATION

* MS. GRADY: Thank you, Diane.

As we've talked about in previous meetings, we have proposed a March 2013 chapter on persons enrolled in Medicare and Medicaid, otherwise known as dual eligible enrollees. In that chapter, we plan to cover Medicaid's role for this population as well as spending and service use across both programs for key sub-populations that have been identified by you, the Commission, and also a discussion of some of the policy implications for this population.

The focus of the presentation today is on spending and service use, which I will cover, and policy

context will be covered by Ellen.

These are numbers you've heard before in various contexts, but just to review, about one-third of Medicare and Medicaid spending is for dual eligible enrollees. It is a pretty large number. About nine million individuals are enrolled in both programs and they represent about 20 percent of all Medicare enrollees and about 15 percent of all Medicaid enrollees. Combined program spending on dual eligible enrollees was more than $200 billion in 2007. And again, this represents about a third of each program's expenditures. Of the $229 billion here, slightly more than half is Medicare. Just under half is Medicaid. And given that States pay on average about 43 percent of Medicaid costs, that means that States are paying about 20 percent of the combined program spending on dual eligibles.

Just by way of some background, demographic information. Among the nine million dual eligible enrollees in 2007, about 40 percent were individuals with disabilities under the age of 65. The other 60 percent were individuals 65 and older. About 60 percent were female, 40 percent male. And more than three-quarters were enrolled in both programs for the entire year, so there is a lot of continuity in this population across both programs.

About six percent of dual eligibles died during calendar year 2007, and I point that out here because, as you know, end-of-life costs can be particularly high. And although this is not something that we looked at specifically in the analysis we're talking about today, it may be an issue for future exploration.

Looking at the basis of Medicaid eligibility for this population, again, among the nine million duals in 2007, about 40 percent qualify for their Medicaid benefits through the receipt of Supplemental Security Income. So this means that these are very low-income individuals with incomes generally below about 75 percent of the poverty line. About ten percent of the dual eligible population qualifies for their Medicaid benefits by spending down to a medically needy income limit, generally because they require institutional care that has high costs. And the remaining half of dual eligibles qualify through poverty-related or other

pathways, some of which are only available to individuals who require an institutional level of care.

So I want to point out here, this tells you about how dual eligibles qualify for Medicaid at a point in time. What it does not do is tell you how they arrived at their dual eligible status in the first place, and that is to say, in other words, were they Medicare enrollees first who spent down their income and arrived to Medicaid, or were they Medicaid only enrollees first who were eventually getting onto the Medicare program by fulfilling the two-year waiting period under Social Security Disability Insurance or aging onto the Medicare program at age 65. Again, this is not an issue we're going to cover today, and there's actually pretty limited information and research out there on this, but I would mention one study of interest.

It's the State of Maryland looked at their data, so it's not generalizable to the U.S., but what they found is that about 60 percent of dual eligibles in Maryland went from the Medicare first and then onto Medicaid pathway. So about 60 percent were Medicare first and then arrived at their dual eligible status. About 40 percent were Medicaid first and ended up on Medicare at a later point in time.

Another point I want to raise that you'll hear more about, actually, in the next presentation by Jim Teisl, who's going to talk about Medicaid payment of Medicare cost sharing, is that the level of Medicaid benefits for the dual eligible population. About 20 percent of dual eligible enrollees have Medicaid coverage that consists only of assistance with payment of their Medicare premiums, and in some cases, payment of their Medicare deductibles and co-insurance, and we refer to these folks as partial benefit enrollees. The other 80 percent of the dual eligible population receives this Medicare assistance and full Medicaid benefits. So they are receiving a wider range of services than the partial benefit enrollees.

I'll point out here that in fiscal year 2011, Medicaid paid about $14 billion for Medicare premiums and at least about a billion for Medicare deductibles and co-insurance, and I say at least a billion because this is an area where we actually don't have great information. The States are reporting at least a billion on their accounting forms, but we see in the claims data that the amount paid may actually be closer to

something in the single-digit low billions. But that's something that we could look into more in the future.

Now that I've given you sort of some background information, I'm going to focus here on the data analysis that we have, and we're looking specifically at all year full benefit dual eligible enrollees, and these folks represent about 60 percent of the dual eligible population and about three-quarters of the combined program spending. So the people we're leaving out here are the partial benefit only enrollees who are only getting, again, that premium assistance and in some cases the Medicare cost sharing assistance, and people who were only enrolled in the program for part of the year. But again, they're a small portion of the spend for this population.

As you requested in previous meetings, we are looking at this population bucketed into different categories according to their acute and long-term care services and support use and the setting in which they're receiving those services, either in the community or in an institution.

The four populations that we're going to talk about today are people who are using institutional services, and that includes either Medicare skilled nursing facility services or Medicaid nursing facility or other institutional care.

We're also going to talk about people who are using Medicaid home and community-based waiver services, and you've heard about these in previous meetings and we covered this in our March report on persons with disabilities, but these waiver services require people to meet an institutional level of care in order to receive them, and the services that are provided under these waivers vary by State pretty significantly.

The third population we're looking at are people who are using Medicaid home and community-based services but may not require an institutional level of care. These might be someone who receives personal care attendant services in their home for a few hours a week but otherwise don't require an institutional level of care to remain in the community.

And then the fourth group that we're talking about are people who are using none of these, so generally their needs are met with acute care services.

I'll just say that our analysis is preliminary and the figures may change slightly according to adjustments that we make in further review of the data.

Okay. What we're showing here are the four populations that I talked about. So the left-hand side of the chart here is showing enrollees by their service use, and starting at the bottom, we're looking at people who are, again, using those institutional services that I talked about. And that represents about 20 percent of the dual eligible population, the all-year, full benefit dual eligible population. Again, all of my figures are referring to that population. Twenty percent of enrollees, but nearly half of the combined program spending for this dual eligible population.

The next slide of the bar here is the ten percent of enrollees who are using Medicaid HCBS waiver services. Again, these are people who are requiring an institutional level of care. They're driving about 15 percent of the combined program spending for dual eligibles.

The next population is the Medicaid home and community-based non-waiver population. They're about ten percent of the enrollees and ten percent of the spend.

And then as you can see, there's 60 percent of these dual eligibles, a significant portion, who are not using any institutional or home and community-based services, and they account for a much smaller share of program spending, only about 28 percent.

Okay. Again, this is the overall perspective. We're looking at both program spending amounts combined here.

On the next slide, what we're doing is breaking out -- sure.

VICE CHAIR SUNDWALL: Excuse me. Just go back a little bit. I'm a little slow. The difference, the ten and the nine percent are about equal amounts, but the distinction, again, between those

using --

MS. GRADY: Sure.

VICE CHAIR SUNDWALL: -- the home and community-based server and then non-waiver --

MS. GRADY: The darker blue bars there, the ten percent bar that you're looking at, those are the home and community-based waiver service users, and they account for a somewhat larger share of the spend than the other home and community-based service users because, again, the waiver users are people who require an institutional level of care, so we would expect that they account for a higher amount of expenditures than --

VICE CHAIR SUNDWALL: So they have a waiver and they have to be cost neutral. They could be in the community as long as it doesn't cost more than a nursing home.

MS. GRADY: That's correct.

VICE CHAIR SUNDWALL: Okay. And the other category was --

MS. GRADY: The other category are people who don't have to meet an institutional level of care, but the State is choosing to provide a variety of services to aid them in the community.

VICE CHAIR SUNDWALL: Thank you.

