Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

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

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9:44 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
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AGENDA PAGE

P R O C E E D I N G S [9:44 a.m.]

CHAIR ROWLAND: Good morning, and welcome to this meeting of the Medicaid and CHIP Payment and Access Commission. We are pleased to start the new year with such a great meeting and so many super panelists to come meet with us and help us to prepare the materials that we hope will be part of our March report. And so I want to welcome both the audience and our panelists, and we'll turn to my Vice Chair for some welcoming comments, and then we'll get to our first panel.

VICE CHAIR SUNDWALL: Well, good morning. Welcome to our Commission meeting. I can tell you that it's interesting for me to be here as I read the agenda because I'm seeing in a conservative state like Utah all the questions that are being asked there about implementing the ACA. Do we expand Medicaid? Is our exchange that we already have up and running going to qualify for federal approval? So it's a very, very dynamic time. Many states are moving forward, some are sitting on their hands, and we're somewhere in between.

So I welcome you to this meeting. I think we're going to talk about some very timely and important issues for Medicaid.

Thank you.

CHAIR ROWLAND: So as we move forward towards 2014 and the implementation of both the ACA's exchanges as well as the Medicaid expansion in many of the states, a lot of changes in the way the Medicaid eligibility system will work, we welcome this first panel to share their insights into some of the interactions and some of the challenges going forward.

Chris Peterson on the staff will lead off our discussion.

INTERACTIONS BETWEEN MEDICAID, CHIP AND THE EXCHANGES: PLAN PARTICIPATION

* MR. PETERSON: Thank you, Diane.

Less than a year from now, health insurance exchanges will provide a new opportunity for plans to offer coverage. Plans that currently offer coverage only in Medicaid may want to participate in exchanges. Commercial plans may want to offer coverage through Medicaid, or not. Plan willingness to participate in both markets may be affected by a number of factors, and we've brought in three experts from different perspectives to discuss these issues with you.

Deborah Bachrach, you may remember, is one of our very first presenters. She's a partner at the law firm of Manatt, Phelps & Phillips. She also served as New York's Medicaid Director, and she'll provide an overview of the issue.

Scott Leitz will then provide a state perspective. Scott is Assistant Commissioner of Health Care at the Minnesota Department of Human Services and oversees Minnesota's Medicaid program. And prior to this, he was director of public policy for Children's Hospitals and Clinics of Minnesota.

And, finally, John Lovelace will provide a plan perspective. John is president of UPMC for You, a Medicaid managed care organization in Pennsylvania. He also oversees the non-group products offered by UPMC and is chief program officer at Community Care Behavioral Health Organization, which I think in our parlance we would call a behavioral health carveout.

So, with that, I'll turn it over to Deborah.

* MS. BACHRACH: Thank you, Chris.

So let's see. It is a pleasure to be here today, and this is a topic that I've been thinking about and first wrote about almost two years ago.

The issue for today really stems from the ACA's vision and requirement for a continuum of affordable insurance options called insurance affordability programs. And I think we all know we're

talking about Medicaid, CHIP. I'm going to skip over BHP. Although it's an option, it's not an option I think states are pursuing in 2014.

So our continuum looks like this. We have Medicaid up to 138 percent, CHIP above 138, going up anywhere at the state options from 200 to 400 percent of the federal poverty level, and then premium tax credits and cost-sharing reductions for qualified health plans, for individuals to enroll in qualified health plans up to 400 percent of the federal poverty level. So for an individual, 138 is $15,000 a year; for a family of three, we're looking at about $63,000 at the 400 percent level.

But the important takeaway here is that the ACA sets up a continuum of coverage, of affordable coverage. For individuals up to 400 percent of the federal poverty level, Medicaid no longer stands as a silo of subsidized coverage. So foundational to this is the requirements in the ACA for an integrated eligibility enrollment system and policies across insurance affordability programs. So we have our single streamlined application for all IAPs. There's no wrong door. That application can be submitted to the exchange, to the Medicaid agency, and wherever it's submitted, however it's submitted, a determination of IAP eligibility will be made, again, confirming our continuum of coverage.

And then, finally, to assure that this works, the exchange and the Medicaid and CHIP agencies enter into agreements which assure coordination and delineate the roles and responsibilities.

So the ACA sets that up, and it's a requirement. It's certainly a challenge, but every state is moving forward to implement aspects or most aspects of that. I say "most" only because of the question of whether a state will expand. But that's what the ACA says.

Here's where states face a challenge now. How do we align our public and private markets? How do we assure, as individuals' incomes fluctuate and they change their eligibility status between Medicaid or CHIP or tax credits, that they don't lose coverage, that they continue to have coverage and, ideally, they

continue to have access to the same providers?

So when we think about this issue, I bucket it into three approaches. The first charge -- and states are really focusing on this right now, which is how do we minimize the frequency of transitions between IAP programs when income fluctuates. And there are strategies and options offered by the ACA that can minimize IAP transitions, and states are looking at those.

But there will be transitions. We know that. And so then the next question is how do we facilitate access to the same plans and providers, when an individual moves from Medicaid, their income is 130, it goes up to 140, they move into the exchange and a QHP or vice versa. So how do we make that work so individuals can stay in the same plan and access the same providers?

And then, finally, even when we're not looking at transitions, we're looking at what I'm calling your mixed-eligibility family where some members are eligible for Medicaid, others for tax credits, and potentially others for CHIP. Wouldn't it be great if they could be covered by the same plan even though their subsidy comes out of a different source. So let me go through each of these.

So in terms of minimizing transitions, some of the options that are available to Medicaid or go for 12-month continuous coverage. Many states have that today for children. It's obtainable through a waiver for adults. I think Wisconsin and New York both do that today. And 12-month continuous will stop mid-year breaks.

Take into account predictable income. Medicaid looks at current income, so if you have seasonable workers during the summer, they might have an income that puts them just over Medicaid, but knowing that the job will be eliminated, will not be available, will go down over the course of the year, they will be Medicaid eligible. That's another option that states can take.

This is an important one. QHP coverage starts at the first of a month. It can be as much as a

six-week delay, five-week delay. Let's extend Medicaid coverage to the end of the month or to the day before QHP coverage starts. And then is there any way to auto-enroll consumers as they transition between Medicaid and QHPs? Easier to do when you're going from QHP to Medicaid because there's no premium obligation. Harder to do but perhaps there are ways when someone goes from Medicaid into a qualified health plan where they will have a premium obligation.

So now we've got -- I want to look at the situation where we've done everything we can, but we're going to have people transitioning among plans. And, ideally, it would be great to find our Medicaid MCOs coming into the exchange and being certified as a qualified health plan.

Now, you know in Medicaid today we have a number of what I would call the pure play plans. A number of them are sponsored by hospitals, community health centers that aren't in the commercial market. And for them to come into the exchange is a new business model. In some states, it would require a different license and additional accreditation requirements. The ACA delays the accreditation requirements, so that's not an immediate issue. Licensure can be, and that's where states have some flexibility if it's considered a high priority.

The reverse. How about getting some of our commercial plans to come into Medicaid? Here -- and John and I were talking about this before -- this can be a problem if there's a Medicaid procurement, and the procurement is every three years. Well, you know, even assuming the plan could compete successfully, we need a procurement for them to participate in. So it's easier said than done in both directions, but it's obviously highly desirable if we can have at least some plans in both markets, and I would suggest that gives the plan a considerable competitive advantage in both markets.

Now, I'll lump the next two together because both of these are ways in which Medicaid plans can be accessible to individuals at lower-income levels. BHP, as you know, is restricted up to 200 percent of the

federal poverty level. A bridge plan, which was conceived of in Tennessee and just recently approved by CCIIO, would allow Medicaid MCOs to be certified as a QHP. Now, you still need to be certified as a qualified health plan, but enrollment could be limited to -- and would be limited -- in fact, that's the only way CCIIO would approve it. Enrollment would be limited to individuals who were coming out of Medicaid or individuals who, as part of a family, someone in that family is in Medicaid. And that's the way we would -- it's a bridge plan.

Chris just told me two minutes. I'm going to try to talk a little faster.

Now, getting plans in both markets is really only half the battle because not all commercial plans have the same networks. They may be in both markets, but they don't have the same provider networks. Your Medicaid MCOs have an awful lot of FQHCs, DSH hospitals. Sometimes your commercial plans, you have physicians who will not take Medicaid. And so how do we ensure that the provider networks are overlapping? Or virtually identical would be ideal. And so how do we get there? Can we require it? Are there ways to facilitate it?

Even without that -- and, ideally, that really is a key starting point -- we would like to see the same requirements across Medicaid and QHPs.

Now, we wrote a paper on this some time ago because Medicaid has a lot of experience on network adequacy, quality, transparency standards. And Medicaid probably goes further in regulating than exchanges will do with QHPs. But there are some lessons there, and we can look at some of the same standards.

And then, finally -- and we see this today in Medicaid -- care transition standards so that if someone moves into a plan and their provider is not in the plan network, they can stay with that provider at least until the end of the course of treatment.

I finished.

MR. PETERSON: Perfect.

MS. BACHRACH: So thank you.

Oh, you know what? Since I have one more minute, I want to say one thing about -- one minute. One minute, Chris. All of this works when you have a Medicaid expansion. I mean, we should be clear that there are two sort of assumptions that I made. One is that there's a Medicaid expansion, and, two, that it's a state that's using Medicaid managed care plans. In both cases, no expansion or fee-for-service or even a primary care case management model. A lot of the alignment that I suggested becomes much more difficult -- not impossible but more difficult. So that was the one caveat I did want to make.

* MR. LEITZ: Good morning, and thank you very much for the opportunity to be here today. We -- obviously I think all states -- have been thinking about very much the issues that you are discussing today, so we appreciate the opportunity to give you some insights into what we're thinking about as one state.

I want to give you a very brief background on Minnesota's Medicaid program, and then I'll talk a little bit about the requirements that we currently have in our state law regarding plans operating in the Medicaid program in Minnesota, and then lastly, I'll just close with a few of the policy issues that we're thinking about, which do include things like the Medicaid expansion and interest in the basic health plan. I think Deborah's right that states are, by and large, struggling with how to implement a BHP, but I can tell you that from Minnesota's perspective -- I'm tipping off my closing here by telling you this on the front end -- it is something that we're very interested in pursuing because it really fits into the environment that we've developed over time.

Minnesota's Medicaid program, I've listed out the two major programs that we operate. Largely Minnesota is a managed care state. About two-thirds of our Medicaid enrollees are enrolled in managed

care. Our Medicaid program, called Medical Assistance in Minnesota, enrolls around 600,000 individuals. The large majority of those individuals are enrolled in managed care plans, so this would be your families and kids, your single-adult populations.

We did exclude the disabled from managed care up until January of 2012. They are now included in managed care on a mandatory basis; however, we allow for an opt-out of individuals if they don't wish to be in managed care. And the opt-out rate is running at about 50 percent right now in Minnesota. So about half the folks are choosing to go into managed care, about half are not.

We have run for 20 years a program called MinnesotaCare, and this is a program that was put in place to sort of fill the gap between where Medicaid coverage ended and where employer-based coverage started. So it's a state-subsidized program, around 130,000 people enrolled in the program. It operates under an 1115 waiver, and it is entirely a managed care program, so we mainly have -- families and kids are about two-thirds of the population; about a third, single adults in that program. And then, obviously, we have supplemental coverage as well for folks on Medicare through the Medicaid program, the duals.

As I mentioned, Minnesota is largely a managed care state, and we have been since the mid-1990s. So this is a longstanding policy decision that the state made, primarily -- or originally conceived to give better access for folks in the Medicaid program through the networks that have been built by the managed care companies. And so folks who are on Medicaid in Minnesota -- and I'll use Medicaid to encompass both our MinnesotaCare program and our Medicaid program -- enroll either through licensed health maintenance organizations or through county-based purchasing plans.

We have five HMOs that operate in our Medicaid program. Three of those plans operate in both the commercial market as well as in the Medicaid market. One plan is specific to Medicaid, and one plan operates in government programs, meaning it does Medicaid and Medicare. And they operate in the

counties they are licensed in, so we allow for those plans to operate in whatever county they happen to be licensed in.

Minnesota law is unique in that it requires the HMOs in the state to be nonprofit entities, so we don't allow for-profit HMOs in Minnesota.

We also operate three -- there are also three county-based purchasing plans that operate, and basically these are plans that are operated by the counties. They operate in 20 of Minnesota's 87 counties. They're all rural counties. They're county-run, and they're enabled under state statute. Essentially, the county accepts the capitation payment similar to the way a licensed HMO would, and then it operates enrollment functions -- in the counties that these operate in, they've essentially re-created HMOs at a county level, and the county board oversees the county-based purchasing plan. They are the sole choice for Medicaid in those rural counties, but we do allow for choice in our MinnesotaCare program. Since people are paying a premium on that program, we allow choice between the county-based purchasing plans and the licensed HMOs in those counties.

A couple things on Minnesota's public program participation requirements for HMOs. I mentioned earlier that health plans in Minnesota by state statute are required to be nonprofit entities. There are also a couple other things that they're required to do with regards to the Medicaid program. So any HMOs licensed in Minnesota have to participate in the state's Medicaid program both as a condition of being licensed, both in the commercial market and to operate in Medicaid, and as a condition of participating in the state's state employee pool -- any state, local, or school district insurance coverage, workers' compensation, or in Minnesota's high-risk pool. So you have to participate in Medicaid to get your license and to be able to be a part of the lives that are associated with these other government-based or quasi-government-based entities. And I just listed out the statutory references there just so you know how

it was constructed in the law. We have two different statutes which govern that: our Minnesota statutes 62D, which is really our licensure statute, and the language is very clear on that. It's as a condition of receiving and retaining a certificate of authority. And then 256B, which is the state's Medicaid statute, which basically says to participate in Medicaid -- or to participate in other things, you have to participate in the Medicaid program as well.

So, obviously, that has led to an environment where we do have robust participation among the health plans in our Medicaid programs. However, it's something that we are now -- as with health insurance exchanges coming up, Minnesota is going to be operating a state-based exchange. So we're obviously taking a look right now around how the interaction of our existing programs, our existing state laws with regard to HMO licensure, and the up-and-coming health insurance exchange kind of intersect. I think Deborah did a fantastic job of sort of laying out broadly what the policy issues are that we are, that every state, I think, is looking at. So I'm going to talk in closing about a few of the considerations that we have in our state moving forward.

One thing I should mention is it's likely that Minnesota will be a Medicaid expansion state. First of all, we have a long history of doing that. Financially, it makes sense to do that. We will probably, with 99 percent likelihood, do that in Minnesota, expand for single adults up to 138. We were an early expansion state. After the ACA was passed, we expanded for single adults up to 75 percent of poverty at current match rates. Minnesota is a 50-50 state currently. We obviously will probably take advantage of the opportunity to do that.

One of the overriding factors, as we think about things moving forward, is our goal of keeping families together in coverage. I think that is a critical thing, and I think, again, Deborah mentioned that in her remarks. That is a huge factor as we're thinking about things moving forward, and so we're sort of

looking at what our policy options are for that.

Now, I'm going to remind you that we've operated in Minnesota a program called MinnesotaCare which covers, with a premium, parents and kids up to 275 of poverty and single adults up to 250 of poverty. Well, those are income ranges that are going to be covered for most other states through the health insurance exchanges with premium subsidies. But when we've stepped back and looking at the analysis, we do have some concerns that, for folks especially on the lower-income range of that 20 percent or below, they're currently getting actually a pretty good deal through MinnesotaCare. It's very good, up-front coverage. It has very low co-pays, and it frankly is a very beloved program in our state.

Moving them into the exchange, for many when they examine this, really looks like a step backward for some of these individuals, and that's why I think we're as a state very interested in taking a look at the basic health plan option. We feel that we have a program that has served well. It meets many of the goals of the ACA, and it's covering a population now that would otherwise be covered under the ACA. And so for us, as we've examined this, it really makes sense to us to be able to maintain our MinnesotaCare program as it has been. Obviously folks above 275 moving into the exchange, but we'd like to overtime create a glide path for them to do that. Keep maintaining MinnesotaCare for our lower-income folks below 150, below 200 of poverty, and then structuring a program that would cover folks above that level.

We do think additionally that if we're able to maintain our MinnesotaCare program as opposed to moving some of those folks who are in that income range into the exchange, when we look at the data -- and we've had Jonathan Gruber at MIT take a look at this -- the folks who would otherwise move in the exchange who are currently in our MinnesotaCare population are actually sicker than the exchange population would be. And so by keeping them out of the exchange, we actually lower and stabilize premiums in the exchange, and our exchange folks are on board with this and believe that that is actually an

accurate thing. So we're really looking at that and talking with CMS about our opportunities there.

I also want to mention, though, moving off that point to a second point here around the interaction of our health insurance exchange rules and our current HMO licensure requirements, the insurance exchange law that's before our legislature now would allow the exchange board to select carriers, to limit participation. And there's an interaction with the requirement that we currently have requiring HMOs to participate in our public programs, because if that insurer is not selected to participate in the exchange but is required to participate in our Medicaid program, those two things conflict a little bit, and we'll need to sort through that issue. I just want to raise that because in the requirement we will have to kind of harmonize those two things as well.

And then the last thing I'll mention in my six seconds over time is that we obviously as a state are interested in moving beyond simply coverage. We think that's a critically important piece of this, but the last bullet point I just want to mention is that Minnesota is also actively pursuing Medicaid ACO arrangements with a number of our large participating providers in our state. Minnesota is a fairly integrated health system. And so anything that we build through the exchange I think we'll want to ensure that we build in some of these risk-sharing, gain-sharing arrangements that we're currently undertaking for about 100,000 of our enrollees through a state plan amendment that we're currently operating through the Medicaid program. I think we want to build that in as well moving forward.

So thank you very much.

COMMISSIONER ROSENBAUM: I'm sorry. One clarification question. The MinnesotaCare vendors, are they the same as the Medicaid MCO vendors, or are there also others?

MR. LEITZ: They are the same.

COMMISSIONER ROSENBAUM: Okay.

VICE CHAIR SUNDWALL: I have one question very quickly before you go on. Could you just say a little more about what leverage you have to get providers to participate? There's a law you passed, must participate in Medicaid if you're participating in other state employee programs? What does that mean?

MR. LEITZ: So if you are an HMO that wishes to operate in providing benefits to the state employee group or to local school districts or to counties, the requirement is that if you operate in those programs, you must also operate in the Medicaid program. So that it's a way I think -- to ensure that we had broad coverage in Medicaid, we tied it to their participation in other insurance programs that operate with government employees as well.

CHAIR ROWLAND: And, Scott, how long has that been a provision of the law?

MR. LEITZ: That provision has been since the mid-1990s. I'm not sure of the exact date, but it's a longstanding provision.

CHAIR ROWLAND: Okay. Thank you.

COMMISSIONER ROSENBAUM: Do your networks have to be the same?

MR. LEITZ: We do not have a requirement that the networks are the same, but I can tell you that our experience is that the networks are largely the same.

* MR. LOVELACE: Well, good morning. Let me join my colleagues on the panel in thanking you for the opportunity to speak to you. We're kind of on the speaking glide path, a 30,000-foot overview to the --

CHAIR ROWLAND: Could you pull the mic a little closer to you?

MR. LOVELACE: Is that better?

VICE CHAIR SUNDWALL: Is it on?

CHAIR ROWLAND: Can everyone hear? Okay. Wave your hand if you can't hear.

MR. LOVELACE: Of course, how would you know to do that if you can't hear, right?

[Laughter.]

MR. LOVELACE: As we're moving down from the grand overview to a state level, I'm really here to talk a bit about a plan perspective on how to approach the issue of integration and continuity of care and quality.

I'm going to talk a little bit about the environment in which we are working in Pennsylvania. UPMC is an offshoot, if you will, of the University of Pittsburgh Medical Center. It's an integrated delivery system composed of a series of hospitals, physicians, a whole bunch of ancillary services, nursing homes, senior communities. It's a very large system, about 55,000 employees, about $10 billion a year in revenues.

It's organized in -- southwestern Pennsylvania is our base. Our primary strength of operations is in the western half of Pennsylvania. We're in four divisions. There's a Hospital and Community Services Division, which is all facilities basically, as well as things like home health care, DME, pharmacy, services of that sort.

Physician Services is pretty clear.

Insurance Services, also pretty clear.

International and Commercial Services is kind of the entrepreneurial side, overseas ventures, business development opportunities and so forth.

I'm really going to talk about Insurance Services here, and there's a whole bunch of structural things at the bottom, just support services basically.

This is -- I'm not going to go through this -- just a picture of the range of products in the Insurance

Services Division. We cover a variety of services, commercial. We do Medicare Advantage. We have SNPs. We have I-SNPs, D-SNPs, and C-SNPs. We do Medicaid. I'm waiting for P-SNPs to come along. We have a Children's Health Insurance Program, and as Scott has alluded to, we have an individual product. We started off with a six-month not-renewable product. We're currently running a guaranteed renewable individual product which is medically underwritten. That will, of course, go away at the end of the year. And we do some ancillary stuff. We have a dental and a vision program. There's a whole bunch of other -- the things on the left are more employee assistance, worker support kind of programs -- and we operate a large behavioral health carveout company I think Chris alluded to.

We're a pretty large operation. We're about $4 billion on the insurance side. We're the largest Medicaid program in western Pennsylvania. But we're fairly new. Medicaid managed care in Pennsylvania only really dates in the mandatory sense from 1999, so we're about 18 years into this, and it has expanded. This March will be the last zone expansion. The northeast part of Pennsylvania will be moved into Medicaid managed care as a mandatory requirement. It has not been that yet, so the last two expansions have been this year, the last -- about 35, about half the counties that are left.

We do pretty well in the quality side. We are number eight in the country in Medicaid for quality, number one in PA, and we're four stars on Medicare, including the dual SNPs.

The climate in Pennsylvania is a little different, of course, from everywhere else or many other places. We will have -- by the end of March, everyone in acute Medicaid will be in managed care with a few exceptions, children in HIP programs, people in long-term care, population who are institutionalized. But all acute care will essentially manage both physical health and behavioral health.

Dual eligibles are not enrolled in Medicaid managed care on the acute side, but they are enrolled in Medicaid managed care on the behavioral side, and the reason for that basically is the Pennsylvania Medicaid

program has a very robust set of benefits for dual eligibles, particularly in behavioral health that do not exist in Medicare. In physical health, the Medicaid focus is really on cost sharing. It doesn't control very much.

So a few things. The state's decision about six years ago was to move dual eligibles out of Medicaid managed care and into fee-for-service when the pharmacy responsibility changed.

Pennsylvania's Medicaid program does include the disabled non-duals, so everyone's enrollment includes a share of ABD folks as well as moms and kids and families and individuals with disabilities.

We are in our case a little overselected, so about 30 percent of our enrollment is disabled people -- overselected in that we're a large health system, so people see this, I think, as an access to services.

Children's health is administered in the Insurance Department, so it's entirely separate bureaucratically from the Medicaid program, which is in the Welfare Department. We happen to do both because we're trying to build a continuum, but many insurers do not. Some do, some don't.

All the Blues run children's health insurance programs. They do not run Medicaid programs, although they invest in Medicaid programs.

Behavioral health is carved out for everybody, so it's not the population, it's the services. Everyone on Medicaid is assigned to a behavioral health managed care organization based on where they live. It's basically a county-directed system if the counties participate because of their own behavioral programs or a state-directed mental health system in the counties that are not large enough to manage this on their own. There's one 23-county state contract that we have actually, and then we have 13 other county contracts that are individual to counties.

The governor currently has said we're not doing a Medicaid expansion and we are not going to run an exchange. Those are continual debates. That may change over time, but that's the current position.

So that's where we start.

We did have a program in Pennsylvania called Adult Basic, which is similar to what Scott was describing as MinnesotaCare, subsidized for people who are above Medicaid. That ended in the beginning of this administration. It was a tobacco settlement-funded project that sort of ran out of money. The administration was not able to, or interested, I'm not sure which, in the way of moving it forward. So it's a big gap of coverage.

Our uninsured population is about 9 percent. We're lucky in that regard. We have a pretty low immigrant population which keeps our uninsured rate down, and we have a pretty high proportion of seniors, which makes the Medicaid proportion up. So we have about 12 million people, 13 million people in Pennsylvania, about 2 million -- about a million and a half are uninsured, I think is sort of the current estimate.

Just a little bit of our -- as we look at our population of people and who we enroll, the people we're expecting to see who we don't currently look a little bit like this. Just our estimate of who is not covered currently. The state has a behavioral health system that covers uninsured people but not a physical health equivalent other than FQHCs and charity care. So those places interact separately as you look at the system as a whole.

Very similar to Deb's slide, this is what the coverage of the system looks like for us, if we're not going to expand, we're not expanding Medicaid potentially. We are trying to build exchange products when the initial product goes away that are really tied to the key point of trying to be sure people have continuous coverage in the treatment sense more than in the insurance sense. So our goal in this process is to be able to be in a position where you can address mixed families, where it's often to a family's interest for their kids to be eligible for exchange coverage but they'd be better off in CHIP coverage. The cost sharing

is better, the subsidies are better, and it's less expensive for the family.

So we certainly envision trying to create a network and a care management system really that allows the scenario that Deb had laid out of a mom who's eligible for Medicaid because she's pregnant, dad is eligible for subsidies, and the kids are eligible for CHIP. They could choose to do other things, but part of the challenge and part of the navigator challenge really is trying to think about how will navigators be able to understand and explain this to people so they're making informed decisions. If they make an erroneous or maybe not the best financial decision, we certainly can intervene later when we see people, but before we see them, we cannot.

In Pennsylvania, in Medicaid and in CHIP, consumers are encouraged to pick a plan. If you do not pick a plan, you're assigned to a plan. You're assigned to a plan on a rotation in both cases. In the case of CHIP, you're assigned to one of the -- if you don't pick a plan, you're assigned to one of the two plans, and it's the lowest cost in the area. There might be seven or eight plans. This is a recent state change in the last six months or so. You're going to be assigned to one of the two low-cost plans.

We are almost always one of the two, so we pick up a disproportionate share of CHIP enrollment, and we facilitate enrollment back and forth from CHIP to exchange when that's necessary.

One of the things we've found in looking at the coordination business is we have sort of on the churn point. We lose about 7 percent of our membership a month in Medicaid through voluntary and involuntary disenrollment. Of the involuntary disenrollments, about a third of the people are back within a couple of months. As Medicaid eligible would suggest, probably they were never not eligible, that some paper got lost, something happened that interrupted their care. And what happens, of course, is they really come back with a little pent-up demand. They haven't used -- been able to afford service in between, so one of our initiatives this year is to reach out to people more proactively. We spend a lot of time visiting

the state to give us redetermination dates, which they don't generally. Now they do. So we can see when people are going to be redetermined, and we can reach out and try to help people, make sure they get their coverage. This is a nice -- actually, people like it mostly, and it's helpful to them, and it's helpful to us.