MS. GRADY: Okay. Here, what we're doing is breaking out the spending in terms of the Medicare portion, which is on the left side of the slide, and the Medicaid portion of the spend, which is on the right side. And the point we want to make here is that, not surprisingly, the long-term services and support users are the ones who are driving the Medicaid spending, and that's by nature of Medicaid's benefit for dual eligibles. Medicare is picking up most of the acute care costs for this population, so Medicaid is primarily serving as a supplement to that acute care benefit. So it's not surprising that we see that about 90 percent of the Medicaid costs for the dual eligible population are being driven by the long-term care users.

On the left side there, what you see is a sort of much wider distribution of the spend on the

Medicare side. Still, a lot of it is being driven by the people who are using long-term services and supports, but a good 40 percent of the Medicare spend is for people who are not using any of those services.

You have a handout that should show this in a larger size for you. I think the two-by-two is a little difficult to see on your slides. Here, we're looking at spending per enrollee, and again, this follows with the sort of program distribution, program-level distribution of spending that we were showing.

The first bar is the average for all dual eligible enrolles, so combined program spending for an all-year, full benefit dual eligible in 2007 was about $31,000, again, with slightly more than half of that coming from the Medicare program and just under half coming from the Medicaid program.

Where you start to see the difference again is with this institutional and home and community-based service use. For people who are using institutional services, Medicaid is picking up a large portion of the spending, not surprisingly, again, because Medicaid's role as a long-term care program is evident here. For those people, the spending per enrollee was nearly $70,000 in 2007.

Moving to the right, again, Medicaid HCBS waiver users who require an institutional level of care but are in the community, the spending per enrollee is about $48,000. Again, about two-thirds of that is Medicaid program spending.

And then as we move over to the right, we're looking at Medicaid non-waiver HCBS users, a slightly lower amount of spending but still significant on the Medicaid side.

And on the right-hand side here, we have, again, the people who are not using any institutional services or Medicaid home and community-based services, where the average spending in 2007 was about $15,000 per enrollee.

Okay. So there's a lot of numbers on this chart, but let me just say that this follows the bars, the per enrollee spending that we just showed you. So if you look at the bottom of this table, moving across, you'll see the same per enrollee spending numbers that I just went over with you. So for the column

showing institutional service users, again, the spending per enrollee is about $70,000. Moving over to the right, we see that the "no institutional care" and "no Medicaid HCBS care" folks are about $15,000.

What this chart is trying to do, in addition to showing the per enrollee spend, is to show the distribution of where that money is going with regard to particular programs and services. And so what we have highlighted here are the cells where either Medicare or Medicaid is more than five percent of the total so we can kind of focus your attention on those particular items.

So, for example, looking at the first column of numbers here, these are people who are using institutional services. And again, of the spend here, about 53 percent of that is for the Medicaid nursing facility and other institutional services. So this is a large chunk of the spending for this population, this dual eligible population.

If we move to the right, looking at the Medicaid HCBS waiver users, again, Medicaid HCBS is about 60 percent of the spending for those people. And as you heard in the presentation this morning, there aren't a lot of standard definitions used necessarily for these Medicaid HCBS waiver services across States. And so one of the issues we have is a difficulty in breaking out what's underneath those waiver services. So for that $29,000 per enrollee, exactly what is being provided?

And so these service break-outs are not reported consistently across States, but in the break-outs we do have, we see that a large chunk of this $28,000, this $29,000, is going to residential care for these individuals in these waivers. About $12,000 of the spend there is for residential care. Another significant component of the spending is adult day care. About $2,000, on average, is in that amount. And then a lot of the care, though, in these waivers falls into an "other" or unspecified category. So we'd like to be able to tell you more about these, but right now, the data is not great and we'd have to go out of other sources for that. But I know that's been an interest of the Commission all along and we'll do our best to disaggregate this for you.

And moving across here, again, the third column of numbers are people who are using Medicaid non-waiver HCBS. These people do not necessarily require an institutional level of care, and here is where you start to see where Medicaid HCBS is about a third of the total spending, but Medicare is also picking up a significant portion of the care for these people.

Then moving over to the right here, we have people who are not using any institutional services for Medicaid home and community-based care. And again, Medicare is picking up the majority of the spending for these individuals.

I've kind of run through these numbers here, but the idea was to bring you a first cut at the different populations and settings that you had requested and then to sort of follow up with some policy issues that might arise from looking at these numbers, and this is where I'll move on to Ellen.

COMMISSIONER ROSENBAUM: [Off microphone.]

MS. GRADY: Sure.

COMMISSIONER ROSENBAUM: Would it be fair to say -- because I think it's going to be incredibly relevant to Ellen's presentation -- that we're looking at two distinct groups of people, some who -- most who probably make their way into Medicaid because they have very high medical needs and their very high medical needs then are caught up with by the health system. Somebody picks them up. They're very disabled, whatever. And they're connected to the Medicaid program.

And then we've got another group that's much smaller, as I understand, that is just simply low income. They're low-income Medicaid beneficiaries who can't afford their premiums, their deductibles, their co-insurance. Other than that, they, at least for the time being, would look like another older person. They just have lower income. So their use of care, everything, is not crazy outside the norm.

Would you say that's what emerges for you from this?

MS. GRADY: I think there is distinctly the population of partial benefit dual eligibles --

COMMISSIONER ROSENBAUM: Uh-huh.

MS. GRADY: -- for whom low income is their pathway to Medicaid and their benefits are limited to that, that Medicare premiums and cost-sharing assistance that we talked about. And within this population here of the full benefit duals that we're focusing on, there is, as you can see, a significant chunk of people who are not using any long-term services and supports.

COMMISSIONER ROSENBAUM: Right.

MS. GRADY: And so, I mean, by definition, that was not their arrival to -- that was not their pathway to Medicaid, so --

COMMISSIONER ROSENBAUM: And I assume that they would be mostly older people, because the under-65 population of Medicare beneficiaries with disabilities, they have such substantial health problems that they've ended up on disability benefits. But I'm more struck today than I have been in the past by sort of this hyperbolic nature of this population, so --

MS. GRADY: Yes. We also have cuts by age, and that's something we can definitely look at. What we did see at a sort of first glance was for the under-65 population, it appeared that their Medicare and Medicaid expenditures were much more uniform, as you might expect. When you look at the 65 and up population, you start to see a lot more variation because, again, if -- you have a significant issue if you've become disabled under age 65, whereas you might age onto the program and have varying needs when you're 65 and up.

CHAIR ROWLAND: April, you know the chart you do on level of spending per dual eligible enrollee varies by long-term care use, I think that in addition to the dollars that you show below, if you added the percent distribution so that you can see that the bulk of them are actually in this $14,000 range, that that would make that one slide really much more meaningful.

MS. GRADY: Okay.

CHAIR ROWLAND: Donna.

COMMISSIONER CHECKETT: Is there a -- I think the answer is no, but I am going to ask. It would be really interesting if we could find out when people came onto Medicaid, at what age, in the over 65. Do you know what I'm saying? Because that would get to the question, at what point is it that your health expenditures are so great that you've either spent down or you can't afford it anymore, or at least you did say, April, you had some age data, and I think it would be interesting to lay the age data alongside this, as well. We'll see what -- at some level, we'll see what you expect. The older you are, the more you cost. But, anyway, I would be interested in seeing if there were any type of interpretation that would be worth looking at.

CHAIR ROWLAND: You know, years ago, one of the studies showed that when a woman's husband died, and especially if he died with a lot of expenses, that that was an impoverishing factor. And so they came onto the Medicaid program more as a result of the death of a spouse as opposed to their own health issues.

MS. GRADY: Yes. I think that's a question that would require longitudinal data and is very interesting. I think it's something we can work on. It probably wouldn't be ready in time for March, but it's definitely an issue we can explore in the future.