Our goal in this process is to find ways to be sure that we have people in integrated networks, so we have a couple tools we're building to make that happen. Besides of a variety of products, which Deb has talked about and we are building and have, our networks are pretty much the same everywhere. They differ in two ways, really. In one sense, we're not -- not all of our products are from the same geographic space exactly, so there's some geographical differences in networks. Medicaid goes further east than commercial coverage does, for example. CHIP sort of is in between where Medicaid is and where commercial is. So as we continue to grow, our intention is to make this continuous across all places where we operate, but we're not quite there yet.

And then in Medicaid, we have a carveout, so our carveout business is in not the same geographic footprint as the physical health Medicaid. There are some overlaps, but they're not 100 percent. So the carveout coverage on both sides will be different. People in the behavioral health program will have various physical health managed care organizations, and our members in the physical health side have various behavioral health organizations. That creates some challenges, and it creates some opportunities.

In terms of coordinating care, however, we've built a data warehouse that includes all the claims of all the lines of business so we can attach Person A to Person A from product to product. We can attach the behavioral health people to the physical health, their same avatar, if you will, on the physical health side. And we can track people over product changes, so if you move from Medicaid to commercial or Medicaid to Medicare, we can tie together records. So our goal in this process is to have essentially equal networks in equal spaces with whatever care management authorization review rules we have for people to start

following them around so you don't have to restart your care every time you chart -- every time you start a program.

We had hoped that the state -- although we even do this ourselves for our own members -- will have this -- finish the course of treatment rules. They certainly do in Medicaid. If you're in the middle of a course of treatment when you change plans, the plan you're coming from is responsible for you to finish what you're doing unless you choose not to. That's something we, again, along with ourselves we can -- it doesn't really matter to the member.

Our goal really in the end is to be able to be in a position, as I think sort of Deb had alluded, that the person, the consumer, the family sort of stands still and the subsidies move around behind you and your cards will change, the cost sharing changes because the plans change, but the clinical services don't have to change, and you don't have to go back and start again -- unless you choose to, which, of course, you can in moving forward. So the quality standards, the quality plans they implement, the P4Ps, the gain-sharing agreements in provider systems, all are sort of tied to all lines of business, so there aren't particular incentives for providers or for us to move people in places where it isn't the best for the person.

Chris asked me to just talk a little bit about limited benefit plans, as they're called, or carveouts or whatever you have to choose this stuff. Pennsylvania has been in a carveout behavioral system since '99, '97 I think in Philadelphia. There's upsides and downsides to this. The upsides are it's, I think, generally a much better system for treating the whole person when they have a serious psychiatric behavioral, substance abuse disability. It's less useful when you're treating people who have mild to moderate disabilities where the services mostly occur in the physical health side anyway. Most of behavioral health for mild to moderate people happens in primary care rather than in specialty care, on the Medicaid side particularly, because the Medicaid behavioral health system really focused on people with the highest needs

and has limited capacities.

We have cooperative data-sharing agreements among plans, both in terms of problem resolution when it's not clear who's responsible for something, you know, brain injury in a psychiatric condition, for example, who's paying for what; and also in terms of global data sharing around pharmacy management and clinical interventions -- all of which is to say, I think, you can operate successfully an integrated program in a carveout situation while you're building on the strengths of human service department interactions as well as the strengths on the clinical side.

Upsides and downsides. It works well in lots of ways. There are some things we'd like to improve as well as we continue to make headway with the state in terms of particularly clinical data information and integration, while respecting people's rights. Lots of people would just as soon their primary care doctor didn't know they had a psychiatric disability, even though the primary care doctor could probably figure it out if they put their mind to it.

I'm going to stop there and see if you have any comments or questions.

CHAIR ROWLAND: Great. Thank you all very much. I think this really is a very important discussion for us to have as we look at the themes of trying to provide more integrated care for the populations that are served by the Medicaid program and also how to fit the exchange with the Medicaid program in states that move forward and states that don't move forward. So let's take some Commission questions.

COMMISSIONER HOYT: Maybe a question for Scott first. I don't know if I heard you say, in the counties where you have county-based plans contracted solely for Medicaid now, what's the future there? Sort of two complementary questions. Will the county-based plans play on the exchange? Will the plans that are on the exchange have opportunity to serve Medicaid? How do you see that playing out?

MR. LEITZ: So with regards to the plans that currently operate as county-based plans, we do anticipate that in the Medicaid space there will be the ability of folks to continue to enroll in those plans. So we do see those continuing to operate into the future through the exchange as an enrollment option for them.

I do think that with regards to the second half of your question, which I think is kind of the reverse of that -- in those counties where they operate, do we see plans that are commercially based being able to operate in those counties? -- you know, that's going to be a policy decision that we'll need to make as a state. I think there was a strong legislative interest initially when we first started the county-based plans, which is approximately a dozen years ago, ten to a dozen years ago, to ensuring that they were viable. And so we made them via state law the only choice for Medicaid in those counties.

That law has since expired as of last year, and so I think we have -- we've done one procurement in counties that do county-based purchasing since the expiration of that. We chose administratively to allow them to continue to be the sole choice in the county for our Medicaid population. That will be a policy issue that the state legislature and the administration will have to look at moving forward with that So I don't think we have a definite answer to that yet.

COMMISSIONER MOORE: A clarification from Mr. Lovelace. You said that one-third of your eligibility -- your enrollees turned over every month. Did I understand that --

MR. LOVELACE: No. I said about 7 percent turn out every a month, a third of which come back.

COMMISSIONER MOORE: Okay, 7. I wondered if I misunderstood you. Can I get all of you to comment on that turnover phenomenon and whether most of those folks do, as John mentioned, really were probably eligible all along? And particularly, Deborah, because I know you've worked in a lot

of states on this, does that 7 percent seem to be --

MS. BACHRACH: Good.

COMMISSIONER MOORE: Good?

MS. BACHRACH: That's at the good end. Yeah, it's frequently much higher than that, and this is one area where we'd hope some of the ACA rules and passive or administrative renewal will be helpful, because actually 7 percent is quite good, and I suspect that's partly because of the outreach of the plan.

MR. LOVELACE: And it's partly because of a large percentage of people with disabilities who stay longer. The average tenure of someone in the TANF category is probably eight months. The average tenure of someone with disabilities is much closer to two years, and some people stay forever, of course, because they don't ever become eligible for Medicare.

COMMISSIONER MOORE: Scott, did you [off microphone]?

MR. LEITZ: I would agree with my fellow panelists on that. One other -- I'm sorry, Madam Chair. Just one thing real briefly on that point. I think because we're a higher-income state with regards to eligibility, where we've seen some of the churn has been as folks leave our Medicaid program and move into a premium-based program. And it's just a new world as they move into that of being a premium, and even though they're modest premiums, we still do see some churn that occurs.

COMMISSIONER COHEN: I have two questions. You'll stop me if I am being too greedy.

The first one I think is for Mr. Lovelace. What's the average -- and maybe you can break it out by subpopulation -- sort of tenure of enrollees in your different kinds of plans? And is it very different?

And then, to follow up, I'm going to ask you a very difficult question, so I want to prepare you.

MR. LOVELACE: You're softening me up first?

[Laughter.]

COMMISSIONER COHEN: Well, the question is, you know, I think we have talked at times here about one of the issues around churn is that it means that the tenure of individuals in plans tends to be short and what does that do to incentives for plans to invest in things like prevention and care management. So if you could first talk a little bit about the length of period that people stay on your plans in different categories, and then if you can -- and I know this is a hard question -- talk a little bit about those incentives and whether they're something that all impact your business.

MR. LOVELACE: Sure. So, in Medicaid, the TANF group is about eight months length of stay. It's mostly, of course, moms and kids. Disabled people is 23 months. But there's a sub-group of the disabled folks who are SSI only, who don't have Medicare, who stay for years and years and years.

We have very little voluntary disenrollment from Medicaid, a percent perhaps. Most of it is people who lose eligibility.

In Pennsylvania you can change plans every month, but after the first couple of months, people hardly ever change plans. There's usually no -- for most people, unless your doctor moves or something of that sort.

In Medicare, generally our Medicare Advantage plan, the renewal, we have about 3 percent voluntary disenrollment annually, so pretty good.

In the special needs plans, our largest special needs plan is a dual plan, and it's turnover rate is similar to that. There's very little voluntary disenrollment. We enrolled 13,000 people passively in 2006 of whom about 11,000 people are still with us. So very nice stick-to-itiveness -- although, to be honest, I suspect a lot of those people don't understand any of this. They don't understand the enrollment or the disenrollment or the -- as long as they go to the doctor and someone is paying the bills, they're probably happy.

Our commercial renewals are about 94 percent. We've only been doing individual products for a year. This is actually month number 10, so it's not really time to renew yet. We expect we'll have a pretty good renewal. Our rates are competitive. Our customer satisfaction scores are always good in all lines of business. We spend a lot of time on that. But that whole product will go away essentially in the fall, so don't expect that to stay too much.

Our CHIP enrollment is -- about 80 percent of the people renew successfully for at least one more year, so the tenure probably is two to three years for CHIP kids. It's an annual renewal for CHIP and for Medicaid. It's annual for kids and six months for people with disability.

On the incentive side, it is a harder question, but our approach to this really is we're a health system-based plan. Whether people are enrolled in a particular product or not, we all live in the same place, and nobody is really going anywhere. So it's an investment in the long-term health of the community. If people aren't in a Medicaid program, the whole goal is they'll be in some other program we operate, or they'll be in our hospitals or they'll be in our doctors. So it's actually to our and the community's interest to invest in things that improve the long-term health and well-being.

It's very hard to invest in much with TANF kids because they're not around long enough. Immunizations, dental care, healthy babies, but it's hard to really get your hands around much when people themselves are not identified to you for very long.

In behavioral health, the tenure is much longer because it's really just based on Medicaid eligibility and you're not moving quite as much.

So the investment really is sort of, from our view, kind of a global investment in the well-being of the community because we're going to pick it up someplace. If we don't pick it up in Medicaid, we'll get it in commercial; if we don't pick it up in commercial, we're going to have bad debt in the hospital.

COMMISSIONER COHEN: So in some ways -- if I can just -- it seems the fact that you participate in so many markets and potentially and sort of so many phases, you know, in so many markets, it may change your approach to how you feel about -- I mean, again, I am putting words in your mouth, but, you know, it does sort of -- the possibility that someone is coming back to you either in a churn situation or in another market is relatively high because you're such a large player in that community.

MR. LOVELACE: Yes, exactly. So you're perfectly welcome to put those words in my mouth, though. It's what I want to put them myself.

COMMISSIONER COHEN: Actually, I did have another, but I do feel greedy now, so I'm going to wait.

COMMISSIONER ROSENBAUM: I consider this issue, and like Deborah have since the beginning, to be the pivotal issue because my great fear is that if we don't deal with it, all of the younger, healthier lower-income families whom we really need to come into the new markets in big numbers will be very discouraged by sort of constant movement, and it will be easier for them to simply drop out until somebody needs health care, which is exactly what we don't want. So I have a couple of questions.

I should also note that I have, like Deborah, given a lot of thought to the enrollment-related issues, and given the past half-century's experience with churn, I would say that even if certain reforms can be introduced, I think that churn is just a problem. And so I've tended, like Deborah and Scott, to focus on this issue of multi-market participation so that we can get to the point where the subsidy becomes a back-end matter, and the only thing that the family sees is your plan's name and your provider's name and some reporting rules, but other than that nothing changes.

I am interested, Scott, in your experience around the basic health program. It is my understanding at this point that we still do not have guidelines for states on the basic health program. It's also my

understanding that there are a number of states that are actually in your situation and are quite interested in the basic health program.

Do you have any sense from your discussions with CMS when guidelines might be expected?

MR. LEITZ: No.

[Laughter.]

MR. LEITZ: We haven't received any real indication of that yet.

COMMISSIONER ROSENBAUM: On this question that you raised, Deborah, regarding multi-market plans, we know about the bridge plan. That's already been in CMS Q&A. I actually am hopeful that that would provide some relief, but I think that it's sort of a slice of the bigger question of getting plans that participate in the Medicaid market today to participate in the QHP market. I think that's probably more realistic, at least in the short run, than trying to get commercial insurers to come into the Medicaid market.

And I wonder if you have any thoughts about the flexibility that states have under the law to certify MCOs as QHPs specifically for subsidy populations. So, in other words, we're going to designate you as a licensed plan for purposes of open enrollment or any kind of enrollment to anybody who is receiving a premium or cost-sharing subsidy and has a risk of fluctuating income. Is there anything to stop that kind of designation?

MS. BACHRACH: Well, I think that we're really looking at the bridge plan in that case because you're taking a Medicaid plan, they have to meet the QHP requirements, right?

COMMISSIONER ROSENBAUM: Right.

MS. BACHRACH: But what's contemplated is they will only be open to individuals coming off of Medicaid or to families with a member in Medicaid.

COMMISSIONER ROSENBAUM: But what if you -- I guess my question --

MS. BACHRACH: But it doesn't work, the reverse. This is the limitation.

COMMISSIONER ROSENBAUM: Yeah.

MS. BACHRACH: If an individual is coming off of a QHP --

COMMISSIONER ROSENBAUM: Right.

MS. BACHRACH: -- and they don't have anyone in their family in Medicaid, they aren't eligible to go into that plan. So it works up. It doesn't work down. It works for mixed families. It also -- I mean, one of the attractive features of the bridge plan, which Scott alluded to, is the affordability question.

COMMISSIONER ROSENBAUM: Yeah, of course.

MS. BACHRACH: Because the sense is with a bridge plan you can reduce the premium obligation and the co-pays. The bridge plan, like the basic health plan, has that same opportunity.

COMMISSIONER ROSENBAUM: But the bridge plan, as I understand it -- and then I will stop -- does not allow navigation and counselors to sit down with families, let's say you have a family, dad's a carpenter, mom is an artist, and they have a couple of kids, so they're all self-employed, they're all on the exchange. But when they come in and sit down, the combined family income is, you know, roughly twice the federal poverty level, but mom's work is seasonal, dad's work is seasonal, and the bridge plan doesn't allow the counselor to say, look, here's a list of plans that you might want to take a look at because they -- even if you go through a period of lower income, you can stay with these guys no matter what. In other words, the bridge plan is fine if you're in the moment, but if you're not in the moment, then the bridge plan notion -- now, there are going to be a lot of people in the moment, as we know from the statistics. But in terms of connecting people mentally with a venue of plans that are, you know, set up just to function well for you if your wages are lower and you tend to, you know, fluctuate some, it's really not a--

MS. BACHRACH: But I think, Sara, we're talking about -- in some sense, it's two related issues.

COMMISSIONER ROSENBAUM: Yes, it is.

MS. BACHRACH: One is affordability, and affordability, the basic health program has some desirable features.

COMMISSIONER ROSENBAUM: Absolutely.

MS. BACHRACH: The bridge plan has some desirable features, and there's now what Massachusetts is proposing, which is a cost-sharing wrap for individuals up to 300 percent. Now, Massachusetts is a little bit different. New York, though, is looking at the same.

COMMISSIONER ROSENBAUM: Right.

MS. BACHRACH: So those are three approaches to the affordability issue and the continuity issue. Then we have all the things we've been talking about which focus more on the continuity issue but don't get at the affordability issue.

COMMISSIONER ROSENBAUM: That's right. And none of this is going to matter if the plans cannot convince their networks to --

MS. BACHRACH: That's right. So they're related, but they're also separate. And the one other piece that I've always thought, if you're a Medicaid managed care state, is to allow individuals who come in through the exchange to choose their Medicaid plan through the exchange shopping functionality, whether or not that plan is a certified QHP.

COMMISSIONER ROSENBAUM: Right.

COMMISSIONER HENNING: My question is for John. I know that Minnesota is a pretty midwifery-friendly state and ARNP-friendly state. Pennsylvania doesn't have quite that reputation, but I'm just curious how you incentivize providers to become part of your network. You've talked about

incentivizing plans to become part of the network, but you need to providers to provide the service. So how do you talk doctors and DOs and nurse practitioners and nurse midwives to become part of your network?

MR. LOVELACE: There are really two global strategies. One is multi-product contracts, so in order -- our preference would be to say to you, if you -- we will contract with you for Medicare and commercial business if you will do Medicaid as well, because Medicaid generally pays less. So all of our contracting, we try to do multi-product.

We have gain-sharing arrangements across all lines of business if you're moving forward a little more rapidly, so there are more opportunities for providers to profit financially while they're improving quality. They're all based on quality metrics to start with, so you have to maintain or improve your quality while you're saving money. You can't save money by not taking care of people. Those are two big incentives.

About half of our business is with ourselves. It is not quite -- it's a different challenge to contract with yourself than to contract outside. I don't know if it's easier or harder, but it's different. And we're in a culture in western Pennsylvania which is quite open to Medicaid. There are not the same differentials there are in other places about "I only do this." There are some people who only do commercial business, but it's not the ethic generally. All products is -- we do commercial coverage with FQHCs. We do Medicaid coverage with cancer specialists. So we try to be broad across both dimensions, and doing a lot of business with ourselves creates an environment in which other people are expected to do the same thing as well.

COMMISSIONER HENNING: And one other follow-up question. Do you pay a nurse midwife differently to deliver a baby than you would an obstetrician?

MR. LOVELACE: We pay nurse practitioners generally, including nurse midwives, I think -- I

think the -- the theory is the pay scale is 80 percent of what a physician would be. The reality is in many cases the nurse practitioners or nurse midwives are tied to an OB practice or a physician practice. We pay at the tax ID level, so we can't really differentiate who the provider is. In reality, we actually pay more than we contractually think we're paying. It depends on how it's set up. If it's a nurse-only practice, then it would be 80 percent.

COMMISSIONER HENNING: And don't you -- do you -- at least I feel that that kind of payment policy restricts the amount of people that you have that are willing to take Medicaid and are able to run a business, and actually restricts access to care in some ways.

MR. LOVELACE: There is, I think -- there's only one -- we only have, I think, one nurse midwife practice that exists. It's not we don't contract with some. There is only one in the area where we serve.

COMMISSIONER HENNING: But there may be a reason for that.

MR. LOVELACE: Well, there could be, and that practice actually, because it's set up as a midwife practice, is paid the same as physicians are paid. But they have to deliver -- including with the delivery.

COMMISSIONER CHECKETT: A quick question. A really interesting discussion, and a question I think probably for Deborah. I'm really interested in the bridge plans and how they might be part of the solution I think we're all looking for. When you look, Deborah, at Medicaid MCOs, what do you think might limit them? And probably this is going to apply mainly to Medicaid MCOs that are just doing Medicaid. What limitations do you think might be in place that would keep them from being able to serve as a bridge plan? They do have to be QHP certified, and so -- and I don't know how much you've dug into that. I'm just curious as to what --

MS. BACHRACH: Well, let me to some of -- yeah. Well, first is the licensure. Some of the Medicaid-only plans don't have the same kind of license you need to go into the commercial market. I

mean, I can tell you in New York we have something called a prepaid health plan license where you have to serve predominantly beneficiaries of public programs. Is a tax credit a public program? That's an open question. So if it's not, then they will need a commercial license.

And then, second, the business model is very different. You know, contracting with a state for a product versus individual contracts is a different business model.

A third issue is will the exchange require QHPs to be both in the individual and the small-group market. We have to go into the SHOP exchange. Again, that's a bigger lift.

COMMISSIONER CHECKETT: A really good point.

MS. BACHRACH: And that's optional, so that would be an exchange decision. So risk adjustment can be an issue.

So there are other -- and then there is, of course, accreditation where there is somewhat more flexibility as well. So all of those become issues as you're pure play Medicaid plans, whether they're privately owned or owned by providers, move into the space in the exchange. I know California is concerned about this with some of their county plans because they are such a big support for their safety net, and they'd like to see them in the exchange and how do we facilitate that. And it does make it easier with a bridge plan because it is at least the less expensive -- you know, low-end, low-income individuals. So it has certain continuity. But they still have to meet the QHP requirements.

COMMISSIONER CHECKETT: Right. And just one more comment on that. That's very helpful, and it's something I'd really like for us to continue to dig into, because my understanding is that if a state is going to do a federally facilitated exchange, then CMS -- I don't know if they're requiring or encouraging, but that you offer -- that if a plan is going to be in the individual market, they have to be in the SHOP market, too. And so that could really be very challenging here. I'm not confident if that's a

requirement or an encouragement.

And then I think, too, maybe some -- I think probably just the technical capabilities around billing and collecting premiums and co-payments and that whole world. But it's an area, I think, of great interest or something the Commission to really get into and continue to look at. So thank you.

COMMISSIONER SMITH: I really didn't have a question. I have a comment. One of my pet peeves is passive enrollment. I'm not a fan. And Mr. Lovelace brought up a point, and he said about half the people passively enroll, don't understand what's going on, but are happy to just have the bills paid. And I disagree with the second part. I don't think they're necessarily happy where they are or that they have to change providers possibly or that they can't get into the cardiologist that their child had seen before. I think that they don't know what else to do. They feel like they're stuck, that they're being told. And so the fact that they don't understand it is actually limiting them to their choices, and I just -- that is my biggest objection to passive enrollment.

MR. LOVELACE: If I could just respond quickly. In the case -- and half is just my guess. I have no idea who does or doesn't like this.

COMMISSIONER SMITH: That was a general comment [off microphone].

MR. LOVELACE: This particular passive enrollment was from our Medicaid plan to our Medicare plan, so it doesn't change the network things at all, and so the point how we're trying to build this. But I do take your larger point.

COMMISSIONER CHAMBERS: Actually, in the interest of time, I'll not ask a couple questions because both Sara and Donna hit upon my comments.

Running a California plan, Deborah, as you just said, about the development of a bridge plan in California, the concern is that the lack of direction from CMS on both the basic health plan option and the

bridge plan is I hope that we take a longer-term view because, as you pointed out, as a number of Medicaid-focused plans, we're a publicly traded company, but even have challenges in multiple states when you're Medicaid focused on a commercial business is how you get provider networks, because as -- I am only responsible for California, but as we've gone out and talked to our Medicaid delivery system is they say this is a commercial product, we don't want Medicaid rates, and we started with a structure in which, as we were building from Medicaid rates, going Medicaid plus something, with approaching providers, is for the affordability issue is because my fear is we're going to have 2014, even if we have Medicaid-focused plans in, is if it's not cost-effective options, you're going to have a lot of beneficiaries, as Sara pointed out, where healthy families or healthy individuals are going to say, you know, the co-pay and the challenge and the affordability is such that we will build it but they will not come.

But also, as I think just pushing the issue is the longer-term view because Medicaid-focused plans have a lot of challenges for January 2014, as with Medicaid expansion. Many of these plans, it's a heavy lift just to expand Medicaid. And then in states, multiple states, they are doing dual-eligible demonstrations. That's a heavy lift. California bringing up transition of moving long-term services and supports into managed care. So plans are a challenge, and I just hope particularly with states is take a longer-term view that January 2014 is not the only solution, is do we continue to look at, if 2014 does not turn out to be the robust alternatives for low-income populations that we'd like to see is that states continue to pursue these options longer term, because we can't say 2014 -- and I hope in contracting strategies states don't cut out the opportunity for entrants.

California said because of those challenges for Medicaid-focused plans, they're providing specific opportunities for those plans to enter in 2015 if they cannot take up the option for 2014.

MS. BACHRACH: Just very quick, I so agree with you and that what we should not lose sight of

is the vision. We acknowledge that '14 is a stepping stone. It isn't the end of the journey. But we can't lose sight of the vision.

COMMISSIONER HOYT: Thanks. A quick question for John maybe. I like your point about covering families under one plan. If memory serves me, your position, at least as a plan, is somewhat unique in that I think -- maybe they've changed this -- DOI administered CHIP, DPW administers health choices. So you had totally different contracting provisions, procurements for CHIP, different plans involved than the Medicaid program. Any consideration by the commonwealth to putting that together so that you would have families in one plan?

MR. LOVELACE: There is I think no official movement in that direction. There has been some discussion about it, but there has been no decision about moving the CHIP program into the Medicaid program.

COMMISSIONER COHEN: Thanks for giving me another chance, actually on the same topic. You know, we have all of these competing sort of values with respect to a whole bunch of programs that cover people in increments of income and eligibility. And, you know, we want continuity for the individual and the provider. We want continuity and, you know, approvals for certain kinds of treatment. We want program integrity. We want a sliding scale so that a subsidy is sort of related to an individual's income or ability to pay some out-of-pocket. And then we want -- you know, among other values that have been talked about today, we want to keep families together. And sometimes these values compete.

And I have to say that keeping families together is the one that I have sort of least understood. I understand -- and thank you so much for actually doing -- you dedicated several points on a slide to it, and that helped me, but I wanted to just dig into it a little bit more. And you said it was such a huge value in Minnesota.

I do understand that there is the possibility, although I always -- I never see a number next to this, that there is the possibility that a single provider could see a family. I mean, obviously a family practitioner could see a family and maybe group the appointments, and that would be very convenient for the family. Also, in the behavioral health context, for example, I could see many cases where you need to treat the family as a unit, and if people are in different plans, that makes it much more complicated to come up with a payment model for something like that.

But besides those things -- and I've never seen numbers attached to those things for how often they really happen -- I don't understand why it is so compelling to keep families together -- again, not something that you wouldn't prefer in a vacuum, but why it would be as high a value as some of those other ones, and yet people say it all the time. So I believe I am missing something.

So I just wanted to hear a little bit more from your perspective about what is the advantage either to the family, to the plan, to the program, to the provider, of having a whole family in the same plan, when I think in general they are seeing different providers most of the time -- although, again, if you tell me that most families are seen by a single family practitioner, maybe that would be exactly the evidence that I need to make me rethink this.

MR. LOVELACE: Well, I can't tell you that. I'm sorry. I think most people are not seeing the family practitioner at the same time. Some people certainly are.

I think the advantage really is from the family's perspective. In our experience, most medical interactions are one person with one provider. They're not family interviews. Even if people schedule together, you bring the three kids to the doctor, the three kids might have different coverage. It's really to make really in two places, I think, the value. One is to make it easier at the provider. If you can process all the claims in one place without sending them back and forth from plan to plan, the secondary payments,

the primary, who's in charge, who's not in charge, you can -- from the administration side, it's easier to manage it from the payer side when you can see the whole picture and see all the parts fit together rather than leaving that all to the provider.

From the family side, it makes -- it sort of helps with things like knowing and understanding who -- where do you call so you don't have to call six different places for help, but also how to manage things like your deductibles and where the out-of-pocket expense limits come, because they come from various places. You can't make it go away because Medicaid has different out-of-pocket limits than CHIP does. But you can certainly make it simpler.

It is really, I think, a comprehension thing more than it is a clinical value.

COMMISSIONER CHAMBERS: I just want to make a quick comment. Maybe Sara could confirm this, but my recollection is when state CHIP programs back in the early 2000s were expanding parent coverage, there actually were some evaluations that showed that when the entire family is insured, the take-up rate and the actual adherence -- maybe that was -- but there have been some historical studies that have shown that there is better, you know, use of services when the family unit is covered as opposed to in different systems. So it might be worth just looking at those studies, that there may be something that --

CHAIR ROWLAND: Andy's point was whether they're covered in the same plan or in different plans, so those studies showed coverage mattered. But I think that the simplification for the family of having one place to go, because we know that the early issues of when one child was on Medicaid and one child was on CHIP and they had different providers were very complex for the families and didn't always get the same level of care for the children, because we used to have that age drop.

COMMISSIONER ROSENBAUM: I think the complexity of using insurance today is such that to have to sort of master two or three different coverage policies is something that -- I mean, it may be -- it's

certainly better than not having the coverage, but --

COMMISSIONER COHEN: But who does, right? I mean, in general, you address the problem when it faces you, and each problem for each member of the family might be somewhat different.

COMMISSIONER ROSENBAUM: That's true. But, for example, policies today are written with a family deductible, a family -- you know, other rules that relate to the coverage of the family. I think it's the financial transaction end of the deal. It's not the network so much. And, you know, watching in Massachusetts the difficulties that previously uninsured people have had learning how health insurance changes their relationship to the health care system generally, I think anything that can be done to make the relationship between the individual and health insurance easier is probably better.

CHAIR ROWLAND: And I think that certainly is the theme that we as a Commission have had, of how do we make things more streamlined, less burdensome for states, less burdensome for providers, and certainly less burdensome for the beneficiaries. And I think this panel has given us a great deal of information to think about both in terms of how to integrate the coverage between the exchange and Medicaid, but especially in the broader world of how do we make coverage more seamless for the populations being served. And, you know, I appreciate the good work going on in Minnesota and especially in Pennsylvania, and thank you for coming and sharing your direct experiences with us today, and Deborah for always giving us the wide perspective as well as keeping New York in focus for us as well.

So I thank you for being here. I know we'll be following up with you because I think your comments today have really given us a lot of information that we need to digest as the questions here showed, and really appreciate being here with you. And, Chris, you're not off the hook yet because we're going to move on to our second panel.

But thank you all again, and thank you for extending your stay since we had so many questions.

And we're going to move on to resume our discussion of the eligibility issues in Medicaid and CHIP and the interactions with the ACA. I want the Commission members to really be focused here because this is a chapter draft for our March report and one in which we are going to look at whether there are recommendations we want to put on the table.

So with that, Chris, very briefly, give us the introduction here so that we can get on to the Commission members' comments.

REVIEW OF DRAFT MARCH REPORT CHAPTER ON

ELIGIBILITY ISSUES IN MEDICAID AND CHIP:

INTERACTIONS WITH THE ACA

* MR. PETERSON: Okay. So in this session, I want to provide an overview of the draft chapter that you have received as part of your materials focusing on ACA eligibility for Medicaid and CHIP. Then we'll review once again the two eligibility-related issues that we've talked about before, churning and TMA, churning, of course, coming up also in the previous session, and the potential recommendations for your continued consideration.

Our two primary goals here are to obtain your feedback on the draft chapter that you have and then to consider which recommendations that we present here today you want to bring back in February for voting.

I will quickly go through the overview of the chapter, but in keeping with the comments made in the previous sessions, some of the key points that you wanted had to do with that.

The Medicaid expansion is one component of the ACA approach to expand coverage. We also mentioned how projected Medicaid enrollment growth will come not only from the new adult group, but also from individuals who are already eligible, and that has different implications on the Federal

Government and States. That there are ACA requirements affecting eligibility that are going to apply regardless of whether States do the expansion, and we mentioned the maintenance of effort, modified adjusted gross income, and the expansion of Medicaid to six- to 18-year-olds to 138 percent of poverty for children who are currently in separate CHIP programs in that income and age range.

So the issues which we'll talk about momentarily, then, are churning with potential recommendations and TMA with potential recommendations.

So the issue number one of churning, and thanks again to Lindsay Hebert for doing the research on the churning literature. In 2014, millions of individuals may move between Medicaid and CHIP and exchange coverage as their eligibility changes over the course of the year. So with respect to churning, we describe the estimates from the literature, how churning will occur in 2014, the effects, and then some State approaches to reduce churning and its effects, many of which were talked about in the previous session -- actually, all of which were -- contract requirements to bridge plan, basic health program, and 12-month continuous eligibility.

One note. The challenge with almost any change affecting eligibility and enrollment policies is how to best ensure that you are enrolling individuals who are entitled to and need benefits while not enrolling those who are ineligible. Where 12-month continuous eligibility exists, it is arguably even more important to ensure that the initial determination and annual redetermination is accurate. We know eligibility determinations are not always accurate. According to the latest PERM analysis, 3.3 percent of Medicaid payments may have been in error because of eligibility issues.

However, it is worth noting that many of these errors were cases categorized as undetermined. So these are cases where the reviewer was simply unable to collect sufficient information to make a determination of error. In addition, we don't know, of this number, the extent to which the findings are

driven by the aged and disabled versus the MAGI-based population for whom a recommendation on continuous eligibility would apply.

And one final note on this. The error rates include individuals who should have been determined ineligible, but based on policies that will not be in place in 2014. For example, asset tests will no longer apply for MAGI-based populations in 2014, even though in 2012, when these numbers were derived, those policies could have had an impact on these error rates.

So to improve the accuracy of determinations, new regulations are calling for more reliable methods and more real-time numbers to verify the reported information with increasing reliance on electronic data source and shifting certain verification responsibilities off of States to the Federal Government.

So with that additional context, let's turn to the proposed recommendations you wanted us to bring back to you. One-A on churning -- so these are all really about continuous eligibility for 12 months -- 1A is provide States with a statutory option to provide 12-month continuous eligibility to individuals enrolled in CHIP.

One-B provides States with a statutory option to provide 12-month continuous eligibility to adults enrolled in Medicaid.

I want to note that we have gotten preliminary cost estimates from CBO and both 1A and 1B are essentially in the smallest non-zero category for projected spending. Again, this is simply continuing options that States currently have that potentially as an unintended consequence go away because of MAGI. And any State costs associated with this, of course, would be at their option.

Recommendation 1C is to institute 12-month continuous eligibility for populations eligible for Medicaid or CHIP based on MAGI. This would recommend that Congress require States to do 12-month continuous eligibility for all MAGI-based populations. If 1C were the recommendation, then there would

be no need, of course, for 1A and 1B, which are all about continuing this as options.

With respect to the CBO score for 1C, the preliminary score, this would cost the Federal Government approximately $2 billion per year and $10 billion over five years. This requirement would cost States roughly $4 to $5 billion over a five-year period.

The remainder of this slide says that if there is no recommendation, current law after December 31, 2013, may require waivers to continue continuous eligibility for adults in Medicaid and for CHIP enrollees.

COMMISSIONER ROSENBAUM: [Off microphone.] I'm sorry. Just a clarifying question. So just to be absolutely sure, the 1B would be a State option.

MR. PETERSON: Correct.

COMMISSIONER ROSENBAUM: One-C would be a Federal minimum enrollment standard of 12 months.

MR. PETERSON: Correct.

COMMISSIONER ROSENBAUM: Okay.

MR. PETERSON: One-A is about the option to continue 12-month continuous eligibility for CHIP. One-B is for adults in Medicaid. And then 1C is essentially the mandatory for all MAGI-based populations.

CHAIR ROWLAND: Chris, could you provide us, how many States currently use the continuous eligibility option that they have? Not all States employ it, I know, but how many do?

MR. PETERSON: Thirty-three States currently use it in their separate CHIP programs, and 23 use it for children in Medicaid.

CHAIR ROWLAND: In Medicaid.

MR. PETERSON: And then there are just a couple States that are doing it for adults at this point.

VICE CHAIR SUNDWALL: And is there a spectrum from the one month to 12 months? I mean, are there other States that are somewhere in between on continuous eligibility?

MR. PETERSON: No, that's not the way we usually think of it. It's usually just 12 months. You may be thinking also of the eligibility window. So there are cases where certain populations have to reapply after six months for their redetermination versus 12 months, but that's a different --

VICE CHAIR SUNDWALL: Well, we just heard from Pennsylvania about the option to change every month.

MR. PETERSON: I think that had to do with changing plans --

CHAIR ROWLAND: That's change plans as oppose to change eligibility.

VICE CHAIR SUNDWALL: Okay.

CHAIR ROWLAND: Andy.

COMMISSIONER COHEN: Can you just review the under -- the MAGI -- MAGI, I noticed that you're saying "Maggie" now -- MAGI eligibility? An individual, you look at their tax return from the year before, right, and then, depending on -- you look at their annual income to determine their eligibility under MAGI, but then if their income fluctuates during that year but the total ends up at the same amount, is that person not eligible in the months -- not eligible for Medicaid under MAGI in the months that their income was higher, or if they average out over the year, are they eligible for the whole year?

MR. PETERSON: So, first of all, "Maj-eye" is a fine term and some people spell it out also, —M-A-G-I.

Now, to your question, the Medicaid rules differ slightly from the exchange rules on this point because the Medicaid rules say you have to use current income when folks come in and apply. Nevertheless, notwithstanding -- and so what that also means is that projected income can be taken into

account. So at the same time you're doing current income, you can still say, but do you know something is coming and take that into account.

What continuous eligibility, though, over a 12-month period says is we don't care what changes. If you're in, then we're going to leave you in for this 12 months.

CHAIR ROWLAND: But the decision that we're looking at today with regard to these recommendations is whether to continue to give States the option to use continuous eligibility if they so choose, which requires a change in the statute, or whether to say this is such an important concept that we would require all States to do it, which is a very different option than what exists in current law, or to say, we're not going to comment on this. We're raising it as an issue and a problem, but if the States want to try and use continuous eligibility for these groups, they're going to have to come in on waivers. And the last one I would say is one that we've been trying to look at how to streamline the program and how to get the flexibility out there to do things that are not going to require an onerous waiver process.

So I think we should weigh those issues as we try to decide what the nature of our recommendations would be here, or whether we want to raise these issues without any recommendations, which is always another option.

So with that, let me find Andy first.

COMMISSIONER COHEN: And, actually, this is really just a factual question, also to help us with the discussion. When you -- when a State -- under current law, when a State wants to do continuous eligibility under a waiver, does that mean that they have to show -- I mean, in other words, is that subject to budget neutrality? Is the cost of that 12-month continuous eligibility something that the State has to show that they will provide cost savings to finance that --

MR. PETERSON: Yes, it would still be subject to the regular budget neutrality requirements --

COMMISSIONER COHEN: Okay. So, basically, so a State option means where the Federal Government is willing to pay. We're basically recommending the Federal Government be willing to take up that cost. If we leave it to a waiver situation, not only is it onerous, but the State basically has to, through other mechanisms, finance that entirely itself.

MR. PETERSON: Umm --

COMMISSIONER COHEN: In a projection.

MR. PETERSON: Yes. Thank you.

COMMISSIONER COHEN: Okay. Thank you.

COMMISSIONER CARTE: Chris, I think in the chapter, it alluded to the -- there's a certain amount of administrative costs that the States bear as children and families, you know, lose eligibility and come back in. Are there any estimates out there that any States have looked at that, or do we know relatively that it's a certain cost but it's not as great as the costs of 12-month continuous eligibility?

MR. PETERSON: Yeah. I think we tried to incorporate some of that in the chapter. We can try to pull out some more of the details so that's clearer. For example, I think California was an example cited, where they had found some savings from administrative -- on the administrative side as well as with respect to continuity of care, because what will happen is if individuals churn off and they churn on later and they come in via the emergency room because of care they did not get, then this could add costs that with the presence of continuous eligibility may have been prevented.

COMMISSIONER CARTE: And I'd just like to say that even if we're not able to identify those costs that well, I think that States do look -- are looking at, as they implement MAGI, how can they reduce the amount of workload they have on their local workers.

MR. PETERSON: And, Diane, I don't know if you want me to go ahead to the TMA, the rest of

the presentation --

CHAIR ROWLAND: [Off microphone.] No, I'd like to just go through and --

COMMISSIONER ROSENBAUM: Just a couple of points. From the prior panel, I assume that two of the major observations we'll want to make in this section, no matter what our final vote might be, are that the average length of plan enrollment, which I understand is not exactly the same thing as program enrollment, but more and more, they tend to run together -- the average length is about eight months now. So we are not suggesting -- for a good part of the population, there is some continuity, meaning that we're not taking people from, you know, a 100 percent chance of churn over a year to no churn. It's a subtle issue. It's a risk issue, really, with health and cost consequences.

The other is that the vast majority, as the previous panel noted -- and, of course, it's something that's been in the literature for a long time -- the vast majority of disenrollment is involuntary. It's not as if low-income people spend their lives trying to pick plans or moving from plan to plan. They may have some initial period when they're trying to figure out if they're in a plan with a provider they like, but then they settle down and the reason they leave a plan is because they are disenrolled from that plan involuntarily because of a change in eligibility.

The other thing that I think is worth noting is that while the 1115 option is certainly an option in this context, I think we're going to have this often. It's always an option to note that a State might want to deviate from whatever the standard is, at least for certain parts of the statute, the 1115, and so when we talk about our recommendations, you know, one question to me is how we treat 1115. Do we make recommendations to do the obvious, which is go seek permission if you don't like the results? How do we want to treat the 1115?

CHAIR ROWLAND: Mark.

COMMISSIONER HOYT: I guess, for me, given that we have health care reform here to stay, now we have a mandate in place, and in the interest of streamlining and simplifying that, I'd recommend going with 1C. I mean, the dollars are significant, but as a percentage of the Medicaid cost, it's awfully small and there's also some advantages to what I think is going to be a larger number of plans playing in multiple States. It just makes it easier for them to have a standard policy on what enrollment is going to look like. And you'd also have more continuity or standardization between CHIP and Medicaid, as well.

CHAIR ROWLAND: Andy.

COMMISSIONER COHEN: I think, in terms of the chapter -- which is great, by the way -- and with respect to this question, I do think that we should be -- again, there's competing values here, right. I mean, you have the value of continuity and seamlessness and administrative burden. One thing I did notice, we don't always distinguish between churning like a one-time change and what I think of really as churning, is when people go back and back and back and back because they have cyclical incomes or predictable changes or unpredictable, but they're just in short periods of time changing their status over and over again, which I think is quite different than one-time changes that are going to occur in 2014, also can be very confusing and difficult but reflects a new policy. When you sort of see this repeat changes in a cycle, it's really particularly frustrating.

So you have sort of the value of wanting to eliminate that, but on the other side, and I think we could do a better job of acknowledging the other side, the other value, is the concern that -- and just to put it right out there -- people can go to get their eligibility determined. There's the risk that someone can have their eligibility determined in their poorest month or lowest-income month and then be eligible for Medicaid during a longer period when their incomes are higher. So there's program integrity is the other value, right? I mean, that's just -- all of this is a balancing of these values and I think we do have to acknowledge

maybe a little bit more fully that other concern.

I guess what I wanted to throw out is the possibility of a recommendation with a modification, and I'm a little bit brainstorming here, so we may decide this is a terrible idea. But why couldn't we, sort of using this idea of sort of seamlessness in the coverage in the program and not bouncing someone to a different provider, but recognizing that in a 12-month period, a person's income might change, could we do some sort of recommendation that suggests consideration of if somebody's income is higher over that year, in the same way that you have to do a reconciliation for subsidies in MAGI, might we say someone can stay in Medicaid for that 12-month period, but some consideration might be given to some premium sharing, you know, some cost sharing on premium during those periods where the person's income is over Medicaid, and might that be a way to sort of acknowledge the concern about program integrity but not yank someone back and forth into one program or another, back and forth and back and forth, in a way that I think we can all acknowledge makes no sense?

So I sort of throw that out there for consideration. I think we can't design that, necessarily, but might we offer some guidelines for Congress to consider that someone could stay in Medicaid for 12 months, but if there was an income rise at the end of the year, you could, you know, impose some sort of a cost sharing, or on a monthly basis impose some sort of a cost sharing that would allow someone to stay in the Medicaid program but acknowledge that they have a little bit more income to contribute.

MR. PETERSON: I think my only limitation on that is with continuous eligibility, the point is that there would be no reporting in that interstitial period. So then you're talking about --

COMMISSIONER COHEN: Clearly, this is a modification. I mean, you get some of the value, but you don't lose all of the -- it is administratively more complicated, definitely.

CHAIR ROWLAND: But, Andy, your option would have them -- that's the option of going from

being on Medicaid to being in the exchange.

COMMISSIONER COHEN: No. You would get to stay in Medicaid. You would get to stay in your program. But if your average income was higher over the year, there might be some way to --

CHAIR ROWLAND: But where people talk about trying to have the plans in Medicaid and the plans in the exchange intermesh, is for that kind of a transition. But if they don't mesh --

CHAIR ROWLAND: We would love to always have that option, but I'm not sure that we do, and the benefits change, as well.

MR. PETERSON: So what you're saying is that if a person's income -- if a person was in Medicaid and their income rises to 150 percent of poverty and they report that, rather than switching them to the exchange, let them stay in Medicaid, let them stay in their plan, but maybe pay --

COMMISSIONER COHEN: For a 12-month -- I mean, for a defined period. You know, this wouldn't be a forever. Next year, if their income is still at 150 when they're at renewal, they would have to move. But if it happened in the middle of the year -- you would basically be giving them 12-month continuous eligibility, but give the State some -- maybe you could do this, like, give the State some flexibility to impose a little bit more, you know, a premium cost share or something like that for those whose incomes rise during that 12-month period. But, again, clearly, it would have to be a defined period. You couldn't say you get to stay in Medicaid forever.

CHAIR ROWLAND: And, clearly, one would have to look at the administrative complexity of doing that.

COMMISSIONER COHEN: Again, it's a brainstorm, but it's just a way of thinking about why would someone oppose what we all think would be a much more seamless program, and it's a concern about people who could pay a little bit more, arguably, being able to stay --

COMMISSIONER GABOW: I have one question and two comments. I think, since the majority of States, at least for children, and a substantial number for adults -- well, children in Medicaid and children in CHIP, I guess, is more correct -- already do continuous eligibility. I think it would be interesting to know more about the outcome of those States as we make our recommendation, particularly if we were going to make a mandatory recommendation. I don't think there's a problem of making it, you know, an option. They already have the option. They exercise the option. Great.

But I think some of these States must have exercised this option for multiple periods of years, and so getting some insight from those that have had it the longest, why they kept it, do they have any data, I think would be useful in making -- if you wanted to make the move to mandatory. So I think if you have more data, I'd really love to see it.

My second comment relates to -- I wasn't going to make it until Andy made it -- I strongly oppose that. That, to me, sounds like an administrative nightmare. And I think we get exercised about -- these people aren't going from being impoverished to millionaires. I mean, you know, maybe one person in 100 million hits the lottery and changes. But do we want to make a law for one person in 100 million? I mean, we all know that these patients who -- these people, I think of them as patients -- these people who churn are churning over small dollar amounts, which I think is the other data that would be useful. But at least in my experience in running a plan, this wasn't that you suddenly made $50,000 more. I mean, it's small amounts of money. It's the difference between McDonald's and something that pays a little more than McDonald's, I mean, in general. So I don't see creating this huge administrative burden, which, to me, what you said was a nightmare. I'd be screaming if I was at the State and had to do that. So I don't think we should ever think about that.

And I think that if I were to weigh in on this, even though I like having consistency across the

country and say, let's make it mandatory, I think that's a big jump, giving that the Supreme Court has just told us they can choose whether to be in Medicaid expansion at all. It seems like a no-brainer to say, let's continue the option. So I would vote for 1A and 1B as a recommendation. I think we should make a recommendation and I think it should be those two. I don't think asking people to continue to use a waiver fits with our philosophy of administrative simplification, to continue something that people already do, so that's my --

CHAIR ROWLAND: Can I just take a -- of whether or not, given Patty's last comment, we want to take the -- if no recommendation may require waivers, we don't want to have waivers as an option. So our decision is really between -- I'd say, 1A and 1B ought to be combined, I mean, for consistency. So it's between making it an option with 1A and 1B being a combined recommendation versus making it mandatory.

I think the comments about gathering additional information on how -- what some of the State experience has been with continuous eligibility.

I thought that one of the pieces missing from the chapter also was the plan perspective, that we have the State perspective and some provider perspective, but with Richard and Donna and others here, I thought I heard strongly from the plan that more consistency of being able to keep someone for a year makes more sense. But is that something that we should also document a little more extensively within the chapter?

VICE CHAIR SUNDWALL: Let me make a comment to follow up on that. I just appreciate your kind of making us focus on this right now.

Andy, thank you for making what I would say is a very sensitive comment about a Republican perspective, cost sharing. I mean, this is terrific. It was an unexpected source.

[Laughter.]

VICE CHAIR SUNDWALL: So I think that your recommending something along those lines is understandable, but I kind of agree with Patty. I can't possibly go along with recommending something that, even though it would be in the, you could say, in the spirit of administrative simplification, it would still add $10 billion over five years to the Federal level and then $4 to $5 billion to the States. That is more money we don't have and that's a big price to pay for administrative simplification, maybe not in the context of Medicaid billions, but it's still costing. So I think I would go along with a combination of 1A and 1B.

CHAIR ROWLAND: Okay. I have Donna, Sara, and Sharon, and then we're going to move on to TMA. Donna.

COMMISSIONER CHECKETT: With just my perspective on the recommendations, I think that it's important that we continue to recognize the State-Federal dynamic. It is extremely, and sometimes painfully, obvious in the past couple of years. And so the degree to which we provide States with a great option, but it's not a mandate, I think will help this recommendation, which should be taken seriously, be taken seriously.

So my recommendation would be to combine 1A and 1B, and I think over time, a lot of States, we should get the data. Lots of States have done continuous eligibility, especially for pregnant women, and so that would be great to get that data in the report. But I think we will see that when States see that it provides benefit, States will do it. So, my thoughts. Thank you.

CHAIR ROWLAND: Sara and then Sharon.

COMMISSIONER ROSENBAUM: Just to act as a counterweight here --

[Laughter.]

COMMISSIONER ROSENBAUM: -- my deep preference is for 1C, but I think the strength of

1A and 1B also is that in both cases, the issue has become -- putting aside the problem with State practice, which you did such a great job of laying out -- it became an unintended consequence of the MAGI shift. And we're going to find other things in the Affordable Care Act where we have unintended consequences of very broad changes that were done for very good reasons, but as we're all finding now and it's inevitable that we find this, that you end up having consequences that we didn't really anticipate too well. And so I think there's a lot to be said. We didn't have 1C before the Affordable Care Act, although this has been an issue going back way in time.

So I think going back to at least the status quo ante, that a State could -- it could decide not to do this, but it could do it when using either the direct or indirect method you point out in the chapter. So I think that the 1A-B combination also sort of reverberates on a sensible correction basis.

CHAIR ROWLAND: Sharon.

COMMISSIONER CARTE: Probably, I am just echoing Sara here, but even though I can appreciate where Dr. Dave is coming from, it seems a questionable time to add the expenditures. But even though I expect the optional position to prevail, I think we should think carefully about C just because I think that it really adds to the stability of the market for the private plans, ultimately, and to move there more quickly is also something to be weighed out.

CHAIR ROWLAND: Okay. So let us integrate 1A and 1B. Let us continue in our discussion and to have 1C on the table. And I think we should also think about both adding in more of the data on what the experience to date with continuous eligibility has been. But if we end up going with a combo of 1A and 1B as our recommendation, I think we can also recommend that that experience be evaluated in order to see whether that policy should be extended more broadly, and I think that would help to get more of the data and information about why States have elected to do it if they so choose and what their

experience has been.

Andy.

COMMISSIONER COHEN: I am sure I'm beating a dead horse here, but if I might say, I would like to support 1C, but I'm not sure I can. I definitely support 1A and 1B, but I am just deeply -- I'm really concerned about the many States that will not take up the option and the -- it's a big policy, probably an expensive policy, for the State. So I do just want to suggest one more time, again, and maybe I should have made this clear, this would be in conjunction with supporting 1A and 1B, whether we might include some wording or option for States to look at ways to make it something other than all or nothing in this option, 12-month continuous eligibility or month-by-month, you know, throwing people off the program, punitive sanctions for someone not reporting, potentially, and whether or not there is some sort of in between for States that would like to extend the eligibility but really have a concern. If we're not going to go to 1C, I think we should try to make this a policy that is as flexible as possible to get the maximum number of States to do it.

So I guess I just sort of throw out again -- I'm not sure I articulated a great design -- but some sort of sort of compromise way for States to extend eligibility, maybe with some flexibility around some policies, if they choose to, to encourage them to take up this option, because I'm very concerned that many States will not. And if we know anything about -- I mean, how many States have done it now and what are the barriers? How many States could we reasonably project --

CHAIR ROWLAND: Thirty-three.

COMMISSIONER COHEN: -- would take up the option?

COMMISSIONER ROSENBAUM: Thirty-three in CHIP.

COMMISSIONER COHEN: Right, for kids. For kids.

COMMISSIONER ROSENBAUM: Twenty-three for both.

COMMISSIONER COHEN: For kids. Twenty-three for kids.

COMMISSIONER ROSENBAUM: -- and a few for adults.

COMMISSIONER HOYT: Arizona --

COMMISSIONER COHEN: But very few for adults, and we're talking about adults here, primarily.

COMMISSIONER HOYT: -- six months and 12 months --

[Simultaneous conversation.]

COMMISSIONER COHEN: But they don't have to take it up. Essentially, they have an option.

CHAIR ROWLAND: But we are -- let's be clear. The States are losing the option --

COMMISSIONER COHEN: Right. Exactly.

CHAIR ROWLAND: -- to do this for children. So part of what we are doing is restoring the flexibility for the 33 States that do it under CHIP and the 20-odd States that do it under Medicaid --

COMMISSIONER ROSENBAUM: But they're losing the flexibility for adults, too, because of the MAGI --

CHAIR ROWLAND: -- and adding flexibility to do it for adults if they so choose.