CHAIR ROWLAND: Patty?

COMMISSIONER GABOW: Can I ask a question? So this chart, or the other one that has blocks, these are people who have been on for a full year, right?

MS. GRADY: That's correct.

COMMISSIONER GABOW: And there are no partial-benefit people on this chart.

MS. GRADY: Correct.

COMMISSIONER GABOW: So the last group that had no institutional service or home and

community-based service, but they didn't get there because they were poor --

CHAIR ROWLAND: Oh, they could have gotten there because they were poor.

MS. GRADY: Yes. So their basis of eligibility is one of the sort of four categories that I talked about earlier. So either they got to Medicaid because they received SSI benefits. They're probably not spend-down people who got to the program because of their high medical expenses. That, again, was about ten percent. And then the rest of the people do qualify through a poverty-related or other --

COMMISSIONER GABOW: But they're not there because they need premium assistance.

MS. GRADY: They're there because they're low income generally. And so they may also -- they may be receiving premium assistance as part of their benefit, but they're also receiving other Medicaid benefits that are available.

COMMISSIONER GABOW: I assume, then --

CHAIR ROWLAND: Unless they're poorer than the people who are just receiving premium assistance.

COMMISSIONER GABOW: This group confuses me a little bit.

COMMISSIONER ROSENBAUM: Well, I assume that who they are -- I'm actually sitting here thinking they're all the people I used to see in the American Legion halls when I was a legal services lawyer. They had retired. Their Social Security payments were low. And because their Social Security payments were low, they got both, as we knew then, a green check and a yellow check. They got their yellow check, Supplemental Security Income, and they automatically got a Medicaid card. And they were fine. I mean, they were fine. They were low income. And there was just a whole bunch of people, just like with AFDC, who automatically just got their coverage. And they use it for their --

CHAIR ROWLAND: Eyeglasses.

COMMISSIONER ROSENBAUM: Yes, exactly. And then there's a whole bunch of people

who come into Medicaid and end up backing into everything because they're very high need, and that's the smaller group, I guess.

COMMISSIONER GABOW: So if you had a column here about the premium support group, how would they differ from this "no institutional service, no Medicare home or community-based services"?

MS. GRADY: Okay. So you're talking about the people who are not on this chart --

COMMISSIONER GABOW: Right.

MS. GRADY: -- because they're not receiving full benefits. They're just getting the assistance with their Medicare premiums --

COMMISSIONER GABOW: And they're getting it because they're poor.

MS. GRADY: Right.

COMMISSIONER GABOW: So how do they differ from this group which --

CHAIR ROWLAND: They have more income.

MS. GRADY: Well, yeah, so -- right. They are not receiving SSI, so their income is higher than probably about 75 percent of poverty, but --

COMMISSIONER GABOW: Which group is higher, this group?

COMMISSIONER ROSENBAUM: No, this group is lower.

MS. GRADY: The group that you're not seeing on this chart here.

COMMISSIONER GABOW: Oh.

MS. GRADY: So their income is higher than the SSI levels or the sort of baseline levels that a State has established for full Medicaid benefits, which may be higher than SSI because there are various options above that. So their income is higher than the SSI, but it's below the income limits that are set for what are called the Medicare Savings Programs, the MSPs. And those, I think the highest level is about 135 percent of poverty. I'm looking. I'd have to double-check that. But essentially, we're talking about

people above SSI but below these other thresholds that are set.

COMMISSIONER GABOW: I think as you do this, explaining how those two groups differ may be useful, because I think it's confusing.

CHAIR ROWLAND: I think we have had previously charts of the pathways on which someone -- of how someone becomes a dual eligible or can apply to Medicaid, and clearly, there is the Savings Program. Then these people are the people who usually got onto Medicaid because they were also getting welfare through SSI. And then the next group up, the partials who only get help with their cost sharing and/or with their premiums, were added by Congress as they raised the premium amounts under Part B, and they were added with just that assistance, and there's three groups -- there's lots of groups of them.

VICE CHAIR SUNDWALL: I just have one more clarification. I'm sorry to be dense on this, but on the category of using Medicaid non-waiver home and community-based care and then the others who are not -- the smallest group -- maybe the largest group, but the smallest cost -- how do you distinguish? I mean, does no one in that other group get home and community-based care, or is that a non-medical service --

MS. GRADY: So the services we're talking about for Medicaid non-waiver HCBS --

VICE CHAIR SUNDWALL: Yes.

MS. GRADY: -- is almost entirely what's called personal care.

VICE CHAIR SUNDWALL: Oh.

MS. GRADY: So this is an attendant who comes to your home to help you with daily activities --

VICE CHAIR SUNDWALL: Activities of daily living, okay.

MS. GRADY: Right. Right. And, again, the level of benefit provided is going to vary significantly by State, and the criteria that are set to qualify for this non-waiver personal care is going to vary by State.

VICE CHAIR SUNDWALL: Thank you. Okay.

CHAIR ROWLAND: Okay. Now, let's shift to Ellen to tell us what to do about all this.

* MS. O'BRIEN: I think this has been a very helpful discussion, because one of my discussions was do you find this useful for disaggregating the population and what more might you like to know. I mean, there's considerable variation even within these four large groups of full year benefit duals, and what I'm hearing is you might like to see the age distribution within each. You might like to know the Medicaid -- the basis of eligibility for that group on the far right, the people who are only using acute care services. It's likely that a substantial portion of those people come in through an SSI pathway and that would be less true of the people who come in through the -- who are receiving institutional services who come in through a medically needy pathway, and the SSI group would be much smaller. And we could show you those things.

We could show you lots of other kinds of things about the chronic conditions that these people have in each of these groups. We can show you more about their service utilization, things that may not be in the slide, that are not broken out right now. So age, chronic conditions, gender, frailty, disability, cognitive impairment, or use of additional services such as DME, which I don't think is on here, and psych services, mental health, behavioral services in Medicaid could potentially be included to give more of a textured kind of nuanced view of who these populations are.

CHAIR ROWLAND: Patty?

COMMISSIONER GABOW: The other thing which would be useful is the mortality per year and the percent of the spend in the last six months of life, if we had that. We may not. But I think it gets to some of the issue of we really need to do a better end-of-life care plan.

CHAIR ROWLAND: Sharon.

COMMISSIONER CARTE: Ellen, I'd be interested to see a break-out by age with these same

figures, like under-65, maybe 65 to 75, 75 and older, just because I suspect once this population hits an age where they start to incur dementias, and I think it would be interesting to be able to look at populations pre-dementia and then -- because, obviously, that's when you get into more intensive institutional services.

MS. O'BRIEN: Yeah. It's tremendously interesting. There have been studies in the past that show just for elderly duals using institutional services, that as they age, the Medicaid spending goes up, not surprisingly as they become more frail, and the Medicare spending drops. And so -- and the overall spending, I believe, across the programs declines. So that kind of thing, I think, gives you better insight into who's using what services and what can potentially be managed better or improved.

And then Ms. Nicolella this morning raised, I thought, a really interesting issue about cost avoidance. Now, we talk about these strategies to better manage care for duals, but what about thinking about these people, Medicare beneficiaries, before they come to the Medicaid program and really are the most significant opportunities for improving care and potentially bending the cost curve with how we deal with those people, and are they a Medicare or Medicaid responsibility or should that be shared in some way.