COMMISSIONER ROSENBAUM: No, no. They're losing the flexibility in the case of adults.

CHAIR ROWLAND: Right.

COMMISSIONER ROSENBAUM: So the fact is, you're absolutely correct, that very few States have done it. But right now, they have the flexibility not to do it, and many don't do it. The problem I see with your hybrid is, I think as has been mentioned, it offers something that becomes a complicating factor in its own right and why a State would expose itself to the very complications that we're saying we're

trying to minimize. I mean, it might not do the option. But that's a different issue from creating a new option that itself is so complicated that we then minimize States' willingness to use the option. And here, I think the beauty of 1A and 1B is we are simply saying there was a problem. There's a spillover. Caught. Fixed. We're recommending go back to the status quo.

COMMISSIONER COHEN: Right, which is a very -- which is, I would say, is less than a solution to the problems that we're identifying -- much less than a solution to the problems that we're identifying. It will be important, very important for children, and probably have not a great impact on adults. And so I just want to sort of flag that.

COMMISSIONER ROSENBAUM: Yes.

CHAIR ROWLAND: Or it may have the impact of, if we want to -- you know, I know you raised issues about keeping a family together. Well, certainly, if you want to keep coverage for the whole family together, then you would want to be able to do it for children and for adults. And I think this is -- obviously, Andy, you have raised some issues about whether States who want to go a different way would come in for a waiver or not for a waiver.

But I think what we're struggling with here is there's a glitch in the way the ACA has structured the eligibility system that can leave some States with the inability to pursue options that they have pursued in the past, and Chris is going to provide us with a really well revised chapter that lays out the experience to date and, I think, needs to focus in looking at our recommendations and our rationale for that, a stronger rationale for why we're putting this forward, but also to look at where we would want this to be evaluated and how we would want it evaluated.

And, obviously, since this would be recommending a statutory change, we would have to see how CMS and others would want to proceed if this was going to go forward.

So, I was going to move on to TMA, but if Patty wants to make a closing comment, that's fine.

COMMISSIONER GABOW: I would just say that I don't think it's a blow to accepting 1 and 2 that a lot of States haven't done adults because they have a longer history with children. I mean, children have been covered for a longer period of time. They know what they're getting into. So that doesn't surprise me. I don't think the fact that they haven't done it for adults is much. It just means it hasn't been there for as long to gain experience. So I wouldn't want that to damn the recommendation.

CHAIR ROWLAND: Okay.

COMMISSIONER COHEN: [Off microphone.] -- the topic. Just to echo something that Patty said, if there is any way that we could get data in the chapter about actual income fluctuations, I think that would be -- and to what extent they are small, large. Any data on it whatsoever, I think that is really critical, because I do agree. I think there can be misimpressions about what these income fluctuations can really look like and I think it's very important to show what they really are.

MR. PETERSON: I am sure there's no problem, because we've tried to put in information about the extent of churn. It is trying to strike the right balance in terms of how much detail from the literature to put in. So I hear your point. We can certainly add that.

CHAIR ROWLAND: I believe ASPE has looked very extensively into the income variation. Rick Kronick, when he testified here, was talking about their studies of income fluctuation, which I think, to Patty's point, at the lowest income, the fluctuation is large, but it's by a couple of dollars and not by thousands of dollars. But we can look into that.

But TMA is our other issue, so, Chris, let's see how we do on this one.

MR. PETERSON: All right. So as has been talked about in previous sessions and you have in the draft chapter, TMA prevents uninsurance primarily for low-income parents whose income has risen, and

so the draft chapter provides some background of TMA.

That six-month TMA has been required since 1988 and there are perennial Congressional appropriations required to continue it. I also want to note that when I say six-month TMA, the six months is mandatory, but States have the option to do more than six months and do.

The last extension of six-month TMA was in the latest fiscal cliff legislation, so that extended TMA through the end of this calendar year. So now is the point where this Commission can think about what is the role of TMA moving forward, now that it's active through December 31, 2013.

In the draft chapter, we mention that there was a GAO report that was going to be coming out any day. That has come out since the draft chapter. And so we know that there were 3.5 million TMA enrollees in 41 States in FY 2011 with nearly $4 billion in TMA expenditures in 32 States.

So the way to think about TMA in 2014 is to bifurcate it into the States that do expand versus those that do not expand. So those States that do expand, of course, you think that TMA was originally intended to ensure that families did not lose Medicaid and become uninsured as their income rose. However, in States that implement the expansion, subsidized coverage either through Medicaid or through exchanges, will exist up to 400 percent of poverty. So, thus, in those -- in the expansion States, the primary reason has arguably been removed. In fact, its continuation in these States may create unnecessary confusion for everyone involved.

For example, a parent could say, okay, it's time for my annual redetermination. My income has gone up to 200 percent of poverty and I'm going to be in the exchange because I'm making more money now. But, no, instead, they would get TMA. They would be in that for six months. Then they would have to reapply again after that six months.

So continuing TMA may present additional administrative burden for individuals, for States, for

plans. The trade-off, of course, is that continuing in Medicaid through TMA would be better for the enrollee in terms of their lower cost sharing.

So the recommendations we're talking about have to do with bifurcating these States. For States that do not expand Medicaid, TMA would still serve that purpose of preventing uninsurance, whether it's the six-month TMA or if it reverts back to the original four-month TMA that's in the statute. So TMA in some form may need to continue in the non-expansion States to prevent parents from becoming uninsured.

So with that background, the potential recommendations are, 2A, to extend current TMA and its funding in all States, so that's talking about six-month TMA. Two-B is to allow States to opt out of TMA if they implement the expansion to 138 percent of poverty. And then nothing that if there is no Congressional action, only the first four months of TMA, which is permanently funded in the statute, will continue in 2014 and beyond.

So one could do 2A and/or 2B, but, of course, if adopting both, 2A would be limited to the non-expansion States.

So let me give information that we've gotten from CBO, which is still preliminary, and they haven't gotten all the numbers in as of yet. But, again, these cost estimates from CBO are in the smallest non-zero bucket in terms of its impact. Extending TMA in all States would have Federal savings in one year -- Federal savings, I will note -- in one year of $50 million to $250 million. And the reason for that is this has to do with how the world changes in 2014, because individuals who in 2014 will go into exchange coverage. Extending TMA by another, you know, six-month TMA, pulls those people out of exchange coverage into Medicaid. And CBO estimates that the Federal cost for Medicaid is less than the exchange coverage. So it doesn't work out to be a lot of money, but that's why there is some modest savings from that.

VICE CHAIR SUNDWALL: A subsidy they get from the exchange?

MR. PETERSON: It's a subsidy, that's right. That's right.

So there would be State costs associated with that of people who would have gone to exchange coverage are keeping them in TMA, but to the extent that 2A is really just continuing current law, then would States really recognize this as new spending? I doubt that they would. So that --

[Comment off microphone.]

MR. PETERSON: Two-B is -- also has a relatively small number associated with it, $50 million to $250 million in Federal spending in a single year. And CBO has told us it is at the low end of that range. And then over five years, it would be less than $1 billion.

And this would actually save States over five years approximately $500 million, and this is because individuals who would have stayed in Medicaid through TMA, for whom the State is making a payment for, those individuals will be going to exchange -- some of those individuals will be going to exchange coverage. Some of them will be going to the new adult group where the State would be getting the newly eligible FMAP.

And then, of course, you could combine the two policies so that you extend TMA and its funding for the non-expansion States and then allow States to opt out of TMA.

COMMISSIONER GABOW: Could I just have a quick clarification. Why not do 2A and 2B, because if you extend it for all States and then allow States to opt out, but if a State doesn't opt out and you only allow it to stay for the non-expanded States, then the opt out becomes confusion. I mean, how could you opt out of something you're not even in?

MR. PETERSON: That's a good point.

COMMISSIONER GABOW: So I think you have to do -- this is just a technical question. I think you have to do both in order to make B make sense.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: I think my reaction was similar to Patty's. That is, if -- and we're going to see this phenomenon. Just like the first phenomenon you presented, we're going to see this phenomenon, which is that after 2014, in expansion States, there are going to be various aspects of Medicaid eligibility standards that cease to make any sense. We're also going to see situations in which we might need to think at some point about new options that don't exist today because of the changes in marketplace relationships.

This is one where, it seems to me, the recommendation is this hybrid of saying the policy should continue except in those States where it needn't continue anymore because health reform has set up an overarching preference for how people are to be -- if they're MAGI people -- how people's health coverage needs will be addressed going forward so that no State is essentially left in the position of having to continue coverage for a group whose coverage now by a matter of Federal policy shifts to the exchange.

MR. PETERSON: And I would also wonder, from your perspective, whether doing 2A, because it is something that Congress deals with every year, if this is an opportunity that the Commission would want to say, we should just do this and not make it an annual appropriation thing.

COMMISSIONER ROSENBAUM: It's our own little SGR. I think this is our chance as MACPAC to deal with one of these annual extenders that we are constantly facing. And again, the explanation being that as a matter of long-term policy now, we have said that people should not experience the loss of coverage because of changes in financial circumstances. And so it makes sense to say that, therefore, we shouldn't have to revisit this issue every year.

COMMISSIONER HOYT: I can't get the microphone to work today. It seems to me that the two recommendations are kind of related between churning and here. I don't know how the question was

posed to CBO, but I would guess the cost of TMA drops substantially if you were to do 12 months continuous eligibility, so they're kind of linked in that sense.

MR. PETERSON: Yeah, and I think that's true. It's just that for CBO purposes, because these are already in the smallest buckets, that they would be not so inclined to spend much of their time trying to work out the interaction. So I don't think it would change where things are in these particular buckets because they're relatively small amounts.

VICE CHAIR SUNDWALL: My only comment is just to make clear that they're linked. I mean, I would just, with the extent of the current TMA, however, allows States to go to 138 percent. I mean, just a single recommendation.

COMMISSIONER MOORE: And we are talking about an extension -- not an extension, but we're talking about the change to Federal law. That does not extend for X-number of days, months, years, or whatever, as we have been doing since 1988, right? I just wanted to clarify that, because I think that's what we want to go for.

CHAIR ROWLAND: Chris, is there -- in terms of the fiscal cliff and the extension there, was there any written documentation about how that got into the fiscal cliff negotiation, or there's no legislative history there, just done? Any other comments or discussion?

Chris, you know how to go forth and produce --

MR. PETERSON: This is very helpful.

CHAIR ROWLAND: -- produce a chapter. And now this is our intent to be a chapter in our March report and we will be, therefore, voting on these recommendations at our February meeting to decide exactly what we want to recommend. So we really need to very carefully look at the language and the wordsmithing of the recommendation. I know you're all very good at wordsmithing and I'm sure we will

work through that and have the ability to move forward.

Chris, I want to thank you for really putting together a very good chapter for our review, and now you're going to add a lot more to that chapter, so I'm sure it'll be even better when we see it next. Thank you.

I'm going to make a slight change here in our schedule. Instead of moving forward to discuss changes in the Medicaid benefit design, we've gone a little over with our discussion this morning on the eligibility side, so I'm going to have us break for lunch and reconvene at 1:15 for our discussion with the actuary, and then add the benefit design discussion. Ben, I'm sorry, but we're going to have you be our wrap-up speaker instead of our pre-lunch. So you'll be pre-adjournment instead of pre-lunch. Both of them are not ideal places, but I'm sure that the benefit discussion will keep us very alive and awake at the end of the day.

So for now, we'll take a break and reconvene at 1:15 and the Commission members here for a luncheon discussion. Thank you.

[Whereupon, at 11:53 a.m., the meeting was recessed, to reconvene at 1:15 p.m., this same day.]

AFTERNOON SESSION [1:20 P.M.]

CHAIR ROWLAND: Okay, if we could please reconvene for this continuation of our MACPAC meeting.

For this session, we want to look at an issue that we know is on everyone's mind, and that's what's going on with Medicaid spending and expenditures for the future. We're extremely pleased to have join us Christopher Truffer, who is the Deputy Director of Medicare and Medicaid Estimates Group in the Office of the Actuary at HHS, and we're very pleased to have you present to us and provide us with some insight into one of the major issues that we know we need to also be addressing as a Commission. So welcome and please proceed.

MEDICAID EXPENDITURES OUTLOOK

* MR. TRUFFER: Thanks, Diane.

I'd like to thank the MACPAC for inviting us to speak today. In the Office of the Actuary, we're certainly glad to support the work that MACPAC is doing looking at Medicaid and CHIP, and we're glad to get a chance to present some of our work and some of our perspectives on the future of Medicaid expenditures and enrollment today.

What we'll look at today are the trends in expenditures and enrollment through 2012, especially with an eye over the last year or two. Then we'll talk some about the factors that are accounting for growth in the next several years, and some of those key factors we'll look at will be the enrollment and demographic trends in Medicaid, growth in health spending per capita, what's driving those trends, and how that fits into the larger U.S. health care picture; and then looking at the impact that state Medicaid decisions have had on recent spending trends and what implications that might have for the future as well.

Lastly, we'll look at the Affordable Care Act. I know reform is a topic on everybody's minds

nowadays, and certainly for Medicaid it has a major impact, especially in 2014, with the beginning of the eligibility expansion. So we'll look at the impact of the Medicaid expansion and some of the factors that should be considered as we get ready for 2014. And, in addition, we will talk about the other sections of the Affordable Care Act that affect Medicaid briefly.

This chart shows Medicaid expenditures over time and the Medicaid annual growth rate in expenditures over time. As you can see, in 2012 spending slowed significantly, falling from what had been a pretty steady rate of about 5.5 to 7.5 percent per year over the last ten years, with the notable exception of 2006, and slowed fairly remarkably and more so than we or anyone had expected at the beginning of the year.

Medicaid spending reached $432 billion in fiscal year 2012. That represented a 1.1 percent increase from 2011. That would mark the third slowest year of Medicaid spending growth in the program's history.

Benefits grew only 0.3 percent from 2011. We've seen a slowdown in the rate of spending particularly on benefits and in light of slowing enrollment growth as well over the last few years, but this was a much sharper slowdown than we've seen before.

On the other hand, the --

COMMISSIONER CHECKETT: Could I ask a question?

MR. TRUFFER: Sure.

COMMISSIONER CHECKETT: Is that federal funds only, or are you including state --

MR. TRUFFER: That is federal and state funds. A great question to ask.

COMMISSIONER CHECKETT: Okay. And provider taxes and all those other things all rolled up into what you're calling the state expenditure?

MR. TRUFFER: That's right.

COMMISSIONER CHECKETT: All right. Thank you. And I apologize if you said it and I missed it.

MR. TRUFFER: No, I didn't say it, but that's a very good question. Thanks.

COMMISSIONER CHECKETT: Thank you.

MR. TRUFFER: I'll mention, on the other hand, administration expenditures in Medicaid actually grew very fast in 2011, up 17.5 percent. Now, the main driver of that was the increase in the health information technology or electronic health record incentive payments that were part of the American Recovery and Reinvestment Act of 2009. And as it turns out, 2012 saw the beginning of a number of states starting their programs and many more providers adopting EHR and HIT and receiving those payments. So while it was a sharp increase, and maybe sharper than we had expected before, I don't think it represented a significant departure from the overall expectation. It's more of a question of the timing of when providers started in the program.

Our next chart shows the growth rate of enrollment and the overall levels of enrollment over time as well. And as you can see, enrollment has followed a much more cyclical pattern over recent history than expenditures has. But enrollment has been slowing as well. This has been coming down since 2009 when the enrollment growth rate peaked at 6.7 percent, and this has been fairly consistent with what we had expected after the end of the recession. And as you can see, some of the other sharpest growth rates in Medicaid enrollment occurred during previous recessionary periods as well -- 2000 to 2001, subsequent to the -- that recession was the early 1990s recession, which was also combined with some expansion in the program, too.

Yes?

VICE CHAIR SUNDWALL: I'm a little dense on this. Could you explain the difference

between the two lines? I don't understand the up and down and the one that's always up.

MR. TRUFFER: Sure, I'd be glad to. The darker line or the black line represents the levels, and those are measured against the left axis, so that's showing the actual level of average annual enrollment in millions of persons per year. So you can see that it climbs from slightly above zero starting in 1966 on the far left and bottom corner of the chart, and then that climbs over time reaching a little over 55 or 56 million in 2012.

The lighter line, the gray line, represents the annual growth rate in the growth of expenditures, so as that line is higher, that represents a year where enrollment was growing faster. And as that line comes down, that represents a year where enrollment was growing slower, or in some years actually declining.

VICE CHAIR SUNDWALL: So the black is the aggregate number of enrollees.

MR. TRUFFER: That's correct.

VICE CHAIR SUNDWALL: Thank you.

MR. TRUFFER: You're welcome.

COMMISSIONER COHEN: What does average mean? Average for the year or is this a point in time or anyone in the --

MR. TRUFFER: Sure. That's a very good question. The average enrollment, the measure that we use most typically in our work and in our presentations, represents the average number of people enrolled over the course of the year, or it may also represent, say, a person-year equivalent. So if someone was enrolled for six months of the year, they would be counted as half for the purpose of our enrollment. It's different than the ever enrolled or a point-in-time number.

In 2012, 56.7 million were enrolled on average in 2012. That represented a 1.9 percent increase from 2011, which was in line with our estimates from before. It's worth mentioning, too, that the

enrollment data that we actually do have at this point is only current through -- completely through 2009. We have most states reported for 2010, but we're still relying on estimates for 2011 and 2012.

The slowdown we've seen in enrollment since 2009 has been most notable amongst children and non-disabled and non-aged adults, which we have found to be those groups most sensitive to changes in economic conditions in Medicaid. So the cyclical nature of economic growth and of changes in the employment and unemployment rates have shown a more significant effect for those groups than others.

COMMISSIONER CHAMBERS: So back to the clarification about how -- excuse me, where you talked about someone was on for six months was counted as a half. So the 56.7 million isn't necessarily distinct individuals, it's like two six-month people would be counted as one person in that 56.7 million.

MR. TRUFFER: That's correct. For the number of people who were enrolled at any point over the year, it was a bit over 70 million in 2012. That's a little bit more than one in five people in the U.S. at some point during the year were covered by Medicaid.

COMMISSIONER CHAMBERS: Thank you.

MR. TRUFFER: You're welcome.

What I'd like to discuss now are the factors that led to this slowdown in 2012 in expenditures with the information that we have. Certainly we're still collecting the final year-end data now, so this is information based on what we have to date.

There are a few factors that led to the slowdown, most notably the state efforts to limit spending growth. There's been a number of surveys and reports that have looked at the steps that states have taken to try to limit the growth in Medicaid expenditure in 2012, and a lot of this seems to have been driven by the changes in the federal and state share after the end of the temporary increases in the federal matching rate that were part of the American Reinvestment and Recovery Act and were also then extended six

months until June 2011.

So while total spending grew a little over 1 percent, there was a dramatic difference in federal spending and state spending growth in 2012. The federal share of Medicaid expenditures actually decreased 8.3 percent, a sharp reduction from where we had been in 2011, and the state Medicaid expenditures actually grew over 17 percent on the heels of growing 19 percent in 2011 as the temporary match rate increases were phased out.

As you can imagine, the state revenues didn't grow nearly as far as state Medicaid expenditures, and Medicaid certainly being a significant portion of their budget. So that difference constrained states in what they could spend, and we believe that that was one of the major motivating factors in states trying to take steps to limit growth in their program. Some of those steps would have included freezes or reductions in provider payment rates, steps to curb optional benefits, and some limited steps to try to limit eligibility or enrollment growth. However, the Affordable Care Act has limited on what states can do to change their eligibility levels prior to 2014, so that was not as large of a factor as the others.

In 2012, we also saw a reduction in supplemental payments. These are the payments that states make in their upper payment limit headroom. They make these two a number of different categories of providers. We saw a sharp increase in those expenditures in 2011, and we saw a similar decrease in those expenditures in 2012. Certainly that's a smaller factor than the overall management of the program, but it's certainly a significant factor.

In addition, enrollment growth slowed in 2012. It was in line with what we expected, but that certainly contributes to slightly slower growth than what we saw in 2011. And I'd mention, too, that there was a limited impact of the Affordable Care Act. It may be easy to think that the Affordable Care Act could have been a major driver of that slowdown, but based on the provisions that have been implemented

and the estimated impacts of those sections, it's unlikely that that produced a significant effect. It contributed a little to the slowdown, mainly in the additional collection of new prescription drug rebates. Looking at the state data quarter to quarter, it appears that a number of states took some time to revise their systems to accommodate those new rebates and only collected them in 2012, even if they were incurring them in 2010 and 2011. So there were probably more rebates collected in 2012 than we had seen previously, and that contributed a little bit to the slowdown, but not much. Otherwise, the Affordable Care Act impacts on Medicaid directly in 2012 were fairly minimal.

So going forward, there are a few factors that account for growth in enrollment and in expenditures, so I'd like to start with enrollment and what are some of the major factors to consider as we move over the next decade that will drive enrollment, and then move to expenditures after that.

First for enrollment, certainly the economy is a major factor in Medicaid and certainly has a lot to do in determining the number of people eligible and the need for Medicaid in the U.S. So what we would expect to see -- and it has been consistent with our estimates over the last few reports we've done -- is that the growth in enrollment in Medicaid would slow as the economy continues to recover and as unemployment rates begin to come down or continue to come down. In our past reports, we've had growth getting fairly close to zero in the middle part of the decade, excluding the effects of the Affordable Care Act, which I'll get to in a minute. But we certainly expect to see slower growth in the number of children and the number of adults, which we've seen consistently over the last year or two, and then resume something closer to a more average trend once the economy sort of resumes a steady state of growth.

Certainly the growth in the economy over the next few years may certainly have an impact on this, though, too. So to the extent that the economy grows faster than our assumptions, enrollment could grow more slowly or even decline. And to the extent that the economy grows more slowly than we've assumed,

enrollment could rebound and start growing faster again.

In terms of demographics, this is an important factor in Medicaid as well. We talk about demographics a lot in the context of Medicare, but it certainly has a bearing on Medicaid as well.

We're just entering the beginning of a fairly significant shift in the demographics of the U.S. that we have a growing aging population. There is a significantly growing number of people in the country over 65 and a growing number of people over 85 as well. In fact, the average rate of growth of number of people over 65 in the country over the next ten years will be about 3 percent per year, which is a fairly sharp increase, and certainly outpacing overall population growth at that time.

At the same time, the number of children in the U.S. and the number of adults under 65 in the U.S., the growth rate in those populations is actually slowing. The number of adults in the U.S. under 65 by the end of the decade is only growing roughly three-tenths of a percent per year and children is growing a bit faster than that. So given that Medicaid is made up of different age and demographic groups, this has a significant effect on the distribution of Medicaid enrollees. If you exclude the Affordable Care Act, what you would see is a growing number of aged beneficiaries growing as a share of Medicaid enrollees over the next ten years, while seeing, you know, slower growth amongst the number of children and under-65 adults.

Now, the Affordable Care Act, which I've mentioned as a factor to exclude, just to make it simpler to explain these other trends, certainly has a very large bearing on Medicaid enrollment. Starting in 2014, in the beginning of the eligibility expansion in Medicaid, we would expect to see a significant number of enrollees added to Medicaid starting in 2014 and continuing over the next two years as people begin to sign up and as states expand eligibility, too.

For expenditures, I want to talk a little bit about the per enrollee expenditure and what are some of the drivers of those trends to consider as well and to try to put some of this in the context of the rest of the

U.S. health care system as well, because what we have seen in Medicaid has differed in some respects, but in many respects it's very similar to what we've seen across other payers as well, and it's important in the context of determining what to do with Medicaid, and as changes are made not just to Medicaid but to other parts of our health sector, they can certainly have an impact on Medicaid as well. And to the extent that there's concern about the rate of growth in Medicaid expenditures, some of the things that would slow Medicaid may also slow some of the growth in other payers, too.

We've seen a recent slowdown in the growth of health spending per capita, not just in Medicaid but across the different payers of health care, including Medicare and including private payers of health care. We've seen a slower rate of utilization growth. That's the number of services used or the intensity of those services. And we've seen that across a number of services, I think most notably in prescription drugs, where, if you go back ten years ago, the rate of prescription drug growth was consistently in the double digits annually. That rate of growth has slowed dramatically, getting close to zero recently, and just starting to rebound, as we've seen fewer blockbuster drugs and more efforts by managed care organizations and private health insurers trying to manage the prescription drug benefits that they offer.

At the same time, we've seen less of a slowdown but still notable in hospital services and professional services, including physicians and other health practitioners.

We've also been in a period of relatively slow economy-wide price inflation. Certainly we've seen very low inflation over the last several years, and while medical price inflation has still been faster than economy-wide inflation, that's certainly had an effect as well that has led to some of the slowdown.

It would also be important to point out that one of the main drivers has been the impact of the economy, that we've seen growth in the number of people who are uninsured in the U.S. over the last several years. We've also seen fewer people with private health insurance over the last few years as well.

And those trends have certainly slowed the utilization of health care spending, too, as people are either paying more of their health care or maybe paying all of their health care out of pocket.

For Medicaid per enrollee expenditures, in addition to those factors we noted above, we've seen the state efforts to limit growth. You know, consistently over the last few years we've seen the number of states taking steps to slow the rate of growth of reimbursement rates to providers, freeze those rates, even cut those rates in some cases. And it's also worth pointing out that we've seen a very limited amount of expansion of programs, too. If you go back prior to the last few years, you've seen states adding benefits, adding eligibility categories, you know, and trying to widen the benefit. We've seen very little of that over the last several years as states have been trying to manage the Medicaid program in the context of their budget situations.

In addition, the demographics have driven slower per enrollee growth when looked at in aggregate. So as we've added mainly more children and more adults over the last several years of faster enrollment growth, we've been adding people who are on average lower-cost beneficiaries to Medicaid as compared to disabled enrollees and enrollees over the age of 65.

So, in Medicaid, while we've seen very slow per enrollee growth, some of that is in the fact that we've just been adding very low cost enrollees relative to those who are already in the program.

So if you look at not just Medicaid but the entire U.S. health sector, the outlook for the next several years has been lowered, I think, consistently, but we've seen slow rates of growth. The rate of national health spending growth has been at a rate of 3.9 percent nationally the last three years, which has been the slowest that we've measured on record. And what we would expect is that while the trends would rebound and growth would resume to something faster than that over the next several years, it may not be as strong of growth as had been expected, say, two or three years ago, just as we've seen a consistent slowdown in the

rate of per enrollee growth and total health care growth in the U.S.

VICE CHAIR SUNDWALL: Let me just interrupt you here.

MR. TRUFFER: Sure.

VICE CHAIR SUNDWALL: Because this is making me uncomfortable. This is too much good news. I can't handle that.

[Laughter.]

VICE CHAIR SUNDWALL: But what I'm trying to put in context, you're talking about slightly less growth. But I look back at these black lines. They're still like this.

MR. TRUFFER: That's correct.

VICE CHAIR SUNDWALL: As far as aggregate expenditures and aggregate enrollment, we're still seeing dramatic, consistent increase year after year, if I read those graphs correctly.

What I'm hearing you say, though, is that the awful news we've been hearing for years is not quite as bad as we expected. But, I mean, should we take much comfort in this? I'm not sure what the message is. It's very interesting, but not in sync with what I'm used to hearing.

MR. TRUFFER: Sure. It's an excellent question. It's tough for us to say this is good news, this is bad news, given our vantage point on this sort of work, and we try to avoid making those sorts of judgments on either our analysis of historical trends or on our projections.

What I would say is if you're concerned about the rate of growth in the program for Medicaid and how this fits into the federal budget picture and the state budget picture is that this is more likely a temporary lull than it is a permanent reduction in the trends. We may not bounce back as high as we had seen growth before. You know, I think, with the exception of adding so many new enrollees in 2014, I would say it's unlikely that we would reach double-digit Medicaid spending growth again any time in the

near future.

But at the same time, it's still growing, and the underlying drivers of health care spending beyond the number of enrollees but the aging of the population and the aging of the Medicaid population, the growth in the use of services, the growth in the price of those services, they still exist, and we would expect that they do trend back up. So, whereas, growth may not be as high as it had been recently, I don't think we would expect to see 1 percent growth. Again, I think that was largely a result of the states' efforts, especially in 2011 and 2012, to try to limit the growth of the program.

That said, Medicaid is also still growing as a share of state budgets, and it's still growing as a share of the federal budget as well. So to the extent that it becomes a growing share of those budgets, it's not clear how states or the federal government might respond to that.

I would say from the states' perspective, where they have to balance their budget annually, they essentially have three choices, which would be to lower the rate of growth in Medicaid spending, to lower the rate of growth in spending elsewhere, or to try to increase revenues to make the pieces match.

That said, they could also use any sort of combination of the three of those pieces, and the future of the program and the future of the economy I think will be a significant driver in that, too. If economic growth resumes and grows more fast than we've seen the last few years, that may alleviate some of the pressure on state budgets, and at the same time alleviate some of the pressure on Medicaid enrollment. Certainly if it grows more slowly, the two trends could converge and create, you know, some decisions that states would have to consider in terms of managing their Medicaid program.

So, again, I don't know if I could say it's good news or bad news. It has certainly been some change over the last few years which we've seen sort of consistently slower growth. But to the extent that that was driven by the economy as well, that could certainly suggest that in the next few years, as the

economy continues to recover, that rate of growth nationally could pick back up.

CHAIR ROWLAND: But, in fact, to David's point, the line that's going up is going up because even a small growth rate on a large base continues to go up. And so it's, in fact, a more moderate -- if it was double digit, then the line would be going --

MR. TRUFFER: That's very true as well. That's a good point. It's certainly one of the largest programs in the federal or state budget.

CHAIR ROWLAND: Patty, did you have a comment?

COMMISSIONER GABOW: Could I ask two clarification questions? I may be confused about this. I probably am. But I thought that one of the biggest increases was the disabled population coming into -- that they were coming in at a faster rate than children or adults. But you said -- I thought you said something different than that, so maybe I'm confused. That's the first clarification.

The second is, given that Medicaid is not one program but many programs, do you have any data on the variability across states in this growth rate of expenditures, particularly expenditure per enrollee, as well as total? Because I would expect that this aggregate number has a pretty large standard deviation.

MR. TRUFFER: That's right. Sure. Let me take both those questions.

Certainly we've seen growth in the number of people who are disabled and enrolled in Medicaid, and in terms of cost, their costs are, you know, relatively high relative to especially non-disabled children and non-disabled adults under 65 in the program.

What we've seen, though, is that while growth has been steady and maybe faster than overall population growth amongst the number of disabled enrollees in Medicaid, we haven't seen the same cyclical trend that we've seen with children and adults. So the growth rate in the number of children and adults enrolled grew faster during that peak period from 2007 through 2009, and then it is also slowing more

quickly than the rate of growth in the number of disabled enrollees in Medicaid over that time, too.

So it has been significant, but it hasn't been as up and down as we've seen with particularly the non-disabled children and non-disabled adult population.

In terms of the variance across states, you know, we certainly have data on that variance. It's certainly significant. It varies state to state and year to year as well. There's not necessarily a clear picture that, you know, there is a group of states that are constantly lower than the national average or constantly faster than the national average. So the picture of who's growing the fastest over time does change quite a bit.

But there certainly is a tremendous variance in the program based on the benefits offered, their plan structure, the makeup of their Medicaid population as well, so for states that have relatively older populations enrolled, their costs may be higher; and, similarly, for states that have a very large percentage of children enrolled, it may be lower. So there are a number of factors that lead to that variance.

Our office has done work on not just Medicaid but on state national health expenditures and looking at spending not just in Medicaid but Medicare and private health insurance and how that varies by state as well. So we'd certainly be glad to follow up with some of that information, too, if it's helpful, and illuminating maybe some of that variance, too.

CHAIR ROWLAND: I'm going to let you get back to your presentation.

MR. TRUFFER: Sure. So I was wrapping up in terms of the expenditures per enrollee and looking at where those trends have been. We've seen slower growth over the last few years, not just in Medicaid but nationwide, and we would expect those trends to pick back up given the factors that have led to that slower growth.

I just wanted to touch quickly, too, a little bit on the variation of spending by service and spending

by groups of enrollees. As we've said in past reports, we would expect that the fastest rate of growth over the next several years would be in capitation payments and premiums, reflecting the growing use of capitation arrangements within Medicaid plans. And that has been consistent over the last few years, and we would expect that to continue as more states pick it up or as they expand the use of that in their state plans.

At the same time, we would expect to see then slower growth in acute care and long-term care, especially as we've seen shifts from fee-for-service arrangements in states to capitation plans. The services that are offered by long-term care are a bit different and have grown more slowly in the past, and we would expect probably more slowly than the other services in the future, too.

COMMISSIONER COHEN: To what extent is -- you know, so this faster growth in capitation and premiums and slower growth in acute care and long-term care, to what extent does that actually reflect -- or do you know -- the change in actual utilization per enrollee? Or is this just who gets paid and we can't really dig under the covers of that too well to know whether there was an actual change in utilization or patterns of utilization?

MR. TRUFFER: Sure. It's something we're continuing to look at. We're certainly limited by what data CMS is able to collect from managed care plans within Medicaid. The difference, I would say, is primarily reflecting the shift to capitation and managed care. So it would be hard to say how much of an effect faster per enrollee growth in managed care versus acute care is having. You know, it's certainly a good question.

I think the hope would be that if you're managing care and, you know, adding more care management, whether it's in the context of an HMO or MCO or within the context of the state plan would slow it, but it's not something we've looked at in detail.

COMMISSIONER COHEN: Will we ever know that? Will you ever know that? I mean, can you analyze that or is that sort of one of these things where, without better data, we're just never going to know until maybe 20 years after it's happened?

MR. TRUFFER: It would require better data, but I would hope that we would be able to find a way to look at that, even if it's not conclusive say nationally, but even if it's a few states or a few different parts of programs, to be able to look at that more closely. But the data is a major limiting factor at this point.

In terms of spending by the different categories of enrollees, you know, we have expected that the spending per aged enrollee would grow more slowly than for the other categories of enrollees, disabled persons, children, non-disabled children and non-disabled adults under 65, and that's mainly reflective of the different types of services those enrollees receive. The aged enrollees in Medicaid tend to receive a substantial amount of nursing home care, which has grown more slowly over the last several years than other services and isn't projected to grow as fast as those other services over the next ten years either.

In terms of the Affordable Care Act, I'd mention that most of the new spending that we would anticipate seeing would be in capitation payments and acute care. That's where adults under 65 and children tend to receive the majority of their care currently. They receive very little long-term care. We would expect that to be true of the new enrollees as well.

We would also expect to see lower average cost for the new enrollees compared to the current adult and children populations in Medicaid. We would expect to see a significant difference between those costs.

Yes?

COMMISSIONER HENNING: I'm just curious why you would expect the costs to go down

with disabled people and with elderly adults. I'm thinking specifically with not just the aging of the population and the baby-boom generation going through, but the obesity rate in the United States and the chronic health disease problems that come with that. Why would you expect those to go down when it's pretty obvious to me and anybody else that works directly with patients that I would think that those costs would be going up per enrollee?

MR. TRUFFER: They're certainly going up per enrollee. When I say slowing, it's really talking about the rate of growth. So how fast are --

COMMISSIONER HENNING: So, in the past, you expected them to be faster than --

MR. TRUFFER: That's right. That's right. And, again, you know, we've seen this relatively slower period where the costs per enrollee have not grown as fast as they have in the past. And while we would expect them to grow faster in the future, it's not as strong as maybe where the picture of national health spending was or Medicaid spending was several years ago, just that we've seen bigger slowdowns in a number of services that has led to the slower outlook for growth.

COMMISSIONER GABOW: Again, I'm surprised by the lower average cost for new enrollees. I thought that there was data that the new enrollees as adults actually cost more given pent-up uncared for issues. So I'm surprised by that statement.

MR. TRUFFER: Sure. We have done a significant amount of analysis for both Medicaid and the health insurance exchanges on what the costs of covering those populations will be, and what we've found, looking at data for people who are currently uninsured and appeared to be eligible under the new Medicaid rules is that, on average, their costs now are very low, and even after adjusting for the fact that once somebody gains health care coverage, they're apt to use more services, their costs still end up well below the current levels of spending for children and adults.

Now, that said, there may be a few reasons for that. You know, certainly to the extent that somebody has higher health costs, they're coming into contact with the health care system more currently, and they are likely -- more likely to seek out health care coverage, whether it's Medicaid or another type of insurance. So there may be some what we call selection effects going on currently within Medicaid that the people who would have higher costs tend to be the ones who seek out coverage first, and that many of the people who haven't enrolled yet are those who have relatively low cost or maybe no cost in a year.

In addition, you know, there's certainly some differences in the current eligibility standards, so for currently eligible adults who may be enrolled, there are a significant number of pregnant women or women who have just had children who would be expected to have higher health care costs than non-pregnant women or men in the same age range and otherwise similar health status. So that may be another factor of why the adult group we would expect to see lower per enrollee cost as well.

I would note, you know, beyond our analysis, there are others who have looked at this. There's a range of opinions of what those costs will be. There are some who think that the costs will be still lower but maybe more close to what the currently enrolled populations look like. There are those who think the costs might be the same, and there are those who have said that the costs may be a bit higher. So there is maybe some difference of opinion on that subject. But based on our analysis, we think there's going to be a significantly lower per enrollee cost once those newly eligible persons enroll.

COMMISSIONER GABOW: So since there are some who have looked and found that costs are going to be higher, and you think the cost is going to be lower, is there some particular difference in the analytics or the data that lead to those pretty different conclusions? Or is it just a lack of data in general?

MR. TRUFFER: Well, certainly some of it is -- you know, there's only so much data that's out there, and, you know, especially for people who are uninsured, there's not necessarily the same way that we

report health care expenditures as a private health insurance company or Medicaid or Medicare would.

You know, I think the analysis we've done, though, is -- you know, I think quite strongly it has certainly been thorough, looking at not just the expenditures but really looking at the demographics of those people, looking at the makeup of those expenditures and by what types of services they're using, and in looking at what would happen once they gain insurance coverage, how much more they would be expected to spend.

I can't speak necessarily for some of the other analysis that's out there, and I don't know how rigorous those analyses were, whether they were just trying to benchmark costs or whether they did something similar and have found different conclusions. But there isn't enough out there on some of those other sources to know why there's as much of a difference. But it's certainly an important question to consider.

And I would say to the other question, you started off mentioning the idea of pent-up demand. Their spending over the course of the year once they're enrolled can certainly look different as opposed to looking at something that's level month by month. You can certainly expect to see maybe in the first few months higher than average expenditures, then tailing off once they've gone to the doctor, gotten their prescriptions, whatever sort of services they might seek out once they gain coverage, too.

CHAIR ROWLAND: Do you want to just move on to the Affordable Care impacts?

MR. TRUFFER: Sure. I'd be glad to. Thanks.

Moving on quickly to the Affordable Care Act impact, certainly the most significant section affecting Medicaid is the eligibility expansion. As you're aware, eligibility is going to be expanded up to 138 percent of the federal poverty level in 2014, which includes the 5 percent income disregard that was added to the Affordable Care Act. So, in essence, all adults under 65 will be eligible up to that standard in 2014, with

one very notable exception that I'll get to.

The newly eligible enrollees will also see their costs matched at a higher federal matching rate than the rest of the program. It will start at 100 percent for 2014 through 2016 and then decline a few percentage points a year until it reaches 90 percent.

In addition to that, there are a number of things otherwise changing the program. Income eligibility standards are being converted to a modified adjusted gross income basis as opposed to the current standards that may vary state by state and group by group. There are efforts to simplify enrollment in coordination with the health insurance exchanges in states to make it easier and quicker for people to enroll, whether it's for Medicaid or for subsidies on the exchange.

And then the exception I mentioned, the Supreme Court decision over the summer in National Federation of Independent Business v. Sebelius, the Supreme Court decision effectively renders it optional for a state to continue in Medicaid and then expand eligibility. So a state can continue their Medicaid program without participating in the eligibility expansion. So that's a major change than we have included in our projections previously where we assumed all states would expand eligibility.

So what we would expect to see is a significant increase in the number of adults enrolled with a majority of those adults being newly eligible in Medicaid. In our past reports, we have estimated that about 80 percent of the adults enrolled would be newly eligible in 2014.

We would also expect to see some corresponding increase in the number of children enrolled, although to a smaller level. Mainly these would be children of people who are now enrolling in Medicaid, and as their parents gain coverage, they would gain coverage as well.

There's other changes related to the expansion that affect Medicaid, so to the extent that exchange policies may have something to do with how easy it is for people to sign up for Medicaid, to the extent that

other changes in the Affordable Care Act are changing people's behavior to seek out health insurance and avoid any penalties associated with the mandate, or to the extent that it's affect employers' decisions to offer coverage or to no longer offer coverage, that may certainly affect the number of people who are eligible for and seeking out Medicaid.

It's worth pointing out the vast majority of costs, again, for the expansion would be paid for by the federal government. And then I'd mention that the state decision to expand eligibility will be a major factor in 2014.

So there has been a fair amount of information that has been collected publicly about where states are in that decisionmaking process with a number of states having said either strongly that they plan to participate or having already started to take steps to expand eligibility in 2014. A number of states have had governors or legislators making statements that suggest that they're not ready to participate in 2014. And then, frankly, a number of states that haven't said anything that is definitive one way or the other. So where that finally falls will have a large bearing on how big that impact is in 2014, and I would expect there's a wide range at this point, although, you know, certainly within a year we will know much, much more as states will be making their decisions for 2014. That decision could be made then currently at any time, so we may see more states participating over time as well.

Beyond the Medicaid expansion, there's a number of other sections that affect Medicaid expenditures and enrollment. I just wanted to touch on a couple of key ones quickly.

Several are increasing costs, most notably the Community First Choice option; the addition of insurance and insurer fees which will also affect Medicaid; the primary care physician payment increase that starts in 2013; and the additional territory payments that will be made over the next several years as well.

On the other hand, decreasing costs to Medicaid are the additional prescription drug rebates that

started in 2010, cuts to the disproportionate share hospital allotments starting in 2014, and then a number of program integrity efforts focused on Medicaid and health care more widely, too.

The sum of those sections and others we expect will result in a net increase in Medicaid expenditures over the next ten years. But we would expect that the states would see a net savings due to several provisions where the federal government is either paying all of it or there is a transfer due to higher matching rates between the federal government and the states.

Just a few notes on some upcoming projections that may be of interest and helpful for looking at Medicaid. The 2012 Actuarial Report on the Financial Outlook for Medicaid should be coming out this month or shortly thereafter, but work is wrapping up quickly on that. Subsequently, we would also expect the President's fiscal year 2014 budget to come out this winter, which would include projections of Medicaid expenditures. And then the national health expenditure projections, which our office also does, will come out sometime in the summer of 2013, which will include Medicaid as well as the other payers and services in Medicaid.

So, in summary, we've seen a sharp slowdown in spending in 2012, which seems to have been driven especially by state decisions as well as slower enrollment growth in 2012. We would expect to see growth resuming more quickly after that with a sharp increase in 2014 with the beginning of the eligibility expansion. And then while other impacts of the Affordable Care Act are relatively smaller, we would still expect to see a net increase in Medicaid spending due to those provisions over the next several years.

CHAIR ROWLAND: Thank you very much.

COMMISSIONER HOYT: Sort of a follow-up to Andy Cohen's question, I guess, because there's such a huge reliance on the part of states, and the federal government, for that matter, in the approval and renewal of waivers on managed care contracting. So are you saying you don't have any reliable data or

opinions that you're forming about the impact on use of hospital or referral to physicians, use of the emergency room, cost trends? You're just not there?

MR. TRUFFER: We do have information on the overall trends in those programs, but something I think that would be as detailed as we would need to do to do a per enrollee expenditure comparison, how fast are spending and services growing amongst the fee-for-service population and the managed care population with then the specific data on the demographics and health status of those beneficiaries would be difficult to do, and I don't think we could do it necessarily with the data that we collect.

The encounter data, so claims data from those plans, is not collected or readily available at CMS.

COMMISSIONER HOYT: What's the source of the data now that you use behind all the things you just presented?

MR. TRUFFER: Sure. So we look at several sources of data that is collected by CMS. We rely on the CMS-64 or the financial management reports for the historical data of spending by state and by category of service of, which there are currently about 70 to 80 services that are reported there.

In addition, we have the Medicaid Statistical Information System, or MSIS, which provides data on spending not just by type of service but by type of enrollee as well as enrollment data within some demographic information behind that, and that's available in a few different formats.

There's also the Medicaid Analytic Extract, which is developed off of the MSIS data, which is, I think, more designed with researchers in mind to use that data.

From there we also would then rely on from sets of assumptions for the growth in the program, so we have population projections which come from the Social Security Administration, as well as assumptions that are given to us by exercise on the economic route. So, for example, when we work on the President's budget, we rely on the economic forecasts from OMB; whereas, for the Trustees' Report, those assumptions

are developed by the Medicare and Social Security Board of Trustees, and we rely on those for our Actuarial Report.

CHAIR ROWLAND: Thank you very much, Chris. I think this has been very helpful to giving us both insight into the black box of the actuarial world of HHS, but also to give us food for thought about some of the issues that we need to look at as we go forward to examine enrollment growth, Medicaid costs, and how to actually try and make some suggestions about other ways to moderate or reduce the rate of increase. So thank you for joining us, and I'm sure we'll hear more from you, and we look forward to the reports coming out, and we'll make sure we read them in their entirety.

MR. TRUFFER: Sure. Thank you. And we'd certainly be glad to talk again, whether it's formally or certainly informally, once the report is available and talk through those estimates, too.

CHAIR ROWLAND: Great.

MR. TRUFFER: Thank you.

CHAIR ROWLAND: Thank you very much.

Now we are going to turn to our examination of the Medicare and Medicaid dual-eligible population and some of the subpopulations within that. So Ellen O'Brien will come and join us at the table, and we're at now Tab 5 of your notebooks. And Ellen's slides I think are at the end of the chapter.

REVIEW OF DRAFT MARCH REPORT CHAPTER ON THE ROLES OF MEDICARE AND MEDICAID FOR DIVERSE DUAL-ELIGIBLE SUBPOPULATIONS

* DR. O'BRIEN: Yeah, I don't have the tab right in front of me here.

Well, thank you. I'm pleased to be here to discuss the draft chapter on dual eligibles, which we

have tentatively titled "The Roles of Medicare and Medicaid for Diverse Dual-Eligible Subpopulations." The chapter has -- hmm, that doesn't look too good. It doesn't at all look like that. I'll skip that one.

The chapter has five major sections, which hopefully you can read on the slide in front of you. I'd like to briefly review some of the major findings in the chapter and then invite your comments on how we can improve the chapter. It's pitched at a fairly conceptual level, so any ideas you have for bringing it down to earth would be much appreciated.

The chapter does not include any specific recommendations on policy for duals, but it does draw the broad policy conclusion that reforms need to be targeted to the problems faced by diverse dual-eligible subpopulations. The chapter seeks to illustrate the wide variation in the needs and circumstances of duals and draws the conclusion that different strategies and approaches will likely be needed to address these challenges across the population.

The chapter begins with a discussion of the role of Medicare and Medicaid for dual eligibles. It briefly describes how people with Medicare come into the Medicaid program, highlighting the different pathways, eligibility pathways through which poor and very low income people with Medicare come into Medicaid. The chapter also describes the benefits, very briefly describes the benefits covered by Medicare and Medicaid. These are often overlapping benefits. Medicaid obviously covers the full range of health care services, physician services, inpatient and outpatient hospital benefits, prescription drug benefits, nursing facility services, home health care benefits and the like. But for duals, Medicare is the primary health insurer, so Medicare is the primary payer for a covered service when the same service is covered under Medicaid, and Medicaid may pay for the service when Medicare benefits are exhausted or all Medicare coverage criteria are not met.

Medicaid, of course, then covers a wide range of services, most notably long-term services and

supports that are not covered by Medicare. These long-term services and supports include services in institutional settings and in home and community-based settings. In fact, the majority of Medicaid spending for dual eligibles, roughly 70 percent, is for long-term services and supports.

The chapter, after this kind of background description of benefits and eligibility, turns to an illustration of the wide diversity of the needs and circumstances of the dually eligible population and does that by describing the substantial variation in the service use and spending of dual eligibles across Medicare and Medicaid, focusing on four subgroups defined in terms of their use of Medicaid long-term services and supports. So that's the primary focus of the chapter. Most of the effort is there on description of the population and its diversity, and then the chapter turns in sort of a more abbreviated fashion to focus on policy implications of that diversity and includes a brief description of where there may be opportunities for program improvement across the dual-eligible population and describes some of the policy approaches that may improve care for duals.

So the goals of the chapter are shown here: one, to illustrate that heterogeneity of the population and then these other lower-level goals, to begin to identify needs for policy reform, to begin to identify approaches to reform that may improve quality for different subgroups, and to make the point that solutions need to be targeted to the problems of these distinct groups.

So these next several slides, seven slides or so, focus on this population heterogeneity, and then the final slide is on other goals of the chapter.

Since we started with a discussion of Medicaid eligibility pathways and benefits, the first look at population heterogeneity takes that Medicaid perspective. I blew by the distinction between partial-benefit duals and full-benefit duals that you're well familiar with, and tomorrow you'll hear from my colleagues on those Medicare savings programs pathways that the partial duals come in through. In this chapter, we

focus primarily on the full-benefit population, those who are eligible for the full range of Medicaid services. But just to show you -- and here the population of full-benefit duals is segmented by age, looking at the non-elderly duals compared to the elderly. But you can see that in both groups, the majority come in through an SSI pathway through the Supplemental Security Income program that provides income support to the elderly poor, very poor, and to non-elderly people with disabilities who are limited in their capacity for substantial work.

Most come in through SSI, but other Medicaid eligibility pathways include so-called poverty-related eligibility groups through which states can at their option provide Medicaid coverage to people with incomes above the SSI income eligibility threshold; medically needy pathways through which states at their option can extend coverage to people with excess income who have high medical or long-term costs; and a special income limit pathway through which states at their option can extend coverage to people who are in nursing homes or other institutional settings or are eligible for an institutional level of care but are receiving services in the community under waivers.

So we started with those, looking at the population, the heterogeneity of the population in terms of those eligibility pathways because those pathways are often related to the underlying health needs or supportive service needs of enrollees; that is, there are specific Medicaid eligibility pathways for people with extensive needs for health care services, the medically needy pathway or who have extensive needs for long-term services and supports, the special income limit pathway. And the result of that is what you see illustrated here.

So this chart focuses just on the Medicaid spending for those duals, but shows you that there's wide variation in the level of need as measured by the level of spending in Medicaid for duals. Here I tossed in the partial-benefit just so you can see for comparison those partial-benefit duals who are only eligible for

assistance with Medicare cost sharing and have really low spending in Medicaid. But even when you look at the SSI population, a lot of that group has relatively low spending in Medicaid and similarly for the poverty-related groups.

Taken as a whole, those groups account for most of dual-eligible enrollment in Medicaid; 74 percent of enrollees are in those relatively low cost or very low cost groups. But then a small number of higher-cost people who have extensive needs for services have very high spending, you know, approaching $30,000 and $40,000 annually.

VICE CHAIR SUNDWALL: Ellen, can I ask a question on that?

DR. O'BRIEN: Yes.

VICE CHAIR SUNDWALL: This is interesting because I think the average person would think that the duals would be poor or have disability insurance. And yet, as you already discussed in the previous slide, the medically needy and I'm assuming the special income limit, those are people above the poverty level?

DR. O'BRIEN: Yes, they can be people with incomes above the SSI financial eligibility threshold, so states can define that threshold for the medically needy, and for the special income limit they can go up three times the SSI benefit rate.

VICE CHAIR SUNDWALL: So they're generally very sick people, but who are not necessarily poor, or not as poor as a Medicaid beneficiary?

DR. O'BRIEN: They may not be poor. They may also be poor, but, yeah, they may not be poor. They may have incomes above the poverty level.

CHAIR ROWLAND: Where they're either spending down to --

DR. O'BRIEN: They're spending down, they're using those resources.

CHAIR ROWLAND: -- the eligibility level.

DR. O'BRIEN: Right.

CHAIR ROWLAND: Or in some cases, in a nursing home where they have --

VICE CHAIR SUNDWALL: See, I would have assumed they would be the minority of people in duals. In fact, they're the significant majority.

DR. O'BRIEN: They are the minority of the people. They are a relatively small share of the --

VICE CHAIR SUNDWALL: Okay. That's what I mean, this 26 percent --

DR. O'BRIEN: But they are a large share of the costs.

VICE CHAIR SUNDWALL: They're the big spenders.

DR. O'BRIEN: Yeah, and here I left out the chart that shows you, when you take these two facts together, the share of enrollment and the share of expenditures that shows that, you know, 26 percent of the enrollees account for -- I forget off the top of my head -- you know, two-thirds of the Medicaid expenditures for duals.