So this is a nice disaggregation of the population. In terms of policy implications, I think you can go lots of different directions here, but I might propose that one way to understand this, one way to interpret these data is to say that the analysis of these four sub-groups begins to illustrate the diversity within the dual eligible population. If you look here, the bars are of different heights. People within the dual eligible population have different intensity of needs and use different amounts of services and use a different mix of services, and that variation has implications for policy reform and what their policy needs -- what the needs for reform are within these groups and what approaches might make sense. So diversity in terms of level of need and mix of service use, and this variation suggests to me that there are likely opportunities for care improvement, and savings vary across these sub-populations and probably, honestly, vary significantly within the groups, as well.

COMMISSIONER CARTE: [Off microphone.] Would hospice services fall within the Medicare in-patient only, or would it be in both the Medicare and out-patient and –

MS. GRADY: In the spending chart that we have here, hospice is included in the out-patient physician and other acute.

MS. O'BRIEN: And we can break out more of those if we chose to. We could show more in the chart.

Okay. So this analysis, this data analysis, focuses on the full benefit population, and so in the chapter, a key question is, should this chapter then focus exclusively on these full benefit people and opportunities for service delivery reform. April has showed us what the partial benefit duals, and we could include them. There are issues that affect both full benefit and partial benefit duals, most especially the issue of Medicaid for all as a secondary insurer to Medicare and whether States limit Medicaid payments for Medicare cost sharing or whether Medicaid fills in the full cost sharing liability for dual eligibles. That's a fundamental issue of program alignment and Federal and State roles for dual eligibles and, potentially, access to Medicare services for dual eligibles, and Jim Teisl, as April mentioned, will discuss some findings on this issue in the next session.

Back to the full benefit duals, the next set of slides are intended just to give you a flavor of some of the kinds of things, some of the themes we might be able to raise in this chapter and we'd just really like your direction on where we might take this. But these are the proposed bottom-line messages about variation and the need for targeted or tailored approaches to dual eligibles.

But in the chapter, we would start with some snapshots of -- some discussion of the perceived problems that policy initiatives for duals have been designed to address. As you're well familiar, the current focus of policy discussions about duals is on the consequences for beneficiaries and for program costs of the conflicting incentives created by the dual-payer structure. The fact that services for duals are

shared between two programs may disincentivize care management and other service delivery approaches that might improve care and outcomes and reduce program spending. Because service delivery is fragmented, duals may receive inappropriate care, either too many services or too few services, leading to expensive use of in-patient hospital and nursing facility services. And so we can provide background discussion in the chapter on these issues and their relevance to the four sub-populations.

Of course, the premise, then, the flip side of this is that the premise is there are opportunities to improve care and lower costs for dual eligibles through better coordination and management of services, through integrated financing and shared savings approaches, and better allocation of resources that are available to meet people's needs. And this can be accomplished in different ways, through managed care approaches, where a single entity is accountable for care and costs, or through fee-for-service approaches adding care management, and we could talk about what we mean by care management for these kinds of populations in fee-for-service settings.

So in the chapter, then, we could describe some of the initiatives, the policy initiatives that have been focused on dual eligibles, looking at both those that are implemented in a risk-based managed care setting or those that are developed in fee-for-service that focus on care management or disease management for certain sub-populations, or enhanced primary care. They are listed here. I won't go through them.

PACE is at the top. It makes me a little nervous after the last conversation, but I think there probably are lessons to be learned from PACE about multi-disciplinary teams, about needs assessment, about, you know, about beneficiary-centered care planning, and lots of lessons and principles that we could look at and learn about from PACE, a provider-based model, and think about the scalability of that approach, as Ms. Nicolella mentioned this morning.

I won't go through these now, but we'd like to hear from you about which of these things you might like to learn more about, and I'll come back to that.

So here are target initiatives. There are, I think we could also acknowledged, broad-based policy initiatives that don't specifically target dually eligible beneficiaries for enrollment but that may hold promise for improving care and lowering costs for dual eligibles.

We like to turn to duals. I think they provide a useful illustration of weaknesses or gaps in the U.S. health care system because so many of them have high needs, complex needs, they use a lot of services, and they illustrate the consequences of our siloed delivery and reimbursement models that fail to support a patient-centered and coordinated system of care, and that fragmentation in the U.S. health care delivery system contributes to too many potentially avoidable hospitalizations, medication errors, duplicative testing, and unmet needs for social and supportive services. But these are challenges that affect patients generally, regardless of payer source. And though they're most evident for people who are heaviest users of health care and long-term services and supports, they affect duals and they affect the Medicare-only population and they affect the Medicaid-only population, as well as people who are privately insured, often.

So we could look at some broad-based reforms and think about how the potential of these kinds of reforms to improve care and potentially lower costs for duals. I won't go through them, but we'd be interested in hearing if any of those hold any interest for you.

Another theme that then we would raise in the chapter would be we could draw some preliminary observations about what we know about these policy interventions for duals. We know that experience with fully integrated models remains relatively limited. There is deep experience in some States and limited or no experience in others. These fully integrated models tend to be relatively small and targeted to sub-groups, such as the elderly who meet the standards for admission to a nursing facility in their State. The existing models tend to rely on voluntary enrollment.

We know a fair amount about effective program designs and the common elements of those approaches. We know less, perhaps, about whether those elements can work on a larger scale than they

work in these targeted smaller interventions. And we have some evidence about improvements in care from these policy interventions for duals that we could review, and I think it's fair to say we have some evidence improvements and maybe less evidence on whether the things that have been tried save money for duals.

So a couple of options for the policy discussion in the March chapter. In addition to hearing from you on what other kinds of analysis of the sub-groups you might like to see, where do you want us to go in terms of describing service delivery approaches and [indiscernible] approaches for key sub-groups. Should we profile some of these interventions, PACE, some of the fully integrated D-SNPs for targeted populations, the Arizona model? We can go wherever you might like. But a review of what kinds of approaches have been tried, which sub-populations have been targeted for enrollment, what are the key components of those models, what do we know about the tools that are being used and whether they can be tailored to meet the needs of different sub-groups. So we could profile and stop there, or we could profile and then review some of the evidence about what works for whom. What is the evidence that PACE improves care and may have the potential to lower costs for frail older duals? What is the evidence that integrated managed care models for duals in Massachusetts and Minnesota and the States that have been doing this for a while have reduced Medicaid costs? What is the evidence of the impact of managed care for duals who need long-term services and supports and those who do not?

I think I'll stop there and take your comments.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: I guess one of the questions that I would ask, and I'm sorry to perseverate on this line, but when you look at this chart and you include also the people who just get premium subsidy, does something jump out at you about how this could be simplified? Most of what you put here is how you would improve care or lower costs, but there's another bucket about simplification.

And in some sense, looking at these all together, I like this idea. There may be trade-offs to say, well, if Medicaid took over all of this group and Medicare took over all of this group, the trade-off is roughly economically the same, but it creates simplification. And that may not be. I mean, I'm not sure if that's obvious from this, but I think this -- one of the things is the confusion that having two programs adds to the provider, to the patient. And so is there some -- does something jump out at us in this?

One of the things that I mentioned last time and I talked to Diane about is that the people who are in Medicaid only for premium subsidy, since Medicare premiums are on an income basis already and may be more on that as we move down, maybe the solution is to say, if you're in Medicare and you are this poor, you have no premium. You know, it's a sliding fee scale and here's how it works. And get Medicaid out of that whole business so you don't have States enrolling them, you don't have people doing it. And maybe if you did that, you look at another group for a trade-off.

But I think some questions like that are worth thinking about, not just what approaches might -- I don't think we should not look at what approaches can improve care and save money, but I think this other bit works, as well.