COMMISSIONER CHECKETT: That was actually what I was going to ask for, so if you can get that to us, maybe even tomorrow.

DR. O'BRIEN: Yeah.

COMMISSIONER CHECKETT: Because it would be so interesting because I think generally in the Medicaid community and larger, you hear people focusing on duals and saying, oh, my gosh, you know, they're -- what is it? -- 60 percent of the expenditures and 20 percent of the people. Or I don't have the numbers quite right, but it would be interesting to even drill that to the next level then, Ellen, and it sounds like you've done that to be able to say of that number of -- you know, relatively low number of Medicaid enrollees, then what percent of that is driving what percent of expenditures? Because I think it could really

help us and others focus where we need to be making policy recommendations.

DR. O'BRIEN: Right.

COMMISSIONER CHECKETT: So it sounds like you were there, you just --

DR. O'BRIEN: No, it is there --

COMMISSIONER CHECKETT: -- didn't put it in the --

DR. O'BRIEN: It's Figure 6 in your paper.

COMMISSIONER CHECKETT: Got it.

DR. O'BRIEN: So, for example, it shows that those partial-benefit duals are 18 percent of the dual-eligible population, but less than a percent of Medicaid spending on duals, and then, you know, 18 percent of the special income -- 18 percent of the population is enrolled in that special income limit, but they account for 42 percent of Medicaid expenditures on duals.

COMMISSIONER CHECKETT: That's really terrific. Thank you.

COMMISSIONER HENNING: But isn't it also true that the partial-benefit people, they may not have a lot of Medicaid expenditures, but they may be a lot of expenditures under the Medicare program?

COMMISSIONER CHECKETT: Yep, right, right.

DR. O'BRIEN: I stuck with these first couple of slides just with the Medicaid expenditures.

COMMISSIONER HENNING: Okay.

DR. O'BRIEN: To hammer home that point.

COMMISSIONER HENNING: So they could still be costly people, just paid by different --

DR. O'BRIEN: That's true. Right.

COMMISSIONER CHECKETT: Right. Good point.

DR. O'BRIEN: Okay. So then we look at population heterogeneity through another lens

focusing on duals' use of long-term services and supports. Why focus on long-term services and supports? For the reason I mentioned earlier, that most Medicaid spending for duals is on those services, so here showing the total expenditure on duals.

So how did we do that? We defined four dual-eligible subpopulations. Again, we focused on people who were enrolled in Medicare and Medicaid for the full year just to simplify the comparison of the average expenditures across those groups. So we took out the part-year people. So here we look at all-year full-benefit duals, so taking out those partials, and see that 21 percent were receiving -- received at some point during the year services financed by Medicaid in an institution, a nursing facility, an intermediate care facility, or another institutional setting.

Ten percent of full-benefit duals received some services under an HCBS waiver. I should point out the institutional service group may have received services under waiver at some point during the year, may have received state plan services, but we defined this in kind of a hierarchical way.

Next comes the HCBS waiver group. These are people who did not receive any institutional services during the year but received waiver services and may have received state plan services. And then a third group, people who used only state plan home and community-based services in Medicaid, so did not receive any waiver services or any institutional services under Medicaid.

So what you see is that 40 percent of the all-year, full-benefit, dual-eligible population used some Medicaid long-term services and supports, but only 40 percent of the dual-eligible population received those services; 60 percent received none.

We're limited in this analysis because we are only looking at whether the person received the services, had claims paid by Medicaid. We don't have information at this point right now on whether they had limitations in their activities of daily living, had disabilities that may have caused a need for services that

may have not been met by the Medicaid program, or that may have been met by other programs, other aging programs, state-funded programs or other federal programs.

Okay. So those are our four subgroups, and then again here looking at the range of needs across these groups, the dark-blue segments are the Medicaid segment. So here we're adding in the Medicare expenditure and showing you that, again, there is a wide range of needs. That wide range on the Medicaid side is clear. Those blue segments vary in height. They range from just $3,000 for people who are not using any Medicaid-financed long-term services and supports to nearly $45,000 for the people using institutional services.

I'm seeing here that there's a typo on the total enrollees. That number should not say 6.9 million. It should say more like 5.6.

So you see wide variation in the Medicaid spending, wide variation in the total spending, but maybe less variation in the Medicare spending. So who was asking about the non-LTSS users who have relatively low spending in Medicaid but have, you know, $12,000 average annual spending in Medicare.

So the point is that the needs vary widely across the -- and the roles of Medicare and Medicaid vary across these groups. The picture you typically see is the one on the far left. It's kind of 50-50, Medicare-Medicaid. But one of our points is, well, Medicaid's role for those high-need, long-term services and supports users is much greater, accounting for nearly two-thirds of the total expenditures.

COMMISSIONER COHEN: So are these costs all based on fee-for-service data? I guess I'm just wondering is there any -- I mean, I'm only asking, is it like a lot of community duals who aren't using long-term care might be in Medicare Advantage and their costs --

DR. O'BRIEN: I don't have my friend April Grady up here today, much to my great chagrin, but those costs are in there. She is not here. Yes, the managed care expenditures are in there. And then she

would make some more sophisticated points about how we couldn't break out type of service across Medicare and Medicaid for those people enrolled in a managed care plan. But they are built in to the total --

COMMISSIONER COHEN: We do feel like the costs kind of reflect utilization. They do reflect utilization, maybe not perfectly, but --

DR. O'BRIEN: Right.

Okay. So substantial variation. Then, you know, just to drive home the point, we looked at utilization rates for services here, because the chart would get too complicated, I just pulled out two of our subgroups, but you get better information here saying what kinds of services do people within these various subgroups use. So, for example, looking at those people using non-waiver or state plan home and community-based services, a big chunk, 76 percent, were using state plan personal care. Some, 12 percent, were using state plan adult day services. These services listed on the vertical axis, nursing facility, that could include Medicare skilled nursing facility services. Obviously, the state plan, those are both Medicaid services, home health could include Medicare- and Medicaid-financed home health. But here you get a sense of the kinds of services that people are using. High rates of use of DME even among that population that's not using any Medicaid-financed long-term services and supports. And then you see the rates of inpatient utilization and such. So this is just a -- sorry, go ahead.

COMMISSIONER GABOW: Do you know what the mortality rate per year is in this group? I was surprised that the use of hospice was so low. And in sort of the same vein, do you know what percent of the inpatient hospitalizations were terminal admissions?

DR. O'BRIEN: We know how many of these people died during the year, 5 percent April is saying, across the whole population. I don't know that we know that across the subgroups. But

obviously these groups include younger people with disabilities and older people. So we could show the age distributions, but we didn't really do that across our four groups.

And we don't know a lot of interesting stuff about these people, like I said, about mortality rates, about disability rates, about their health status, severity of illness. So those are all really nice things we'd like to be able to add to our picture in the future.

COMMISSIONER CHECKETT: Could I just interject? You know, hospice, one of the reasons it's such a low use is because you have to declare you have six months to live in order to be eligible for the Medicare hospice benefit, and usually state Medicaid programs copy that. So there's in general very low usage of it because people are reluctant to do that for a whole host of reasons. So I suspect that's why that's there. There's a lot of interesting work on hospice and why it's so low in general, and that kind of thematically seems to be one of the things that you see.

COMMISSIONER HENNING: It sounds like a potential recommendation [off microphone].

CHAIR ROWLAND: You don't have to die in the six months. You just have to think you're going to.

COMMISSIONER CHECKETT: Or you keep -- my father re-upped, I'm here to tell you. It was a great story. So, anyway, an aside, although it would be an interesting thing to look at at some point.

DR. O'BRIEN: For the institutional users, the institutional subgroup, the hospice use rate was 11 percent. So it goes up in the way you'd think, but maybe not as high as you would have. And this is, of course, use during a single calendar year.

Okay. So then we also point out that even within these groups, there is significant variation. Here just looking at HCBS waiver users, that second group, substantial variation in the types of services that are being used by these people, for people under age 65, much more likely to be receiving some assistance

with their housing costs through HCBS residential, more likely to be using adult day, much more likely to be using targeted case management services under Medicaid, much more likely to use dental services, and Medicaid psychiatric services, so all of these things suggesting different implications for how service delivery could be reformed -- adding to our point that this is complicated. Duals are not a homogeneous group, but there are lots of different subpopulations with widely varying levels of needs and kinds of needs. So that's our population description.

Then we move from there to identifying some needs -- or a discussion of needs for policy reform across these groups. The next section looks at some briefly, looks at indicators of the need for program improvement for dual eligibles, for example, relatively high rates of potentially avoidable hospitalizations among duals, especially the elderly in nursing homes are said to reflect the need for enhanced primary care in nursing homes, though these potentially avoidable hospitalizations are caused by conditions such as urinary tract infections, heart failure, and respiratory infections that can in many cases, though no all, be prevented or treated outside of the hospital.

Another indicator of the need for reform for duals is the fact that some frail and disabled people end up as long-term nursing home residents when nursing home use could have been avoided with better community care. Sometimes these stays, long-term nursing home stays, begin with an admission to a skilled nursing facility upon hospital discharge, and for duals it's sometimes suggested that better care management at these post acute transitions can potentially shorten these stays and assure discharge to the community. But better coordination between Medicare and Medicaid may be needed.

The chapter also discusses some more general problems of -- general evidence of consequences of inadequate care for people with serious physical disabilities and chronic conditions, physicians like Bob Master, the CEO of the Massachusetts Community Care Alliance, a managed care plan that seeks to provide

fully integrated disability care for duals and for the Medicaid-only population in Massachusetts, points out that better care is needed to address the well-known but avoidable consequences of serious disability and chronic illness. He points to examples such as the risk that people with severe disabilities face of developing sores that can invade the bone, leading to the need for surgical intervention, an outcome that may be avoidable with the right access to appropriate DME and therapies, services that too often are not provided in a timely fashion.

Dr. Master also points to the serious cardiac complications that may develop among some people with biologically based mental illness, perhaps due to the kinds of prescription drug regimens that they're on, and notes that high and increasing rates of early mortality among this subpopulation suggests the need for program improvements.

The discussion in the chapter of these issues is, again, fairly cursory, and the discussion in the chapter I think can be deepened in future work to better identify the specific problems faced by subgroups we've identified to further refine these by focusing on additional factors that we have not included in our subgroup analysis, including age and types of chronic conditions and disabilities.

The chapter also includes a discussion of approaches to policy reform that may improve care and services for dual eligibles. I think what we found is that there's not a lot of research on the problems that these diverse groups face, but there is somewhat more that look at the effects of various kinds of interventions targeted to duals. So the approaches to reform that may improve quality for subgroups can include broad-based reforms in Medicare and Medicaid, such as efforts to broaden and improve the coverage that each program provides. These might not be reforms targeted to duals, but that may improve access to services needed by people who are frail or disabled and who have complex needs.

The chapter also notes that reforms could be targeted to duals, and those include fully integrated,

financially integrated models like PACE, the Program of All-Inclusive Care for the Elderly, and the various duals demonstration programs that have gone on in a number of states, including Massachusetts Senior Care Options and the Minnesota Senior Health Options. So the chapter includes a list of the kinds of interventions that have been tried and provides some early evidence on the impacts of those reforms on duals. So we note that in some of these programs, PACE and the SCO program, there is some evidence of reduced or delayed nursing home admission, some evidence of reduced rates of hospitalization. Similarly, a program, EverCare, targeted to people who are in the nursing home has shown evidence of reduced rehospitalization, improved quality of care for the frail elderly.

We also point to the fact that in states where duals have better access to Medicaid-financed home and community-based services, that there's some evidence of lower rates of potentially avoidable hospitalizations. So although this chapter doesn't look at variation across states and how they structure their benefits, there's some evidence that doing better on the HCBS side could improve the quality of care for duals.

Similarly, we point to some care coordination models that have been tested in Medicare that have produced improvements in the quality of care for duals.

So the chapter concludes by noting that more needs to be learned about the challenges faced by different subgroups of duals, but that we really need to better understand which approaches, broad-based approaches, in Medicare and Medicaid or targeted approaches to duals can reliably improve the care for these distinct subgroups and better information on the cost of those alternative approaches.

So we'd like to know if this succeeds in meeting its goals.

CHAIR ROWLAND: So this chapter in essence I think does begin to meet our desire for more information on how the different subgroups compare, and that's the goal of trying to look at the

heterogeneous population.

Judy has a comment.

COMMISSIONER MOORE: You know, I have been dealing with the duals in a general sense as opposed to this kind of a deep dive for a long, long time, and the thing that strikes me most about this, as somebody who has sort of thought I had a general good grasp on it, is how incredibly complex it is and how complex it is to follow. And it seems to me that it would be easier for the reader to absorb and understand all that we have presented in this very thorough chapter by reversing it and sort of starting with the goals, maybe, or in any event making -- having some of the policy findings around the fact that the most studied groups of duals have received the least amount of real attention in terms of the quality of the services and the number of the services and the cost of the services. And maybe that's just me, but I think the readers are going to need a little more hand holding than is here now in terms of what we are trying to say and what we are trying to do and what it means and what it means in the context of actions that people could take and research that should be undertaken and that sort of thing.

VICE CHAIR SUNDWALL: Thank you, Ellen. It's really good, and a lot of information, and like Judy says, very complicated, but it helps bring some understanding to the different categories.

I'm just going to challenge us as a Commission -- and maybe you, Ellen -- to see if we can't get some recommendations out of this. I've been hearing about the duals since we started, and it's been of high priority to the Hill. And when I come read this and hear, well, this is our goal but we need to know more, we need to know more about this and this and that and that, isn't there something we can agree upon now that would be useful to the Hill, for example, a recommendation on expanding the PACE program that we've all heard are successful, or limited ones? But I'm just asking. I'm not sure what the recommendations ought to be. But I would hope by now we might be able to come up with something,

and we've now begun to outline the research agenda.

COMMISSIONER GABOW: Well, I have a recommendation that we should consider. In my goal to always go toward simplification -- and we talked about this before, I think. But when you look at the partial duals who are partial only to subsidized premium payment, it still eludes me why we would choose to deal with poor people who can't afford the premium in Medicare by making them join Medicaid to get that premium subsidy.

And when you look at the dollar amounts that you present here that are being expended for those partial duals to do it, it seems like -- you know, I think you said it's 0.1 percent of the Medicaid spend -- that to think about at least putting out there the why don't we have a sliding fee scale for premiums and co-payments for the Medicare services that follows the trend? You know, if you're richer, you're paying a higher premium for your Medicare. So if you're poorer, why not have it be zero rather than have you enroll in Medicaid to get your premium pay?

Now, if you need other services, you know, and you become a full Medicaid person who's also getting payment, that's a different kettle of fish. But for this small group, for this small amount of money, it seems like it would be better for the patients. And either in this chapter or one of the others, it points out that very few of the people who are eligible for the premium subsidy actually do it because it's so complicated, or they don't even know that it exists. So that would be another reason.

And I think when you look at what's presented in Box 2 of the spending that is occurring, it's very, very small. And it seems like there would be some way to, if there's somebody who's losing money in this, the state of the feds, that since it's such a small amount, there would be a way to offset it through something else. We're not talking about huge amounts of money.

VICE CHAIR SUNDWALL: I would just second that. I was just in Texas last week talking to a

Medicaid legislative committee, and that issue came up. And they would very much favor not having to do the Medicaid subsidy of a co-pay for Medicare. That would be something that we can address, I should hope.

COMMISSIONER GABOW: I mean maybe there's some glitch in this that I'm not understanding. That certainly could be true.

CHAIR ROWLAND: Well, the historical glitch was that Medicare did not do any means testing or income relating. But then, obviously, with the introduction of Part D, Medicare has moved into that. And so it is an issue that could be reexamined. Previously, Medicaid was the place in which income determinations were done, not Medicare.

COMMISSIONER GABOW: But even outside of Part D, your premium for the other components in Medicare go up if you have a higher income. So it has already, in some sense, entered that terrain. I'm sure there was a reason, but is there some barrier to --

CHAIR ROWLAND: There's no barrier to our examining it. And there's no barrier to our suggesting that MedPAC take a look at this. But our statutory authority says we can recommend changes in Medicaid, not in Medicare. But we can refer those to MedPAC, just as MedPAC can't make changes -- so it's a very good issue and perhaps we can entertain, with MedPAC, talking about that.

VICE CHAIR SUNDWALL: Why don't we just recommend Medicaid stop paying it. Then Medicare will have to.

[Laughter.]

DR. O'BRIEN: And just in case I caused a confusion here, that 421 annual expenditure is just for services cost-sharing. It doesn't include the premiums in that case.

COMMISSIONER GABOW: No, but there's someplace else where I think you have due

premium -- maybe I missed it. But it's in the aggregate --

CHAIR ROWLAND: Well, let's have a specific little issue paper come back to us just about the partial duals and the different partial dual groups for our February meeting.

DR. O'BRIEN: I think we have one coming up tomorrow.

CHAIR ROWLAND: Tomorrow we're talking about cost-sharing.

Mark?

COMMISSIONER HOYT: This is a complicated topic. Good job with the chapter.

If I pull back a little bit and just look at this at a higher level, you now have a group that's fast approaching 10 million people. You spend a huge amount of money in the aggregate. Not the largest amount of money per person of the different Medicaid groups we look at.

And we write reports for our servant audience that's intensely concerned with the expenditure on Federal entitlements and how to control costs. It seems to me that the way the benefits are delivered now, that design might be an inefficient as you could possibly make it.

This might be half crazy but it seems to me like a natural recommendation would be to take all the money, all the responsibility, and give it all to Medicaid -- states would probably flinch at that, depending on the details -- give it all to Medicare, or set up a third agency and eliminate all of this confusion and the dividing lines and the fighting between the two agencies about the savings and who's doing what and who's responsible for this.

So that's kind of a draft recommendation, for whatever it's worth.

I think any normal person reading this would go -- I mean, we're all just like way too deep in the weeds sometimes. So we just keep reading this like oh, it's totally normal. Yeah, duals are always done this way.

Why do we have to keep doing this? Honestly.

CHAIR ROWLAND: Andy?

COMMISSIONER COHEN: Great job and I thank you so much for illuminating this fact that dual eligibles are -- like in a very concrete way that dual eligibles are -- I mean, the only thing that they have in common with each other is that they are both in two programs and that's about it. Otherwise, they're just a really diverse group.

I agree with what Mark is saying, although I'm not quite sure I'm ready in the recommendation yet, but the sort of big picture.

I just wanted to fly a couple of thoughts.

One is when it comes to potential solutions, you know, I just feel like I read this before: it is always a list of programs that do some form of coordinated care, whether it's an integrated plan or something like that, PACE and everything. And every time it says there's some evidence it saves money and improves quality, but we're not really sure. And then we move on to the next one.

And I feel like it's a lot of space devoted to a description with no plan forward to figure out if any of them are sort of scalable, useful, actual policy solutions.

And it's a little bit limited just to look at sort of models of plans or coordinated care. I think that one thing that I always really focus on -- perhaps it shows my lawyer bias. But the real reason that duals are a category is because they are subject to rules of two different programs that aren't very well aligned. Like that's actually the thing that sort of pulls them together.

And I do wish we could do a deeper dive on what are those regulatory issues that particularly relate to maybe increasing cost and reducing quality of care.

So one leaps out at me -- I think I've said this before, too -- but on this potentially avoidable

hospitalizations that there's so much perhaps primary care that's not provided in nursing homes. Well, I hear it again and again, anecdotally only, but there are potentially regulatory and payment reasons for that.

That sort of goes to Medicare's rules for what kind of nursing home stays they will pay for and bed hold policies in states. And I just thing can't we just do a deeper dive on some of those? I mean, it comes up and again and again and again and again, and can't we just do a deeper dive on what those policies really are?

I know there's been change in this arena in recent years but let's take a real look at that.

And just sort of other issues like that that go just beyond PACE and D-SNP's. And those may be wonderful solutions but we seem to get a little bit stuck at saying they might be, they might not be, we don't really trust whatever evaluations that have been done to really go forward in a big way.

So that's sort of one constellation of comments or suggestions, some of which maybe could be addressed in this chapter and some of which may need to go to our plan forward.

And I had one other thought, and it's escaping me. So I'll stop there.

CHAIR ROWLAND: And Trish, who couldn't be with us today, has asked that we also take a deeper dive on what the potential impact is of the change as a result of a lawsuit in Medicare's home health provision for not having to show progress. And so I think that is one where we want to take a look at the implications of that, as well.

COMMISSIONER COHEN: And I'm sorry, I did remember my other one, if that's okay. It's not a new question, just another suggestion on -- I think it would be helpful to put a little bit more in the chapter about what CMS is currently doing with the dual demonstrations and talk about how those do or do not share the characteristics of some of these programs that might or might not be good ones for skill. But just to really connect up the dots. What are the policy changes that are currently in action? And how

do they relate to some of these proposals that we have sort of seen again and again, maybe models, maybe not.

CHAIR ROWLAND: Also, the nursing home readmission projects, as well as the broader dual.

Thank you, Ellen. I think you've done a great job of laying out the diversity we wanted to see in the population. Clearly, we want to figure out how to go forward beyond this with some improvements in how to deliver these services and look at the cost. But I think you've got a lot of suggestions for where we might go from very focused on the savings population, those who come on to Medicaid mostly because of premiums and cost sharing -- which I know we're going to get into more this afternoon -- as well as to the broadest scale thing of telling Medicare to take care of lots of people.

VICE CHAIR SUNDWALL: Diane, I would like to just suggest that in February we have some draft recommendations to consider. We may not be prepared to vote on them, but I'd sure like to see a list of things we might consider as recommendations for the MACPAC on this report.

CHAIR ROWLAND: Patty?

COMMISSIONER GABOW: To Judy's point, I did. I assume, and I just want to verify it, that in all of the chapters the beginning will have the key points, so that people don't have to read through everything to get to the bottom line. Is that true?

CHAIR ROWLAND: True.

COMMISSIONER GABOW: And I think for this chapter, how this chapter deals with Jim's chapter later on, so that it doesn't overlap but flow from one to the other in some way, is going to be important, I think.

CHAIR ROWLAND: Right, and I also think that how these two chapters fit together for March may be a prelude to what we want to do further in the June report. So we may want to do this as a

two-step process rather than trying to step on both issues at the March meeting.

But thank you, Ellen.

And now we will take a brief break and reconvene at three o'clock.

[Recess.]

CHAIR ROWLAND: Okay, if we could please reconvene. We're going to move on in this session to return to the issues related to access to care for enrollees in the Medicaid program with disabilities, and so we're going to ask Anna Sommers to do a literature review of what she's been able to learn about their access today and about some of the challenges that we need to address in the future.

Anna.

ACCESS TO CARE FOR MEDICAID ENROLLEES WITH DISABILITIES: LITERATURE REVIEW

* DR. SOMMERS: Thank you. The purpose of this session is to report to you our assessment of the literature about access to care for Medicaid enrollees with disabilities. Please refer to Tab 6 for additional materials on the review.

In prior work, the Commission's March 2012 Report to Congress examined the characteristics and spending patterns of persons with disabilities enrolled in Medicaid. And at the November 2012 meeting, a panel of invited speakers provided beneficiaries', State, and provider perspectives on the challenges and opportunities under the current delivery system to serving persons with disabilities. Themes emerged around integration of government programs and agencies, development of quality measures, more rigorous network adequacy requirements, and identifying best practices. We now begin to take a closer look at access.

I'm just throwing this up here briefly to remind you the Commission's framework for monitoring

access. This prevents the elements essential to consider when examining access. Enrollees, of course, their unique characteristics and health needs. Provider availability and service utilization. The Commission further acknowledges in this framework the importance of appropriateness of services and settings, efficiency, economy, and quality of care, and health outcomes.

For this review, we focused on adults under age 65 who are not enrolled in Medicare and who are not institutionalized. I'll first give a brief overview of the health needs of this population, discuss the access issues that have been raised in the literature, discuss studies of program interventions, and then identify major gaps in the research.

As you know, people with disabilities are a heterogeneous group with a wide range of health care needs, disability attributes, and sources of support. In Medicaid, they include persons with physical, intellectual, developmental, behavioral, or mental conditions. In addition to these challenges, they are more likely to face socio-economic disadvantage compared to people without disabilities in Medicaid.

They have unique health and medical needs due to the disabling condition and other secondary conditions. As examples, people with mobility impairments have a high risk of osteoporosis. People with intellectual disabilities can manifest common illnesses differently than other individuals. So provider training on disability-specific issues is important for providing quality care.

They also have the same needs for preventive services as the non-disabled, such as cancer screenings and family planning. In addition, preventing functional decline is a vitally important aspect of wellness for people with disabilities.

Studies of adults with disabilities in Medicaid have identified these major access concerns. Transportation. Through in-depth interviews and focus groups, people with disabilities in Medicaid commonly report transportation as a major barrier to accessing care. They describe unreliable transport

services, and in rural areas, very long distances to see doctors.

Primary care. Studies also raise concerns about receiving appropriate and timely primary care. These include difficulty finding a doctor who accepts Medicaid, difficulty getting an appointment, and finding a doctor who understands their disability. People with disabilities also have described a lack of communication aids and poor communication process as barriers. A small number of studies report low use of primary care by certain sub-populations enrolled in a waiver program or a single State. On the other hand, national studies report that, overall, enrollees with disabilities are more likely to have a usual source of care than the non-disabled, an apparent contradiction to concerns about provider availability that warrants further inquiry.

Accessibility of health care facilities generally is identified as a barrier pertaining to all kinds of providers. This includes physical access to medical facilities, exam rooms too small to accommodate a wheelchair, exam tables and diagnostic equipment that are not height adjustable, lack of certified interpreters, and phone systems that do not accommodate the use of TTY services for the deaf.

Clinical competence of physicians. People with disabilities report that finding a doctor who understands their disability is a barrier to obtaining appropriate care. Experts and stakeholders point out that physicians are not trained in medical schools to provide competent care for people with disabilities. This refers to training on basic procedures, such as how to safely transfer a medically fragile patient to an exam table and disability-specific clinical training. As an example, a 2004 survey of primary care physicians in Connecticut found that 91 percent of physicians treating adults with intellectual disabilities had no formal training in regard to the care of this population.

Studies have also reported disproportionately low use of preventive services, such as cancer screenings for women, outpatient mental health visits, post-discharge physician visits after a hospital stay,

and poor access to dental care.

Scope of benefits in Medicaid is another barrier reported. Stakeholders have recommended that scope of Medicaid coverage be reassessed for mobility aids and assistive devices, physical and occupational therapy to maintain function, vision rehabilitation for people who are blind or have vision impairments, and dental services.

In our assessment, there are important limitations in this area of the literature. First, research provides little information about the magnitude and scope of specific access issues that have been described. Virtually all of the research on barriers to care experienced by enrollees with disabilities is drawn from in-depth interviews or focus groups with people with disabilities or other stakeholders. The strength of this literature is that it does give us a very good picture of how people experience these barriers. The limitation is that we know little about the prevalence of access problems or the distribution of them in the population, providing us with no baseline data to track improvements.

Access to care in the MACPAC framework places value on the appropriateness of care and efficiency of care delivery, and studies related to access are mostly silent on the link between access and appropriateness of care and cost-effective care.

While a number of studies compare service use between Medicaid enrollees with and without disabilities, evidence of low service use for cancer screenings, preventive care, and outpatient mental health care is often based on a single State, locale, or program for a specific sub-population. We found a total of 14 studies like this. We did not find comparisons across States or over time in a single State.

In addition, the most recent data on some topics is over ten years old. As an example, we found only one study that looked at the adequacy of prenatal care for pregnant women with disabilities in Medicaid. This study used data from 1995 and 1997 from four States.

We identified six national studies that analyzed at least one access measure for people with disabilities in Medicaid. Together, these report high rates of unmet need for medical and dental care, postponed care, and skipped medication doses, and one found a low rate of physician follow-up after hospital discharge. The limitation of these data sources is that they do not provide sufficient depth to serve as policy guidance, and sample sizes are too small to compare people by disability attribute, demonstrated in other studies to be an important source of variation.

We also searched for studies that directly assess the effectiveness of program interventions as they relate to persons with disabilities in Medicaid. Virtually no studies assess the relationship between State program features or policies and access, and it is rare to find multi-State comparisons on access or service use for the disabled.

The few studies to date on the impact of Medicaid managed care on people with disabilities draw conflicting conclusions and do not help explain or test how plan behavior affects access. A few plan and provider programs do show promise, but a greater number would need to be studied and findings synthesized to extract policy lessons. Interventions showing promise include case management, seeing the same doctor, comprehensive primary care, integrated services, and co-location of services.

Our review of the literature finds major gaps in research, and thus, our knowledge about access for people with disabilities. As mentioned earlier, many topics using very old data have not been updated. Some areas of research still unaddressed and that policy makers would be interested in include multi-State comparisons on key measures, including studies comparing access in sub-populations, such as people with serious mental illness, across States. Quantitative studies of service areas other than primary and preventive care, particularly specialty care, rehabilitation therapy, habilitation therapy, and durable medical equipment.

Finally, development of a framework for measuring medical facility accessibility and program accessibility and support services, such as the availability of communication aids for persons with sensory impairments, is another area that needs research.

Comprehensive evaluation of new Statewide programs would be informative to policy makers, especially for approaches that are rapidly proliferating, such as health home initiatives, telemedicine, and integration of mental and physical health services. To be helpful, these evaluations would include data measurement and outcomes specific to persons with disabilities enrolled in Medicaid and reflecting needs important to these individuals, and, furthermore, provide comparisons between persons with different disability attributes.

That concludes a brief overview of the literature. Our next step will be to draft a chapter on this topic for the June report to Congress, and in ongoing work related to high-needs subgroups, we're conducting a data analysis of access to care using the National Health Interview Survey that will include comparisons of disabled and non-disabled adults and children in Medicaid. And we're also tracking the development of new access and quality metrics that are designed specifically for disabled populations.

So, today, we are looking for additional guidance on the Commission's priorities related to people with disabilities and access. Are there analytic questions that should take priority in further work? What are the Commission's priority policy areas for examining access and appropriate use among people with disabilities? And then with respect to the access framework we rely upon, are there ways it could be tailored to better reflect important factors relevant to access for persons with disabilities? Thank you.

CHAIR ROWLAND: It appears from your review that the literature is old and scant.

DR. SOMMERS: Spotty, yeah.

CHAIR ROWLAND: And that one question is what we can do to contribute to the research, but

also what we could recommend that others should be doing so that for this very vulnerable population, we have a much sounder base on which to have policies developed.

But I'll take other questions. Mark, Denise, and then Judy.

COMMISSIONER HOYT: Thanks, Anna, for your presentation. How old were the managed care studies that you said had the mixed results?

DR. SOMMERS: They varied. One of them is recent, 2009.

COMMISSIONER HOYT: I just wondered, if they weren't recent, then maybe we could get something that's more current, but also the mixed results. Are there lessons learned in there that we could cull out? Going back to something I had mentioned in a different presentation, there's such an increased reliance on the part of States, especially the last few years, of managed care contracting to perhaps address some of the concerns you had earlier in the slides relative to disabled people, I wondered, is that working, or what worked in this State and why didn't it work over here --

DR. SOMMERS: Yeah, the national studies can't really inform that. What would be helpful is for a State to do a multi-plan comparison, so look at the outcomes and process for various health plans that they contract with and see what kind of variation is and report on it. I think that kind of activity is done at the State level, but it's not readily available.

CHAIR ROWLAND: Denise.

COMMISSIONER HENNING: I'm sorry that Sara is gone because she probably has the answer to this question, but it just strikes me as odd that part of the access issue for a disabled person is the lack of exam tables that raise and lower in height. I mean, you have to have ramps that go up to your medical office, so why isn't that a requirement of care also?

DR. SOMMERS: It is a requirement.

COMMISSIONER HENNING: Okay.

DR. SOMMERS: So there are two statutes that govern accessibility of facilities for people with disabilities. So there is the Section 504 of the Rehabilitation Act of 1973 that prohibits programs that receive Federal financial assistance as well as federally conducted programs and activities from discriminating against individuals with disabilities. And then there's Titles II and III of the Americans with Disabilities Act of 1990 that prohibits disability discrimination and requires health care providers to be physically and programmatically accessible to people with disabilities.

According to the National Council on Disability, who assessed this matter in 2009 in a report, they say that the ADA has had limited impact on how health care is delivered for people with disabilities. There continue to be significant architectural and programmatic accessibility barriers that still remain. And health care providers continue to lack awareness about steps that they are required to take to ensure that patients with disabilities have access to appropriate, culturally competent care.

COMMISSIONER HENNING: That answers that.

COMMISSIONER MOORE: Well, then, speaking personally, my mother, who was in a wheelchair and could not move at all, I'm just sitting here thinking of five providers' offices, and in one case a hospital, that had no table that moves up and down. She was examined sitting down in her wheelchair. That was not what I was going to say, however.

I wondered if you would comment on the status of the Health Interview Survey work and when -- how much we might get out of that and whether it would be coming soon.

DR. SOMMERS: Yeah. They are making improvements, the National Center on Health Statistics that sponsors that survey. To date, there is still no consensus on a standard definition for disability to be used in surveys. They are measuring disability and functional limitations, use of assistive

devices, special equipment, in the National Health Interview Survey. So it is possible now to look at that. They also have significantly expanded the number of measures no access to care in the NHIS that we're already seeing in the 2011 data, and so that is one area that I mentioned where we'll be doing some comparative analysis on a national level.

Now, the NHIS has capacity to do some State-level estimates in that area. We're right now trying to determine how many States we can do that for. But it's going to be a small number. There isn't sufficient sample size when you get down to subgroups like that to really get good, reliable State estimates for a large number of States.

COMMISSIONER MOORE: And I'm assuming this is not going to be ready in the next month or two for us, our review of their existing data or things that they may be doing for us or others at the State level.

DR. SOMMERS: Right. So kind of in tandem to this work, we've been compiling information about data development efforts around this, so that's ongoing work right now. The analysis of NHIS data will be published in the June report.

COMMISSIONER MOORE: Oh, okay. All right. I guess the only other thing, if I can say one more thing, it seems to me that we should think through, possibly based on the NHIS data that we are analyzing now or the literature review and that, what seems to be appropriate for us and what other institutions there are that would be interested and could do this sort of thing and almost develop a research agenda and pick off the pieces that make sense for us to do. And then, after we finish with adults, we ought to move on to kids.

COMMISSIONER CHECKETT: Well, very interesting and not surprising, but I would also say, disappointing when you think how great this issue is and the impact it has on our country. I guess I had a

couple of thoughts in terms of what we might want to think about, and what Judy's saying, is I think the Commission might, as a first place for us to start, is to really tease out, well, what are our priorities? You know, Mike, my initial reaction is, okay, my priorities would be what can we find out about access to primary care for people with disabilities? Why? Because people who have disabilities, when they're really sick and they get into the hospital, generally, the hospital can figure out how to take care of them, but not in all of those steps beforehand. So that's one area. But, obviously, we would want to think that through.

So in terms of priorities -- from my reaction, we need to think about where should we work first, and, I think, also just recognizing that the States aren't in any type of position to be doing this analysis themselves, and so I think we need to also think about, given that I think we've identified a really great need and an area where the Commission could be meaningful, you know, who do we go to and how do we go about raising this as an issue for others to research. The States won't do it, don't have the capability, but it's certainly important. So just some thoughts.

CHAIR ROWLAND: Thank you, Anna. One more --

COMMISSIONER MOORE: Before you leave, Anna, the one other thing I think would be really useful, if you can identify models that -- and in particular, States -- I think that is a role that we could play, is to identify and highlight at some point --

DR. SOMMERS: Yeah, sure. And there have been some organizations that have done some work on that and with some evaluation work. But I think where it's lean is how that informs policy action, particularly with underlying financing mechanisms that might need to be changed and that kind of thing. So we could do -- we could look at models from those angles.

CHAIR ROWLAND: Thank you again, Anna, and Jim.

So we're going to shift briefly now from our disability discussion to going to a payment issue, and

we've asked Jim to really brief us on Medicaid payments to disproportionate share hospitals. There's been a lot of interest among the Commission members in the safety net and in the financing of the safety net and this begins our discussion of that. And that is at now Tab 7 of your book.

OVERVIEW OF MEDICAID PAYMENTS TO DISPROPORTIONATE SHARE HOSPITALS

* MR. TEISL: Thank you. So as Diane indicated, this topic is intended to inform the Commission regarding the Medicaid disproportionate share hospital payments, especially in preparation for reductions that were enacted through the Affordable Care Act and that are scheduled to begin in fiscal year 2014. The Secretary of Health and Human Services is expected to issue a rule. They've indicated the proposed rule will come out in early 2013 and will implement the DSH reductions. So we want to provide the overview now and start to get a sense for the Commission's thoughts on the issues that might be important should you decide to comment on the proposed rule when it's released.

A little bit of background. So DSH payments are statutorily required payments to hospitals serving low-income patient populations. They're intended to improve the financial stability of safety net hospitals and to preserve access to care for low-income patients. The most recent year that we have available, fiscal year 2011, DSH payments accounted for over $17 billion in total Medicaid spending. That's both State and Federal dollars. Federal dollars alone, a total of about $11.3 billion was allotted for States for DSH in fiscal year 2011, and State allotments varied dramatically, from $10 million or less to over $1 billion in a couple of States.

One other thing I want to be sure to point out is this is about Medicaid DSH payments. DSH payments are also made through the Medicare program. Medicare DSH payments are paid to qualifying hospitals through an adjustment within their applicable prospective payment system.

A little bit of history regarding Medicaid DSH payments. So in 1981 --

VICE CHAIR SUNDWALL: Just real quick. Were they cut for the Medicare as well as Medicaid?

MR. TEISL: Yeah, there are reductions, though I'm not up to speed on exactly how they work or what they are, so -- but I believe there are reductions in Medicare, as well.

So in 1981, as I'm sure you all recall, the Boren amendments delinked Medicaid hospital payment from Medicare and States were required to take into account hospitals serving a disproportionate share of low-income patients. At first, the total amount of DSH payments that States could make was left open-ended, but States were slow to adopt DSH payment methods and make DSH payments. So in 1987, the Congress required States to submit State plan amendments authorizing DSH payments.

Around that same time, the Congress also clarified that upper payment limits didn't include DSH. There was also some guidance letting States know that there was flexibility in how they financed their DSH programs, including through the use of donations and even health care-related taxes that were imposed only on Medicaid services.

As you can imagine, DSH payments soon thereafter increased dramatically, going from $1.3 billion in around 1990 up to almost $18 billion in 1992. Following that dramatic increase, limits were imposed on the DSH program, including in 1991 State-specific limits on DSH payments were enacted, and at that same time, as you'll recall, limitations on the use of donations and provider taxes were also enacted.

Then in 1993, the Congress imposed individual hospital DSH limits, which said that hospitals can't receive DSH payments that exceed their costs of uncompensated care, and that includes the costs of care for the uninsured as well as the shortfall between the cost of care for Medicaid enrollees and what they are paid by the Medicaid program.

Finally, in 2003, the Congress added statutory requirements for States to submit annual reports and separately to submit annual independent certified audits of their DSH payments. For each DSH hospital, the annual reports are required to include, just as some examples, the hospital-specific DSH limit, the Medicaid inpatient utilization rate, low-income utilization rate, how the State makes DSH payments, and then the total amount of payments received. So the purpose of the audit is to ensure that hospitals don't receive more than their individual hospital DSH limit.

A hospital must receive DSH payments if it has particularly high Medicaid utilization, which is at least one standard deviation above the Statewide mean, or a low-income utilization that includes 25 percent. However, and this is important, a hospital may receive DSH payments if its Medicaid utilization is at least one percent. Hospitals receiving DSH payments, they have a couple other requirements, including that they have to have at least two obstetricians that treat Medicaid enrollees, and there are certain limitations around that requirement. But the statute provides States with broad flexibility in distributing their DSH payments.

And a recent Congressional Research Service report pointed out that DSH spending accounted for a little more than four percent of total Medicaid service spending in 2011. However, DSH spending as a percent of Medicaid service spending in individual States ranged from less than one percent to about 12 percent. So, again, there's a lot of variation in the use of DSH among States.

So the DSH reductions, or you often hear them referred to as the DSH cuts required by the Affordable Care Act, these are aggregate reductions and they're intended to coincide with the decline in the number of uninsured beginning in fiscal year 2014. As you can see, they start out relatively small, $500 million in 2014, ramping up to $5.6 billion in 2019, or roughly half of current DSH allotments.

Initially, when the Affordable Care Act was enacted, following fiscal year 2020, DSH allotments

would have rebounded to their pre-fiscal year 2014 levels. A bill last year extended the DSH reductions to 2021, and then more recently, the American Taxpayer Relief Act we referred to earlier as the fiscal cliff bill again extended these reductions to fiscal year 2022. Under current law, in 2023, they would revert to pre-2014 unless the reductions are extended again.

So requirements for the DSH reduction methodology. According to statute, the Secretary shall use the methodology that imposes the largest reductions on those States that have the lowest percentages of uninsured or do not target their DSH payments based on high Medicaid utilization and uncompensated care provided by individual providers. The methodology imposes a smaller reduction on low-DSH States, so those are States whose Federal DSH allotment is particularly small. It is also required to take into account the extent to which a State's DSH allotment was included in a coverage expansion done under an 1115 demonstration. The proposed regulation, as I said earlier, is expected in earlier 2013.

There are a number of policy issues for consideration, and I put these bullet points up there to sort of spur some thinking by the Commission about the kind of things that you want to consider, should we decide to comment on the proposed rule. Again, I don't know what's going to be in the proposed rule, but this is just sort of to start thinking about it.

One of the most significant policy issues, obviously, is the extent to which reductions are based on the levels of uninsured, and there's more uncertainty around that, given the fact now that States will decide whether or not to expand their Medicaid programs, or the extent to which the reductions are based on the extent to which States target their DSH payments to hospitals that provide more care to low-income individuals.

Another question is the availability and timing of data. For example, are determinations of the level of insurance and targeting of payments made just once prior to 2014 or are redeterminations made

annually or on some other time schedule.

Again, how will States be treated that choose not to expand their Medicaid programs? How will the methodology treat 1115 demonstration States?

And then, obviously, very importantly, State DSH payment policies will have a big effect, ultimately, on how the reductions are passed along to individual providers. For example, how will States -- or would States consider changing their DSH payment policies, for example, in the case of children's hospitals who may not see such a significant decrease in the level of uninsured, but who may be reliant on DSH payments now.

So that's a relatively quick and high-level overview and I welcome any thoughts that you have.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: Well, I think this is a really important issue as we think about Medicaid, because, clearly, these safety net institutions that receive DSH are really major providers for the Medicaid population, and if we look at what happened in Massachusetts, I think the reduction of DSH to create an expansion put a huge stress on the two principal safety net institutions there. So I think it's important for us to think about this and be prepared to comment.

I do think that one thing we should think about is the targeting of the DSH payments. I could imagine a scenario in a State hypothetically like Colorado --

[Laughter.]

COMMISSIONER GABOW: -- where there is one very large provider for care to the uninsured, hypothetically Denver Health, in which perhaps the State overall uninsured rate went down but it didn't happen that the uninsured rate at the hypothetical institution did not. So then if you see a reduction in the overall State DSH payments but the State policy doesn't change, that could be an extremely detrimental

situation for that safety net.

So I really think that as we look at this, we should think about, do we really need to think about targeting DSH payments specifically to the hospitals that are doing a disproportionate share of care to Medicaid and the uninsured. And since the -- it's written into the law, but the Secretary has to take into account the uninsured in the State, there may have to be something specific to say, well, yes, they will, but then those States should have to be targeted to.

I think there's a real dilemma around the States that don't choose to do the expansion of Medicaid because the DSH cuts are still going to come, and if these safety nets in those States, if you look at their margins, they're very small, if not negative. And if you look at them without the DSH payment, they're virtually all negative. So if they don't see this increase in people moving into Medicaid from uninsured and the DSH cuts come, I think in those States that don't do an expansion, I really don't see how the safety net will survive in those particular States. On the other hand, you can imagine not wanting to reward those States.

So I think it represents a dilemma that we should think about. Do we have an opinion about it, how that should work, since if those safety nets fail in some of those States where we expect perhaps expansion not to occur, they have some pretty large safety net providers that I just don't see making it.

CHAIR ROWLAND: I mean, I think this has been a nice description of the policy, but I think what Patty is pointing out is we need to look at the implications, and the implications in different States but also in those that go forward and those that don't, because that really is going to be very different, depending on both the State -- the situation within the State and the State's general policy and how they previously allocated their DSH funds and how they would do it post-reform.

Denise.

COMMISSIONER HENNING: I think Patty makes a really important point. In Lee County, where I live, there's one hospital system that takes care of, like, 90 percent of the inpatient population in the county, and they are really dependent on the DSH payment. And, of course, Florida is one of those States that's dragging their heels on the Medicaid expansion. The hospital system is going to suffer.

And I think we really need to make the point that the ACA, as good as it is, is not going to completely eliminate uninsured people. There's, what, 13 million, is it, uninsured non-citizens in this country that it just does not cover. So those people are going to be the ones that show up, hopefully in my office but possibly in the ER and then an inpatient admission to the hospital, and those hospitals don't have a choice. I mean, they have to take care of the patient. So it's going to hurt them and they're going to go under if something doesn't change.

So I think that that point needs to be really out there in bold print, you know, that the uninsured don't go away because of the ACA. I wish that it did, but it doesn't, and maybe we can't afford for them to go away, but that's a discussion for another day.

CHAIR ROWLAND: Mark.

COMMISSIONER HOYT: You know, I think if you look at, and the chapter does a good job of highlighting this, what DSH was originally designed to do, where it started, and where it's ended up now, either through waiver negotiations or a bunch of other different reasons, it almost seems like it's just screaming for the need of a recalibration of the allocation of the money, and we are ready to prescribe time of change, and there's certainly some clear logic to reducing those payments if you just think at a global level of a mandate and more people covered and so on. And I doubt that you could do something so drastic as to, we're just going to come up with a new formula or algorithm or whatever it would be and starting now it would be that. Maybe there would be a period of transition while some of the waivers expire, just because

that would be a better thing to do. But it seems worth considering as we review the regulation, maybe layer some additional changes in there that would get this to a more rational basis for how States get money as well as the targeting comments are on point.

CHAIR ROWLAND: Andy.

COMMISSIONER COHEN: A couple of questions, actually, Jim. One is, do we know to what extent DSH payments are typically matched by other than sort of traditional State match, meaning local matches or other mechanisms, provider taxes or other things?

MR. TEISL: Not any --

COMMISSIONER COHEN: We know it's common, but don't know exactly where and where it doesn't?

MR. TEISL: Right.

COMMISSIONER COHEN: Because, I mean, DSH is just a match. I mean, there's really -- what's special about it is that States have unusual flexibility in targeting it. But besides that, the financing is the same. It's not free money to the States. So another sort of, like, factual question, are States, if they were to -- can they use factors related to sort of disproportionate shareness in setting rates at all? Could you sort of, like, build a DSH rationale into your just traditional rate setting, where there is no cap?

MR. TEISL: Yeah. Yeah. I mean, I think there would certainly be the flexibility. As you know, States have a lot of flexibility in how they set their individual provider rates. But as long as it was, you know, a methodology that was approvable through the State plan process, I think that would be possible.

COMMISSIONER COHEN: So, really, what we're kind of, like, grappling with is the loss of, like, the States' discretion and perhaps the loss of a history of using a different matching source for this funding.

But, again, just to be clear, the State has the same ability to use its Medicaid funding at the same match rate under their State plan, or they could change their State plan to sort of basically result in the same funding to providers. It's like there's just a lot of history and sort of policy barriers and difficult challenges for States, politically and otherwise, to do that. Is that -- I just want to make sure I understand that.

MR. TEISL: Well, I also, just as a follow-up question, so I guess the thought would be to sort of counterbalance the reduction in the Federal DSH allotment by increasing rates through normal Medicaid payments.

COMMISSIONER COHEN: I'm sort of wondering, if that's possible, then what are the barriers to that and what is really -- what is it that is unique about DSH that is -- I mean, certainly, the way it's used in States is unique. It is typically, not always, but used to support the safety net in a big way. It may also be used to enhance rates in other ways. But it is typically a huge supporter to the safety net, as it is in New York State, and without it, some very critical institutions, one I know very well in particular, would really face, like, an untenable challenge.

But I guess I'm just sort of trying to understand what really is unique about DSH, and if we were to think ambitiously about making some recommendations about what a new kind of DSH policy might look like, considering all the change that we're in, or some features of it, we should just sort of keep in mind what really is unique about DSH versus sort of, like, other features of --

MR. TEISL: Off the top of my head, and obviously, this is something we could think about a little bit more, but I'm inclined to say that increased Medicaid payment rates, obviously, the effect on an individual provider would have to do with their Medicaid utilization. So the more Medicaid they see, the more they might be able to, I guess, benefit from the increased rates.

But hospitals are DSH eligible with a Medicaid utilization of just one percent. In those cases,

obviously, those hospitals might be less able to mitigate the effect of a reduction through Medicaid payment.

CHAIR ROWLAND: I have Richard and then Judy.

COMMISSIONER CHAMBERS: Yeah. I was just trying to do some quick calculations on your slides and I think you said in fiscal year 2011, it was $17 billion, total. That's what it says on Slide 3, I think. And then looking at the reductions, and when you go from 2014 to 2020, if the $17 billion doesn't increase, it's only a three percent decrease in 2014 and only -- in 2020, it's a 25 percent decrease overall. So it's not like it falls off a cliff and there's no DSH. I mean, still, certainly, even with 25 percent or $4 billion a State can have, that would still impact it, but, I mean, we're not talking about --

MR. TEISL: These are reductions --

COMMISSIONER CHAMBERS: I'm sorry.

MR. TEISL: These are reductions in the Federal allotment, which is a little over $11 billion. So at least around 2019, it's about half.

COMMISSIONER CHAMBERS: Half, okay, from 11 to -- oh, I see, to 5.6. Okay. I was looking -- I didn't realize it went up and then went back down. I was just using 2014 to 2020. But sort of talking to Andy's comments about the DSH is unique, and for those of us who have seen the way it is -- how the formula is driven from both level and who gets DSH, I mean, it's not all pure, pure in hospitals. You know, I'm not going to make any comments, but it's like there's hospitals that get DSH dollars that -- I mean, like, the requirement of only one percent, as we talked about, is, what, you see one patient every five years or something and you get a DSH dollar.

[Off microphone.]

COMMISSIONER CHAMBERS: Yeah. So, anyway, it's just that I think it's a program that's ripe for reform. I mean, maybe we take the Federal dollars and -- because I bet you if you took the total

$17 billion, you say the Federal allotment of that is 11, and I bet you -- okay, so that's not even the total. Eleven out of $17 billion is more than the Federal match, isn't it? I mean, it's like the overall Federal match in general Medicaid or something is. But, anyway, it's just a program I think that's ripe for change, and I think this Commission potentially could make some recommendations as to how to try to reform a program, as Mark said, started with grand goals, and certainly in the 1980s and early 1990s probably got really abused as to how it was abused and how much Federal dollars were involved in the program. So with that, I'll stop.

CHAIR ROWLAND: I think, in response to Andy's question about what's unique about it, what's unique about it is it's not a categorical program that's run through HRSA subject to appropriations, but instead built in as a funding mechanism within the Medicaid program that's not directly linked to a particular patient.

COMMISSIONER COHEN: Right, or to a particular service, either.

CHAIR ROWLAND: Right.

COMMISSIONER COHEN: Right.

CHAIR ROWLAND: Okay. Judy next, and then Donna, I think, had a question.

COMMISSIONER MOORE: As we think through if we want to consider taking this on as a part of the Medicaid program that we could think about some ways to reform, I wonder if we could come up with several different targeting policies and array what that would look like on a State-by-State basis if you took DSH money and you allocated in X way versus Y way versus Z way that had more to do with services rendered to patients in different categories than it did to State politics and the history of what the States have done. And I know that flies in the face of reality in some ways, but it would inform -- it might inform the process a little if we modeled what the DSH dollars would do if only related to the number of Medicaid

and uninsured patients served in particular States and particular facilities, what would that mean goes there.

Now, part of this would, I think, relate to how much transparency is there now. I mean, there were all these requirements that things be submitted to CMS, but the last I checked -- which admittedly was a couple of years ago -- it really -- it is not available. I mean, there are not -- there's not national data and information about what each State is doing with its DSH money, is there?

MR. TEISL: Well, so, as I mentioned, States are required to conduct annual audits of their DSH programs. There's a significant lag in the data. Also, the first several years of the DSH audits are -- it's an opportunity, I guess, for States to look at their DSH spending and then make changes. So there isn't take-back associated with sort of failure to adhere to certain limits for the first several years.

The most recent data, as far as I know, that's available is 2007, and we're waiting for more to be available. But the data that is available through the audits is hospital-specific and pretty detailed. There's just a lag in --

COMMISSIONER MOORE: So it's old, but it is becoming available?