CHAIR ROWLAND: You know, I think that, following up on that point, if you think about how this has all changed, too, with the Medicare drug benefit, one, it's changed in terms of the philosophy of whether Medicare can income test. But if you look at this column of "no institutional services or Medicaid community-based services," you see that the big expenditure there is Medicare drugs, which used to be Medicaid's role for that population. Right, the claw back.

But maybe what you're also adding, Patty, is it would be helpful, although it wouldn't quite fit as nicely on this chart, to have the final column be showing what the non-full benefit duals, the partial duals, how their expenditures rack up, just so that you could see kind of where they're using their services. And maybe they're all now in drugs, whereas before that would have been a service they needed from Medicaid.

Then it was Sara, then it was Donna.

COMMISSIONER ROSENBAUM: Yes. I'd like to -- I mean, I had the same reaction. I felt like I had a Judy Moore moment. And the one refinement I would make to what Patty said is that I don't want to sell the full duals short. Most of our full duals are poor people at the American Legion hall playing pinochle and they get a yellow check and a green check and they happen to have a Medicaid card. But there are a couple of benefits in Medicaid that are very important to that population, specifically vision and dental, and also things like hearing aids.

So we can probably think about the services that show up in Medicaid for a healthy 72-year-old woman who happens to get SSI and her Social Security retirement benefits and it's this same principle that we were talking about before. Medicaid is just a secondary payer for standard ambulatory services, plus the cost sharing, okay.

Then there is the healthy 72-year-old woman playing pinochle who is not getting two checks. She only gets one check, and she's really just a Medicaid cost sharing, Medicare cost sharing person. She's a partial dual. But she looks a lot like the other one except that she's a little bit better off, gets a couple hundred bucks more a month.

And then there's this third group of heavy users of health care. And I would say that we may be doing a service to this whole discussion by taking a step back from full dual, partial dual, instead of leading that way, leading by explaining who these people really are, what they need, and then certain things begin to sort of become evident to me, I think, like you, Patty.

One is with the LIS system now, why are we continuing to do the cost sharing out of Medicaid anyway? But on the other hand, you want to be sure that if someone gets SSI, Medicaid is there for those classes of benefits that are not in Medicare. It's the whole benefit classes that are not in Medicare that we should be worrying about for them.

And then there are these other people who are people who have very high medical costs, who need many classes of Medicaid, that are not in Medicare. But it's really they're on a spectrum, and the big variable to me is the cost sharing issues, the point that Diane was making and that Patty made.

But I just want to be sure that we don't see this as a bi-varied group. Actually, there are three groups. There are low users who happen to be very poor. There are low users who are low income, not poor enough for Medicaid outright. And then there are Medicare beneficiaries who are very sick.

And what's happening, and I think the reason that this is so important, is that the duals discussion is being dominated by that sub-group of Medicare beneficiaries who are very sick. And so a lot of the things that we have on the list are things that you would do for very sick people, whether they're Medicare, or going back to our earlier discussion about people who are sick or have a serious disability.

But we ought to be reminding Congress, hopefully in concert with MedPAC, that that's not the majority of duals. And it's come out again and again, but for some reason, this time you guys have just made it clearer and I think we want to capture that, so --

CHAIR ROWLAND: Donna, then Judy.

COMMISSIONER CHECKETT: I'd like to focus my comments on the options and preliminary observations. My concern -- I think when I ask myself, what is the goal of this? What do we want to be pointing out, focusing on? And I think the need is for models with whom, you know, that have some demonstrable, measurable success, that are scalable and that can address duals kind of across the nation and across States. And as much as I am a fan of PACE and have personally toured a number of PACE sites, I think it is so limited because of the physical requirement, the requirement that it is built around a physical location. That's why it's not scalable. That's why after all these years we still have 200 -- and I would urge us to think about not focusing on that, but instead looking at some of the models that are really very community-based, that I think are replicable, that are scalable.

And then I'd like to find out, you know, where we have successes, why, and where we have failures, why. That, to me, would be of value and how I would like to direct the report, so simple comments.

CHAIR ROWLAND: Judy.

COMMISSIONER MOORE: I like what Donna said about models and pulling those out and highlighting some of them. And at the risk of contradicting myself from the previous session, we do have all this wonderful data that Mathematica has been putting together for us, and keying off what Sara said about beneficiaries who are really sick, it seems to me that we need to lay out, and I assume we probably are planning to, data around people who are really sick who are very high cost, what kinds of conditions do they have? How many conditions do they have? What's the incidence of behavioral health problems? How much money in percentages are going in?

I mean, I think we need to have all of that and we need a big look at who this population is. I think we need to zone in on as much data as we can, especially since the Hill is very interested in this and we have been complimented over and over for being a source of very useful information and that's what I thought we had Mathematica doing for us. So I would put some attention there.

And then, finally, the implications of some of those numbers for policy. That's more detailed than what we've seen here. And then with the addition of the models as examples of why we think those policies are worth pursuing in more detail.

That's, I mean, that's sort of my global view of what I would think this might look like.

CHAIR ROWLAND: And I'd add one more dimension to the request for data Judy has put on the table and that's that much of this debate is around hospital admissions and readmissions, and so to the extent that we can look at the role that hospital care plays, because when you look at this non-institutional services population, there clearly -- some of what they are spending their money on has got to be a little hospital care. And so how many admissions are we seeing in these populations and how much is

readmissions driving some of the spending.

Trish, and then Norma.

COMMISSIONER RILEY: I have two issues, one little, one bigger, I think. When we look at the models, and this may be too in the weeds, but it strikes me that there's so -- and you talk about the individualized care planning and there's so much focus on care coordination and case management across two funders, it strikes me both -- who authorizes services? Let's drill down a little bit. Who actually has the determination of authorizing services? If it's a managed care plan, do they abrogate that responsibility? If it's not one entity authorizing services across payers, it's not really a care plan. So how does that work and does that affect outcomes differently? I don't know how granular the data is, but I think that's really important, because we all just glibly say, oh, care coordination and care management, but are we really managing and authorizing services?

The bigger issue is around election time -- all I know is what I read in the paper, so I don't know much -- around election time, there was this discussion about a Medicare settlement whereby Medicare would have to pay for long-term care, and I sort of thought, hmm, does that mean we don't have a dual eligible problem any more? Should we shift the whole thing to Medicare? What was that settlement and what implication does it have for dual eligibles, because it strikes me --

[Off microphone.]

COMMISSIONER RILEY: Yeah. That looks like -- if I was still sitting in a State, I would have convened my people immediately and tried to maximize Medicare and figured, how do I do this? This is great. But how wide does that open the door and how much new Medicare funding and how much savings for Medicare? I think we can't talk any more about dual eligibles without looking at that.

CHAIR ROWLAND: Because it changes who pays for their home health services.

VICE CHAIR SUNDWALL: And it's Medicare now?

CHAIR ROWLAND: Well, there used to be a standard where you had to show improvement to qualify, continued improvement, and now it's maintenance.

[Off microphone.]

COMMISSIONER RILEY: To me, that's huge, and I think we've got to really look at that, because it seems to me it changes the -- and as we look at the sub-groups, it fundamentally changes who's going to pay for what.

CHAIR ROWLAND: Norma, then Patty.

COMMISSIONER ROGERS: What case was that?

COMMISSIONER ROSENBAUM: It's called Jimmo, and it's a case involving a challenge to what has been a longstanding limitation on Medicare on what is considered medically necessary. In Medicare historically, not because of the statute but because of informal guidelines, the contractors would look to see whether you were improving, and improving meant getting better, okay. And a group of beneficiaries challenged the standard on the grounds that nothing in the statute actually limits "medically necessary" to getting better. It's medically necessary if it keeps you from getting worse or if it allows you to maintain your functional status and it's an otherwise covered service.

And the administration entered -- the beneficiaries won the case at District Court, and rather than challenging it, the Medicare program has now entered into a settlement agreement with the class. It's a nationwide class, so it's a nationwide decision. And I think Trish is absolutely correct that it's important to look at the new standard and look at how that standard will be applied in both institutional and home health settings, and, therefore, think through what this means for the duals discussion, so --

[Off microphone.]

COMMISSIONER ROSENBAUM: It's basically all Medicare beneficiaries who need home health and -- right.

COMMISSIONER ROGERS: So the question that I -- the addition I wanted to make, I said something that I think we need to know, also, is based on readmissions in hospitals. Are they coming from cities that have better programs or better resources, or are they coming from rural areas where they lack the resources? Is that where the readmissions are coming from, or does it matter, because I think that's significant.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: I don't want to add anything. I just want to say that I think that this chapter with what's here and what we've talked about should be very useful, because the discussions, I think, that we've heard so far is that everybody's lumped in one bit. These are the duals. And I think the assumption -- I think Sara said that they were all the sick people. I think, if nothing else, it sets up thinking about these in different bins and thinking about managed care for these groups in different bins. I mean, it's not going to be the same in every one of these. So I think this is very useful in terms of making the discussion more realistic.

COMMISSIONER ROSENBAUM: [Off microphone.] And it is J-i-m-m-o, not G. If anybody wants to go look at it --

CHAIR ROWLAND: Which were the attorneys, right? Okay.

Well, I think more data, more information, more cuts. But really, I think what we're all saying is we're trying to get underneath these different boxes to really understand what drives the utilization and how policy changes would interact with that. And I think we also really want to look at the population using institutional services, because some of the strategies for them are likely to be very different than the home and community-based service users, which may be more similar to some of the things you want to do with non-institutional, non-home and community. Those groups may have some similarities, but those may be around chronic illnesses and different kinds of physical versus behavioral issues and whatever. So the

more we can understand what -- not only what their characteristics are in terms of age and use, but even what's driving their use, that would be very helpful.

VICE CHAIR SUNDWALL: Just one comment before we leave this. I also welcome this. It's really much better information than we've had and I think the Hill will appreciate it and maybe give them pause before they do simple policies to correct a really big problem.

What I would like for us to think about is the Commission recommending a single payment system for this. Why do we have duals in the first place?

CHAIR ROWLAND: [Off microphone.] -- started it already.

VICE CHAIR SUNDWALL: I mean, it -- pardon?

CHAIR ROWLAND: That sounds like Mark.

VICE CHAIR SUNDWALL: Yes. Well, it doesn't make sense --

[Off microphone.]

[Laughter.]

VICE CHAIR SUNDWALL: No, I'd like to be in your company. I trust it. But anyway, it's just something that we need to think about because I think the Commission, if it's going to be valuable over time, has got to come up with some bold ideas and this is one that I, in the spirit of simplification, Patty, I think it makes sense.

CHAIR ROWLAND: Well, I think that when we call Jim up to talk about how State Medicaid payment policies affect Medicare cost sharing for the partial duals as well as for the full duals, it'll be even more to your liking for calling for simplification.

Thank you both.

We've never called for more complexity, have we?

[Laughter.]

COMMISSIONER GABOW: Thank God.

CHAIR ROWLAND: Welcome back, Jim, to be our closer.

STATE MEDICAID PAYMENT POLICIES FOR MEDICARE COST SHARING

* MR. TEISL: All right. So thank you very much for the opportunity to speak with you again. As has been alluded to a number of times today, I'm going to talk about one of the areas of interaction between the Medicaid and Medicare programs, specifically the requirement for State Medicaid programs to cover cost sharing for most individuals who are dually eligible for both programs.

So the overall purpose of the session is two-fold, to provide an overview of State Medicaid payments of Medicare cost sharing, and then to summarize the current State policies based on some work that we did to go out and see how they actually do this.

Clearly, this topic is part of our ongoing work on issues relating both to dual eligibles and to the intersection of payment and access. We do plan to include at least some sort of a descriptive chapter of this issue in the March 2013 report.

We looked into the issue to better understand some of the issue between the two programs at the State level as well as to lay the groundwork for analysis of the effect of State policies for paying for cost sharing on the provision of services to dually eligible individuals. This is just a first step, and I sort of want to caution everybody that this is in no way intended to be an assessment of payment adequacy or of the appropriateness of States' policies for the way that they handle payment of cost sharing. But to our knowledge, an accounting of these State policies, particularly across the different services -- hospital, nursing facility, and physician -- isn't currently available. So we look forward to your comments and guidance.

A quick overview of the Federal requirement. So State Medicaid programs are required to cover cost sharing for most individuals that are dually eligible for Medicaid and Medicare. The Balanced Budget Act of 1997 gave States the explicit authority to limit the amount of cost sharing that they pay only up to the

standard Medicaid payment amount that they make for the same service under their State plan. And as you all well know by now, providers are required to accept that combined Medicare and Medicaid payment as payment in full and may not balance bill the enrollees for any unpaid amounts of cost sharing that result from the State payment policies.

This presentation, we talked a little bit about the payment of premiums. This statutory provision in this presentation is specifically applicable to State payment and deductibles and co-insurance for services that are actually provided.

So we reviewed cost sharing payment policies in each State for the four services that you see here, in-patient hospital, out-patient, nursing facility, and physicians. In most cases, we limited our review to publicly available policy documentation -- State billing manuals, State administrative code or statute. In some cases where either we couldn't identify publicly available information or the information that we identified was unclear, we placed some phone calls to talk with State staff to get clarity about what the policies did.

So what we found is across all of these services, State do typically limit their payment of cost sharing to what's termed "the lesser of," and what that means is that the State pays the lesser of the full amount of Medicare cost sharing, the co-insurance or deductible amount, or the amount that Medicaid would normally pay for that service minus the amount already paid by Medicare.

So there's a couple of examples here, and the examples that are on this slide are specifically for a day of care in a skilled nursing facility. The first 20 days are fully covered by Medicare, but from days 21 to 100, there's a copayment of about $145. If a State paid the full amount of cost sharing, they would simply pay the $145. But if the State chose to limit its cost sharing under this "lesser of" policy, one of the three examples here would apply.

In Example 1 and in Example 2, the amount of cost sharing is limited by the State Medicaid rate for

a day of nursing facility care. In Example 1, the Medicare rate is $300, so Medicare actually makes a payment to the facility of $155. The facility would then bill, or the bill would cross over to the State for the co-insurance of $145. The State would say, well, the facility already got $155. Our rate for this person would have been $185. We'll pay up to that $185, which is a $30 payment. If the Medicaid rate was only $150, the State would say, well, you already received $155 from Medicare. Our rate would have been $150. We'll make no additional payment for cost sharing.

In Example 3, if the State paid $150 more than what the provider already received from Medicare, then the cost sharing payment amount would be limited to, again, the lesser of the full cost sharing or the difference, and in this case it would be that cost sharing amount of $145. Clear?

[Off microphone.]

MR. TEISL: The same principle would apply under other services, like medical services, for which the cost sharing amount is typically 20 percent. The State would look at the 80 percent that the provider already received from Medicare and compare that payment amount to what they would pay if Medicaid was paying for the service.

So more specifically, you can see on the chart, and I know on the slide the numbers are a little bit --

CHAIR ROWLAND: Going back to the previous slide –

MR. TEISL: Sure.

CHAIR ROWLAND: -- I assume that Example 3 is not very common.

MR. TEISL: Yes. It is relatively uncommon, and so it is also -- I'll leave it at that.

CHAIR ROWLAND: But it can occur?

MR. TEISL: It could occur, that's right. And there are cases where it does, so, you know.

So on the next slide, you see our results, the count of States that pay the full amount of cost sharing or limit their cost sharing as statute permits them to do for each of the four services that we've mentioned.

And as you can see, generally speaking, somewhere between 36, 38 to 40 States limit their payment of cost sharing for each of the services that we looked at. Thirty States limited their amount of cost sharing across all four services, while only four States appear to pay the full amount of cost sharing across all of the services.

So there are a couple of cases, and when we went through the policies and tried to categorize them, they weren't necessarily a pure "lesser of" policy, but the State might have a policy to, for example, pay a set percentage of the cost sharing amount, and that percentage was set to approximate what they would pay if they applied the "lesser of" policy. For sort of simplicity's sake, you can think of this as States that pay the full amount and States that apply a limitation pursuant to the statute.

This is also probably a good time to sort of take us back to our discussion this morning where we talked about for primary care services delivered by eligible physicians in 2013 and 2014, the required Medicaid payment amount will come up to the Medicare payment amount, in which case for those physicians and those services, even if the State has a "lesser of" policy, in effect, they'll end up paying the full amount of cost sharing to bring them up to the Medicaid [sic] amount. And in those cases, States will be eligible for a 100 percent match for those two years.

So there's an important additional policy that goes along with this story and that's the fact that some providers can claim the unpaid amount of cost sharing as Medicare bad debt. And specifically, those are institutional providers. So in fiscal year 2012, for dually eligible individuals, Medicare would reimburse 70 percent of the bad debt incurred by hospitals. So 70 percent of that unpaid cost sharing, hospitals could recoup as bad debt from the Medicare program. And for dually eligible individuals, 100 percent of the bad debt to nursing facilities. Recent legislation will reduce the bad debt reimbursement to 65 percent beginning in 2013. And for those nursing facilities that were at 100 percent, that's going to phase down over three years. Again, providers that are paid on a fee schedule basis, including physicians, are not

eligible to claim bad debt from cost sharing.

So regardless of how States treat Medicare cost sharing, one important thing to keep in mind is that the statute also legally protects dual eligible beneficiaries from balance billing. The providers can't go to the actual enrollees to recoup any unpaid amounts.

Still, the information presented here raises a number of important policy questions. We've heard both from people who have testified in front of the Commission as well as through the literature that the Medicaid cost sharing limits may affect access and quality, so there's a big outstanding question about what that effect might be. Specifically, do these cost sharing limitations affect provider participation? Is there an effect on quality of services? What's the fiscal impact for States, the Federal Government, and providers? And as with so many other things in Medicaid, the impact really is going to vary by the individual State payment levels and methodologies. To the extent that States already pay close to or even more than Medicare, there's no practical effect of applying a "lesser of" policy. But the fiscal impact grows as the disparity between the rates grows.

I'd just say that based on the work we've done so far, it appears that there may be more work to do in this area and we open it up to you for sort of your input on the work we've done so far and where you might like us to go from here on this issue.

COMMISSIONER ROSENBAUM: Just one thing that I believe I've noted before in a different context, but it's worth raising here, as well, because it may suggest something else the Commission can look at. Over the 1997 -- so this all was the Balanced Budget Act of 1997 -- so over the 1997 to 2011 time period, the number of elderly patients at community health centers doubled, and there's no good explanation demographically. I mean, the low-income population didn't go up that high. It didn't suddenly skyrocket. Nothing happened, except that it began in 1997 and what you see in the national UDS data is this fantastic growth in the number of elderly people.

I've always assumed that, especially because it began in 1997, that it is directly related to shifts in State Medicare payment policies, that as States began to go to the "lesser of" standard, more physicians who had been treating dual enrollees stopped and dual enrollees are more -- more of them go to a community health center where, first of all, they can't be billed, but also, of course, they get -- they wouldn't pay anything. And the health center, of course, is on an alternative payment mechanism so it's shielded to some degree from this.

And I think that in terms of having some insight into how this payment policy might have shifted patterns of care for low-income people, it would be worth looking at these data State by State to see -- because you can look at the UDS data State by State -- to see whether there are bigger shifts occurring in States that go to "lesser of," and then what does that tell you? I mean, it's not that there's anything problematic about going to a community health center, but at the same time, there's clearly been some -- my guess is that there's been either some dislocation or people who became Medicare eligible at that point moved. I mean, it's the one thing I've ever seen that's sort of some signal of some consequence.

The other point that I think is worth noting, on your last slide about the bad debt, is that providers have to bill. They have to bill Medicaid. And they have been extremely opposed to billing Medicaid first, before they can declare the bad debt. There was just a Federal ruling upholding the Secretary's authority to require that providers bill first. And so, clearly, there's been a lot of bad debt absorbed by Medicare that was being absorbed because providers were just automatically declaring it, and the numbers may begin to drop if they've got to go through more billing obligations.

COMMISSIONER RILEY: To me, this is the perfect sort of microscopic look at what the problem is with dual eligibles because it's a perfect example of misplaced incentives. And when you look at -- if you're a State, you're saying, why should I pay dual eligibles more than I pay any other person? I have a limited budget and why should -- that's not fair.

And especially why should you do it if you know Medicare -- I mean, I remember these discussions. Don't do it. Medicare will pay it as bad debt and it's a Medicare obligation, after all, from the State perspective. And the painful discussions about cross-over claims and the data mix-ups, it was a mess, as I recall.

So I guess I'm curious to know what the States have told us about this and where their thinking is, because this is a pretty thorny one.

MR. TEISL: Well, at this point, we haven't talked to States specifically about their sort of thoughts, I guess, about the policies, but it might be something that we could consider doing.

CHAIR ROWLAND: You gathered most of this from existing documents, right?

MR. TEISL: Yeah.

CHAIR ROWLAND: And follow-up.

MR. TEISL: What we focused on were things that were publicly available basically through Internet search, and then in some cases we had to follow up. Either we couldn't find reliable information or what appeared to be reliable information, or what we found was unclear.

CHAIR ROWLAND: I mean, it would also be interesting to know what the administrative costs of trying to do this are. For providers, too.

Donna.

COMMISSIONER CHECKETT: So I --

CHAIR ROWLAND: Oh, I bumped Mark.

COMMISSIONER CHECKETT: Oh, I'm sorry, Mark. Go ahead. No, go ahead.

COMMISSIONER HOYT: So, personally, I love the chart with the three examples. I can probably give up afternoon coffee if I just pull that out and just glance at it.

[Laughter.]

COMMISSIONER HOYT: What I think would be more helpful for some of the other people this is going to go to eventually is can we tie it to aggregate dollars, like how much money is being pulled out of the system towards paying the lesser of. I think in your paper you sent us in advance, you had trends over time, so we should assume that continues into the future, I would think, or even accelerates. I'm guessing States are going to just continue to do whatever they can to reduce their own costs and let the Feds deal with it.

Also, do we know the -- do we have a projected number on how many duals there will be in 2016, 2017? If there's nine million now, is that going to be 12, 15? If we could get that from somewhere, that might help magnify the issue. But I think big dollar signs draw attention faster than almost anything else --

CHAIR ROWLAND: I don't recall that it's projected to go up dramatically, but --

MS. GRADY: No, I think the projections that I've seen from CBO have the elderly Medicaid population, I guess, which I would use as a proxy, growing at low single-digit, pretty constant rates, not huge.

COMMISSIONER HOYT: Okay.

COMMISSIONER GABOW: About the growth, though, didn't we hear today that the disabled population is the single largest growing group? And I wanted to ask that but didn't get around to it this morning. Why is that? I mean, do we under --

CHAIR ROWLAND: That's the Medicaid-only disabled population.

COMMISSIONER GABOW: But still --

CHAIR ROWLAND: Well, it could change -- the economy and some more people applying and some of the changes in some of the definitions of access through behavioral health and whatever.

COMMISSIONER HENNING: How about baby boomers and obesity?

COMMISSIONER HOYT: I just think -- my point, to close out, was if we're moving to a period

of a presumed doctor shortage, you have to assume -- I mean, it's America -- they'll go to wherever the reimbursement is higher. And if this money is being kind of taken away from them covering the dual population, then when they get to the point of being able to pick and choose, some of them, anyway, who they're going to serve, they're not going to pick this group.

COMMISSIONER CHECKETT: Well, and maybe Mark actually just started to answer it, because my question, or my rumination here was, all right, this is interesting. I know about it. I agree. It's just the perfect example of kind of really bizarre policies that have developed over time for which there's no really good policy reason. But I was wondering, so what's the take away? I mean, if we do this, so we've pointed this out, but so what? Do we have a policy direction we're going with this or what are the recommendations or learnings from it? So you started to help me think about that, Mark, and, I guess, Jim or others, I would just be interested in your thoughts on that, because otherwise, I mean, it's really interesting, but there are so many examples of weird things that, you know, almost why this one, so --

[Laughter.]

COMMISSIONER CHECKETT: So, no, I'm being really serious. Where are we going with this in terms of a policy recommendation?

CHAIR ROWLAND: But this one does go a little bit with the primary care payment bump, as well. So there's at least that overlap in terms of the primary care piece.

COMMISSIONER CHECKETT: Okay.

VICE CHAIR SUNDWALL: Well, with the primary care piece, I hope our policy agreement will be that MACPAC can try and ascertain, to the extent we can, if that policy accomplished what it wanted to, and that is improve access to care. And that's how we can help the Hill. Did it work or not? And maybe, as Patty said, it's too complicated to find out, but I think we ought to try.

The policy here is, I think, that we don't need dual eligibles. We should have a program that cares

for these people that's unified and doesn't do cross-overs. And I think that's in the spirit of simplification.

A question I have for you, Jim. The last slide you did about the -- this kind of caught me by surprise, that providers can claim unpaid debt, unpaid cost sharing as bad debt. Is there any way to measure the cost of that policy, because that's a -- I'm anticipating that's a lot of money.

MR. TEISL: Yeah. I can't give you the numbers off the top of my head, but we can look and give them to you. There were estimates developed quite recently because there were reductions in the amount that could be claimed as bad debt, so I can look for it.

VICE CHAIR SUNDWALL: That would be enlightening for most people, I think, if they knew how much -- that's another way for providers to get money.

MR. TEISL: Keep in mind that the portion attributable to dual eligibles is just sort of one piece of the bad debt that providers can claim for uncollectible amounts of payment.

CHAIR ROWLAND: Other comments? Well, thank you, Jim. I think this is an important complement to the work we're doing, and I think it reinforces, though, going back to Patty's comment, the importance of looking at the disability population and keeping in mind Medicaid's role for that population for Medicaid only and how that relates or doesn't relate to the dual eligible population.

We've now concluded our talk, but we will open the mic to any comments or issues from the audience. No one wants to ask a question or -- you can come up to the mic, please, and identify yourself.

PUBLIC COMMENT

* MS. CAMERON: Hi. I'm Joy Cameron. I'm the Senior Director of State Relations for the National PACE Association.

CHAIR ROWLAND: Oh, surprise.

[Laughter.]

MS. CAMERON: So I just wanted to first make the offer that we'd be absolutely happy to give

you any recent information or data about PACE and what's going on today with PACE. As you know, it is an older program, but we are moving with the times, so to speak.

Just a quick update. There are 89 PACE organizations in the United States, some of them with multiple sites, so there's more like 160 sites nationwide. We are serving over 25,000 people. Twenty-five thousand was our January 1 number, which we update every year, but I'll give you an example in a minute of how quickly we're growing. So there's -- PACE is now in 30 States, which is a little different, because we, as mentioned, are growing. And there's 20 applications in the pipeline with CMS currently for more PACE sites to come on board. Since January 2009, we've grown from 65 sites to the 89 that I just mentioned, so we are moving right along.

Yes, we are a little picky about who does come into the PACE program because we want to be sure that we're serving those who are truly in need. So we aren't exactly cherry picking to the really easy people. We are getting the much more difficult, high-risk, high-need individuals at our PACE sites.

Studies that we've used that we've looked at to talk about cost effectiveness, the only really peer reviewed effective study on cost effectiveness comes out of South Carolina that we'd be happy to forward and send along to you. There's been other studies. Recently, there was one from Kaiser that was written by Mathematica that talked about best bets for dual eligibles, and they actually had said that smaller-sized, moderate-sized programs like PACE would be considered a best bet because of our IDT teams, which are the interdisciplinary teams.

Just -- I promise I'll be quick. So, like I mentioned, there are more in the pipeline. We have four new States that are part of that pipeline, so PACE is growing.

Someone -- I'm sorry, I was in the back, I couldn't exactly see who asked, is PACE kind of clustered in certain areas within States? PACE has actually been working very hard. Both the MPA and then PACE providers have been working hard with different States to assess States to make sure that there is

eligibility throughout the State. The State of Pennsylvania is our most recent example, where those that are eligible for dually eligible and nursing home certified, over 80 percent of them would be able to choose PACE throughout the State of Pennsylvania, and that includes in areas where sometimes there's only, like, 40 eligible duals in one county. So they have been working hard.

I think our best example of the way that PACE wants to grow is we've worked on some legislation called the PACE Innovation Act which would allow us to -- currently, under its current structure, there are a lot of rules around an adult day center and we'd like to see the use of more alternative care settings, be able to reach below 65 to some of these disabled individuals that might benefit from care coordination, like PACE. So we are shopping that legislation around, like we all do.

But our good example is the CenterLight in New York City -- actually, in the Bronx -- and they have -- there was some grandfathering. They have the ability to use alternative care settings and others. They've grown by 2,200 members this year alone. So they are showing what we can do with that kind of flexibility in place.

So, honestly, it was just kind of a -- I just wanted to give you some updated news and to let you know that we'd be more than happy to share any information with either you or the MACPAC staff with what's going on with PACE currently, so --

CHAIR ROWLAND: Well, thank you. We really appreciate that. Obviously, your comments today will be entered into the record for this public meeting, as well as providing any information to staff that we can continue to learn more about this. I know Patty was the one who asked for some of the geographic distributions, so we've been getting some maps. And I know that Norma is very interested in how models work in both urban and rural areas.

MS. CAMERON: Great.

CHAIR ROWLAND: So any information that you or others can provide us on sort of the

on-the-ground experience with both PACE and other integrated care programs would be appreciated.

MS. CAMERON: Great. Happy to provide it. Thank you.

CHAIR ROWLAND: Thank you.

Other comments? Other offers of help?

[No response.]

CHAIR ROWLAND: Well, if not, then we thank you for joining us today. We will not be reconvening until the new year, so we wish you all a great Thanksgiving and good holiday season and look forward to continuing to hear from you and work with you and see you in the new year. Meanwhile, there is still a lot of work for the Commission members and the staff to do before we hit the new year.

* Thank you. The meeting is adjourned.

[Whereupon, at 4:34 p.m., the meeting was adjourned