MR. TEISL: Right.

COMMISSIONER MOORE: Okay.

COMMISSIONER CHECKETT: You know, very interesting chapter and interesting subject. I think that one of the things we'll want to take into account is what role we have in reacting or commenting to the regulations that are going to come out, because this is a really, really big deal for a lot of States and a lot of providers. So I think the timing is right for us to look at that and figure out, is that a way in which we put forth some of our policy recommendations. But we'll have to see what those regulations say.

VICE CHAIR SUNDWALL: [Off microphone.] When are they due?

COMMISSIONER CHECKETT: I think it is soon.

MR. TEISL: Yeah. All that I've seen is early 2013 is the expected time frame.

CHAIR ROWLAND: Mark.

COMMISSIONER HOYT: I did read the chapter, but I don't remember now. Do you have a paragraph in there on Medicare's DSH policy, what was that intended to do? It seems like we ought to at least acknowledge a little bit that Medicare is also addressing this, has DSH payments, how were those originally designed, what are they supposed to do, so we get all that on the table.

MR. TEISL: It's not in there now, but we can definitely add some information.

CHAIR ROWLAND: Thank you very much.

And now we're going to return to the morning and to Ben Finder and be alert and awake and have Ben talk to us about benefit design. Tab 3.

CHANGES IN MEDICAID BENEFIT DESIGN

* MR. FINDER: Thank you. Thank you for the opportunity to present today. My name is Ben Finder. I'm a Senior Analyst here at MACPAC. I just joined recently, in October, so I'm new to the organization.

The topic of this session is the evolution of Medicaid benefit payment and -- or, sorry, Medicaid benefit design, rather.

The Patient Protection and Affordable Care Act allows States the option to expand eligibility, and with any eligibility expansion, it provides policy makers with the opportunity to think about what coverage will be made available, what coverage and benefits. And in this case, coverage for the new adult group is limited to benchmark or benchmark-equivalent coverage, and that's often called alternative benefit plans. You'll hear me use the two terms interchangeably throughout the presentation.

So during this session, we will review the history of Medicaid benefit design. We will talk a little bit

about alternative benefit plans and how they have changed Medicaid benefit design. And we'll highlight some of the changes made to alternative benefit plans by the Affordable Care Act.

So the Medicaid program is charged with providing medical assistance to enrollees, and that takes the form of mandatory and optional benefits. States that participate in the Medicaid program are required to offer mandatory benefits, and these are benefits like inpatient and outpatient hospital services, physician services, some diagnostic, lab, and x-ray services, just to name a few. So these mandatory benefits represent the minimum standard of coverage for Medicaid programs.

Optional benefits provide States with the flexibility to define how comprehensive their coverage will be. Optional benefits include things like prescription drugs, which most States cover, dental, home health services, home and community-based services, substance use disorder services, just to name a few. States may weigh the population health needs and costs when choosing to offer optional benefits.

And over time, benefits have been added to the program both on the mandatory and optional side, considering things like public health needs, consumer demand, and the evolution of medicine and health care delivery. So we've seen new services and providers added over time.

Another component of Medicaid benefit design includes comparability, which means that for most enrollees within a program, the amount, duration, and scope of the service has to be the same no matter what your eligibility pathway is. Statewideness, which is self-explanatory, if you offer one benefit, it has to be the same throughout the State. And freedom of choice, which means that beneficiaries are eligible to go to any participating provider.

So this process of adding over time has continued and changed a little bit in 2005 with the Deficit Reduction Act. The Deficit Reduction Act provided States with the option to implement alternative benefit plans. So alternative benefit plans formerly were called benchmark coverage. Some of you might

know them better as benchmark coverage or benchmark-equivalent coverage. Going forward, I think these terms will be used more synonymously or interchangeably. And alternative benefit plans generally include both benchmark and benchmark-equivalent coverage.

So this authority allows States to select a benefit design from existing specific private plan options, which include an option from the Federal Employee Health Benefit Plan, a State Employee Health Benefit Plan, the largest commercial HMO in the State by enrolled individuals, or a Secretary-approved alternative. Benchmark-equivalent coverage includes certain services and must be actuarially equivalent to one of the benchmark plans.

Now, there's two caveats to this. States often make some of these benchmark plans available to children, but oftentimes, private coverage doesn't include EPSDT benefits. So in those cases, States must supplement the private coverage benchmark option with EPSDT benefits.

Also, we're talking a lot about benefit design, and on the private side, that often includes the cost sharing structure. But for Medicaid, we're really only talking about the covered services. Medicaid has specific cost sharing limits that are set forth elsewhere and those apply to benchmark plans. So a State that opts to cover a benchmark plan or opts to use a benchmark as a benefit design cannot take those cost sharing requirements and apply them to Medicaid. They have to continue with the Medicaid limits that are already set forth.

So since 2005, 12 States and Guam offer at least one alternative benefit plan. Two of the States benchmark to specific private insurance plans. Kentucky has a benchmark plan that's benchmarked to the State Employee Health Benefits Program available to families and children. And Wisconsin makes a program available to pregnant women, newborns, and some other certain beneficiaries that matches the largest HMO insurer in the State.

But more often, it's the case that States are choosing Secretary-approved alternatives, and this provides States with considerable flexibility in the design that they're going to offer. Some States target specific populations with narrowly-defined benefit packages. So I mentioned Kentucky before. They offer, actually, four alternative benefit plans. Two of them require a certain level of care, either for individuals with developmental disabilities or individuals with a nursing home level of care need. These benefit plans offer higher benefit limits on things like speech, occupational therapy, physical therapy, and some of the home and community-based services that this population needs.

On the other hand, or in contrast, some States use Secretary-approved coverage just to provide the full State Medicaid benefits plan. So, for example, the District of Columbia has already expanded to 133 percent of the Federal poverty level. For this new adult population, they're required to provide a benchmark or alternative benefit plan, and in their case, they've chosen to just provide the full Medicaid benefit program as their Secretary-approved alternative benefit plan.

So I hope this gives you a sense of some of the flexibility and broadness of the authority and how States have used it.

The Patient Protection and Affordable Care Act changes this authority in a couple of ways. It increases the role of alternative benefit plans by limiting coverage for the new adult group to these alternative benefit plans. So that means that every State that chooses to expand Medicaid eligibility will have to establish an alternative benefit plan for this population.

It also requires that alternative benefit plans provide coverage of the essential health benefits, and this slide, as of yesterday, is now out of date. The rules were published yesterday, and true to the State Medicaid Directors letter that they published in November, they largely defer to the essential health benefit rules that they published for the individual and small group markets that make up plans that are offered in

the exchange.

So for Medicaid, they're largely deferring to the exchange essential health benefit rules with a couple of exceptions, which are habilitative services, pediatric services, and prescription drug coverage. Pediatric services and prescription drug coverage are a little bit of an aside because they have other specific rules that are laid out in the Medicaid statute and regulation. But in terms of habilitative services, the rules require that States create their own definition of habilitative services. And part of the new rule that was published yesterday really asks whether or not they should create a State Medicaid specific habilitative service definition separate from the exchange habilitative definitions. So one area where they might distinguish between Medicaid and the exchange rules.

So with this departure from the iterative benefit design process and a movement towards private benefit design, that raises some questions for us for discussion. What are the needs of the new adult population? Which alternative benefit plan option will States choose? Will this create inequity within a State? How will traditional Medicaid evolve alongside the expanded role of alternative benefit plans? And what are the implications for insurance carriers and health care providers?

So where do we go from here? The rules were published yesterday and we'll act quickly to interpret and analyze what they say and how they follow what the State Medicaid Director letter that was published in November. But beyond that, we'd invite your thoughts and guidance as we move forward. Thank you.

CHAIR ROWLAND: Thank you, Ben.

Comments, questions. Well, we know Sara has a lot of comments that she's going to give directly to you. David.

VICE CHAIR SUNDWALL: It probably goes without saying that these essential benefits are

likely to be quite a bit slimmer than traditional Medicaid?

MR. FINDER: So there's ten categories that are outlined. It's ambulatory patient services -- to your question specifically, there are more essential health benefits than there are mandatory services.

VICE CHAIR SUNDWALL: Okay.

MR. FINDER: However, when you consider the mandatory and optional coverage, that definition sort of slims away, and the fact that States have such a wide variety of services, or have implemented such a wide variety of optional services, it's difficult to make that comparison on a national level.

VICE CHAIR SUNDWALL: It's taken away a lot, too.

CHAIR ROWLAND: States have.

VICE CHAIR SUNDWALL: Yeah, States.

CHAIR ROWLAND: Denise.

COMMISSIONER HENNING: I am just a little bit confused because I still don't have my mind completely wrapped around the exchange idea. But it would seem to me that to the extent possible, it would make sense to design your exchange plan and what it offers to be very similar to what your Medicaid plan in your State offers, so that as people switch from one plan to another, the services wouldn't really change. Maybe who pays the bill changes a little bit. Maybe you'd have to cough up some money for a copay where you didn't have to before you got your new job. But you still would be able to get the same services that you got before. Is that your understanding of what's going to happen, or are they going to be completely different animals?

MR. FINDER: I think that's one option States can choose to implement. Another option might be to make it more like the Medicaid program and offer some of the benefits like home and community-based services or long-term care services that might not be offered as frequently within private

insurance benefits, or we might not expect to see them as often in exchange plans. So I think there's a lot of different ways States can go with this.

COMMISSIONER HOYT: I'm not the best one to try and channel Burt, but --

[Laughter.]

COMMISSIONER HOYT: Maybe later. But I think a phone call to Commissioner Edelstein would be well worthwhile. I know he's got a number of comments on this topic.

VICE CHAIR SUNDWALL: What would they be about?

COMMISSIONER CHECKETT: Well, I think it would be very interesting to do at some point a side-by-side or comparison of the traditional Medicaid benefits and what the now-eligible population is receiving. There are State differentiations, but there's certainly a general, pretty solid core of what are covered services, even services that are technically optional but have become, you know, standard for lack of a better word, and compare that to what will be available under the essential health benefit.

I think it's interesting, because in working with my colleagues at Aetna who are in the commercial business, the concern is they look at Medicaid and it's so broad. And people at Medicaid look at the coverage under the essential health benefits and there's a lot of services, I think what we've identified, that's really not covered is what I would call the social supports.

You know, think about it. Everybody here at the table, I assume, has commercial health insurance. I mean, most of what you need is getting covered, let's be honest. But what isn't covered is transportation or significant extended habilitation services or rehabilitation services, and those are the roles, when I look at it, especially like a lot of the really unique behavioral health programs that have been developed for people with disabilities, is to me one of the fascinating things about Medicaid, is that it really addresses social issues and people whose disability and income is such that it affects their ability to live within our society and

we've used Medicaid to try and fill in and we've created special provider groups and special services. And, no, that is not going to be available on health plans sold through the exchange. It is not even really the target, so I don't know that we would expect it to.

I think the challenge is going to be what States -- and so you do a nice job of identifying the lead question here, which are really what are the needs of the new adult Medicaid population and how will that alternative benefit design fail them or meet their needs. And that really is, I think, what's going to be interesting.

I think there's very solid reasons for the two programs not to be identical. I mean, there are just very logical, solid reasons. There's sound fiscal policy. There's sound social policy. But the issue on this adult population is intriguing.

COMMISSIONER COHEN: It also puts this sort of segmenting people by their eligibility pathway into a benefit plan, it just puts tremendously more pressure on getting that eligibility determination right, and not just -- you know, when I think about New York City does eligibility determinations for New York State for people who live in New York City, and basically there's, like, I don't know, 250 million possible eligibility pathways and a worker goes through them, you know, sort of like has a sense. Someone walks in and is talking to them and they get a sense that maybe ten are relevant and the first one they hit is, boom, they are in and that is what they get. You know, this really puts a great deal of pressure and probably the need for a lot more training and expertise and just really different ways of doing things. Maybe not every State is like New York State in that way, but, you know, to make sure that somebody who isn't disabled isn't just sort of lumped into the general adult population because that's the first -- you know, they're also low-income and it's easier to show it.

So I think dividing this population into sort of finer and finer eligibility categories has costs as well

as potentially cost savings, I guess. I can't sort of help but say it. In a perfect world, this would be done by rational, evidence-based sort of allocation of resources based on what your need was, and all the benefits would be available to you but you wouldn't use those that you didn't need according to some agreed standard. I guess we're far from being there, but this is really -- it's a rough way of doing that because it just puts great pressure to make sure that you are in exactly the right plan and that your eligibility has been established in a way that I think is much finer than most States actually do it today. So it's just a concern to flag.

COMMISSIONER HENNING: Are the people that are determining eligibility for the Medicaid program going to be the same people that determine the eligibility for the exchange programs? I mean, is that, nuts and bolts-wise -- I know I'm looking at it at the ground level, but if I'm a person that has no clue what I'm eligible for and I go for help, who's going to help me figure that out?

CHAIR ROWLAND: There's no wrong door.

[Laughter.]

COMMISSIONER HENNING: Yeah, I've heard that before.

MR. FINDER: Which means that they may not be the same people. It could be that there is an exchange process that routes you to Medicaid or a Medicaid process that routes you to the exchange. There's no wrong door, so --

CHAIR ROWLAND: Okay. Other comments?

Okay. Thank you, Ben.

And now we come to the point in time in our day where if there are any comments that the public would like to offer or suggest, please rise and come forward and identify yourself, and there's a microphone coming.

PUBLIC COMMENT

* MS. HUANG: Good afternoon. My name is Xiaoyi Huang. I'm here on behalf of the National Association of Public Hospitals and Health Systems. NAPH represents about 200 hospitals, safety net hospitals and health systems around the country. We are about two percent of the acute care hospitals in the country but provide 20 percent of the hospital uncompensated care. And about 75 percent of the care provided at our members, both inpatient and outpatient side, are provided to Medicaid, Medicare, or uninsured patients.

So we appreciate the discussion today on Medicaid DSH, and as MACPAC takes on this issue in the coming months, we urge the Commissioners and staff to focus on the needs of the patient that these DSH hospitals serve and recommend that the DSH reduction methodology be developed in two phases.

During the first couple of years of cuts, when the amount of the reduction is relatively small compared to the latter year of cuts, the DSH reduction methodology should focus on the targeting prong of the ACA language. In large part, this is because data on the uninsured that would reflect the impact of the expansion won't be available then. Also, focusing on the targeting prong will incentivize States to direct DSH dollars to hospitals with a high need for DSH.

And during this time, we ask that both HHS as well as MACPAC do an assessment of the data that will be coming online that will more accurately reflect the needs of the DSH hospital and the patients that they serve and assess whether the methodology needs to be adjusted to reflect the ongoing needs of the DSH patients across the country.

And consistent with the intent of the DSH program, NAPH also urges the Commissioners and staff to take into account the disproportionate nature of the program. That is, it was and is meant to aid hospitals that treat a disproportionate share of low-income patients. And toward that end, we believe the

DSH reduction methodology should be implemented in a way that ensures that DSH dollars in the future go to hospitals with the highest uncompensated care burden and, thus, the highest need for DSH.

And as the Commissioners consider how States' decision with respect to the Medicaid expansion should be treated within the context of the Medicaid DSH reduction methodology, we urge you again to consider the intended purpose of the program and not subject the hospitals and the low-income patients that the program intends to benefit to be harmed based on decisions outside of their control.

Thank you again for the opportunity to comment, and NAPH works forward to working with MACPAC in the future on this issue as well as others that are important to safety net hospitals.

CHAIR ROWLAND: Well, thank you, and those are very good suggestions and I know that we will take them into account as we consider our deliberations. I think, as you heard, we are both looking at DSH specifically, but that that needs to be also assessed within the broader context of how we provide the kind of safety net services that are so critical as we move forward.

Any additional comments from anyone?

[No response.]

CHAIR ROWLAND: Seeing and hearing none, we will conclude our day's meeting today and reconvene in public session at 10:45 tomorrow morning. And for the Commission members, there will be a session starting at 9:30, an Executive Session. Thank you.

[Whereupon, at 4:15 p.m., the meeting was were adjourned, to resume at 10:45 a.m. on Wednesday, January 16, 2013.]

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

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

Wednesday, January 16, 2013
11:02 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
SHARON L. CARTE, MHS
RICHARD CHAMBERS
DONNA CHECKETT, MPA, MSW
ANDREA COHEN, JD
HERMAN GRAY, MD, MBA
DENISE HENNING, CNM, MSN
MARK HOYT, FSA, MAAA
JUDITH MOORE
SARA ROSENBAUM, JD
ROBIN SMITH

ANNE SCHWARTZ, PhD, Acting Executive Director

P R O C E E D I N G S [11:02 a.m.]

CHAIR ROWLAND: Good morning, and if we could please convene for our continuation of our MACPAC meeting.

This morning we wanted to start by looking at the issues of Medicaid rate setting for dual eligibles in integrated care plans, which is a proposed draft chapter for our March report to Congress. And I'm pleased to have Chris Park guide us through the chapter and some of the highlights in that chapter and then open it for Commission discussion.

Chris, do you want to kick us off with our discussion?

REVIEW OF DRAFT MARCH REPORT CHAPTER ON MEDICAID RATE SETTING FOR DUAL ELIGIBLES IN INTEGRATED CARE PLANS

* MR. PARK: Thank you, Diane.

Today's session provides an overview of the draft chapter on Medicaid rate setting for dual eligibles in integrated care plans for the March 2013 report. Increasingly, states are looking to put dual eligibles into risk-based managed care. Financial alignment demos have the potential to move millions of dual eligibles into managed care.

Considering the number of enrollees and spending that could move into managed care, it is important to understand how states will set the Medicaid capitation rates. This chapter begins our discussion of the key drivers of the rate-setting process and what challenges states face in setting rates. We would appreciate the Commissioners' feedback and guidance on the draft chapter.

The chapter focuses on several policy and technical issues related to setting appropriate Medicaid capitation rates for integrated care programs serving dual eligibles. The chapter begins with an overview of the general rate-setting process and highlights the significance of long-term services and supports in developing these rates. We then describe various design features states have used in current dual-eligible

plans, such as the dual-eligible special needs plans and Program for All-Inclusive Care for the Elderly, otherwise known as PACE. Also, we provide some examples of what states have proposed under the financial alignment demonstrations. The chapter concludes with some issues for consideration when developing these capitation rates.

In the current program of D-SNPs and PACE, the Medicare and Medicaid payments are developed independently. The Medicare rates are developed as part of the Medicare Advantage and Part D bid processes and not discussed in the chapter. The states set the Medicaid payment separately.

When setting the rates, states typically use historical experience trended forward to the payment period with certain adjustments, such as any changes in program or policy roles or differences in utilization under managed care. Risk mitigation strategies and risk adjustment are often applied to account for differences in the population.

The challenges for Medicaid in setting rates for the dual-eligible population include how the states account for LTSS since it is the key driver in Medicaid spending. As mentioned in yesterday's presentation on the dual eligibles, about 70 percent of Medicaid spending is for LTSS services.

The dual-eligible population is also very diverse and has a wide range of service needs and costs. As seen in yesterday's presentation as well, the average Medicaid costs for four-year, full-benefit dual eligibles not using LTSS was about $2,800 compared to about $44,400 for those using institutional LTSS.

The states must take account the high cost of LTSS services and the significant diversity of the population in the rate-setting process. The rate structure must pay plans appropriately for the characteristics of their enrolled populations and balance the savings incentives and plan risks in serving the duals.

Most of the variety that you see in the rate-setting design is on how states approach this and adjust the rates for population differences and balance the plan incentives and risk.

States can contract with Medicare D-SNPs to provide Medicaid services in a fully integrated plan. Only a few, small number of Medicare D-SNPs are fully integrated with Medicaid. States' participation with D-SNPs is typically an extension of their managed LTSS process, so many of the states with managed LTSS programs have their plans also become D-SNPs as well.

These states have used a variety of design features to balance the managed care incentives and plan risk, particularly around the LTSS benefit. As discussed in the November Commission meeting, states have used a variety of design features, including rate cells, partial risk for nursing facility services, risk corridors, and other options to limit some of the plan's risk but still have incentives in place to provide services in a cost-effective manner.

Only a few states have developed risk adjustment due to the limitations of the current risk adjustment models. These models use diagnostic information, which are poor predictors of LTSS costs. The states that have created risk adjustment for LTSS have developed their own models, which can be a resource-intensive process.

Under PACE, there is less flexibility in how the rates are designed compared to D-SNP. The rate cells can't take into account differences in health status over the year so the payment to a particular provider is pretty constant in terms of, you know, their health status or frailty status.

The key driver in the rate-setting process is the frailty adjustment. This is typically based on an assumed mix of nursing facility and HCBS populations. Similar to D-SNPs, few states use risk adjustment and PACE. Those that do have usually included PACE as part of the LTSS risk adjustment process they use for their D-SNP programs.

The financial alignment demonstrations are just getting started. For the first time, CMS will take a step and coordinate the Medicare and Medicaid rate-setting process and take into account the total payment across both programs. CMS and the states will develop a baseline estimate of what has been spent in each

program in the absence of the demos. CMS will develop an estimate of aggregate savings across both programs, and these savings are shared regardless of if they come from acute-care services, where Medicare would be the primary payer, or LTSS services, where Medicaid would be the primary payer.

So far, only two states have released a memorandum of understanding where there is more detail on states' Medicaid rate-setting process. Massachusetts and Ohio share some similarities. They have the same savings percentages and withhold percentages. The savings percentages are 1, 2, and 4 percent for years one, two, and three, respectively; and the withholds are 1, 2, and 3 percent.

Where these two states differ is in how they've designed the rate cells, the risk mitigation, and risk-sharing strategies. Massachusetts has separate rate cells for nursing facility versus community LTSS beneficiaries. Ohio has a single rate cell for nursing home level of care versus kind of all other non-LTSS users. There is also a transitional policy kind of seen in the Massachusetts SCO program where enrollees go from -- when an enrollee goes from the nursing facility level of care rate cell to the community well rate cell, they are paid at the higher nursing facility level of care rate for 90 days.

Massachusetts uses a high-cost risk pool for LTSS spending over a defined threshold to the plans for LTSS services. They also plan to implement an enhanced risk adjustment model to take into account for LTSS services in future years.

Ohio does an enrollment risk adjustment in the nursing facility level of care to adjust for relative differences in LTSS needs between plans.

On the risk-sharing side, Massachusetts will use a risk corridor in year one. Ohio is implementing a minimum medical loss ratio where the plan must pay back CMS and the state if the medical loss ratio is below 85 percent. If the medical loss ratio is between 85 and 90 percent, there may be some sanctions or penalties that the plan will have to pay.

There are a few issues for consideration as the use of risk-based managed care for dual eligibles

increases. The financial alignment demonstrations are going to be voluntary enrollment. This can be a complicating factor in the rate development because the population characteristics of those who actually enroll in the program may be different than the population characteristics used in the rate-setting process. This could create misalignment in the payment from what was used to develop the rates into what the plans actually need to serve their beneficiaries.

Effective rate development and risk mitigation are needed to provide rates that reflect the differences in the population enrolled in the program. There is also a need for new risk adjustment models that are more predictive than Medicaid LTSS costs. Diagnostic risk adjustment has become the standard for rate adjustments on the acute-care side. This capability needs to be expanded to take into account LTSS services by looking at different measures such as functional status and other frailty measures that are more predictive of LTSS costs.

A few states have developed LTSS risk adjustment models, but it can be resource intensive. Due to the variation in the dual-eligible population, different models may need to be created to take into account different needs of the population.

For example, Wisconsin has three different models they use for the elderly, physically disabled and developmentally disabled populations as the measures that are predictive are different for these three different populations and their relationships to LTSS costs are different.

Also, states need to consider what measures of functional status are the most predictive and determine who should be collecting these measures. The plans may have the best access to collecting these measures, but it also creates some incentives for the plans to upcode frailty to kind of create a higher risk score.

An additional issue is the treatment of supplemental payments. UPL supplemental payments may be used by several states to increase payments to nursing facilities. These UPL payments have not been

allowed in the capitation rate under actuarial soundness principles and have been a barrier to managed care in other programs. It is unclear as to whether these supplemental payments will be allowed under the demonstrations.

Thank you. We would appreciate any feedback as to comments on the chapter, if it reflects the right tone, and if there are other outstanding issues or further clarification needed.

CHAIR ROWLAND: Thank you, Chris.

COMMISSIONER ROSENBAUM: I have a question. I don't know if it's like terribly stupid. I'm always one, when we're into rate setting, I feel like I'm truly on shaky ground here. But when the states and the federal government start their work together, which I think is at the heart of the demonstrations, how does the joint effort differ from each going it alone?

In other words -- and this is what I don't understand. The service mix -- the service mix for both sides becomes something different. I mean, I assume they see the service, the benefit package as an integrated benefit package. So what you might pay for hospital care, if you're just worried about the cost of hospital care, would change if your service mix is also going to include other stuff that actually is not in the Medicare benefit design, it's in the Medicaid side of things. But it also may mean that you're, at least indirectly, paying for some of that benefit design that's not on your side of the ledger, right?

MR. PARK: Right.

COMMISSIONER ROSENBAUM: So, you know, home attendant service or something. So how do we expect that they're going to start thinking about coverage and payment differently by sitting at the table? Were you able to get any sense of that other than both wanting to pay less for their respective parts?

MR. PARK: So I think we've often heard about some of the misalignments in the program. It was mentioned yesterday, you know, there could be some things generated if there are, like, primary care

services provided in a nursing home that would prevent some hospitalizations. And right now, you know, that would maybe increase the payment on the Medicaid side, but Medicaid would not realize any of those savings. And so states have been somewhat reluctant to do anything like that because they are not going to get any of the financial incentives for doing so.

On the flip side, you know, Medicare, they're looking kind of only at the Medicare services. So when they set their rates, they don't consider what the impact may be on nursing home services. So CMS is working with the states to come up with a total payment that includes Medicare and Medicaid and looking at that and trying to figure out in an integrated care model where you do have more incentives, now that all of the payment goes to a single plan. You know, if the plan does want to put some primary care services in a nursing facility and that does prevent some hospitalizations, now both programs may see some of the savings because they're going to share it across Medicare and Medicaid regardless of where the savings occur.

Similarly, if Medicaid investments in LTSS can reduce hospitalizations or if, you know, better discharge planning on the acute-care side can reduce the need for LTSS services, you know, both programs may benefit.

So for the first time, CMS is really going to look at that total payment and try to consider all of the different interactions between programs and how that might create savings on the total payment side, and then split the savings equally based on kind of the contribution of each program to the payment.

COMMISSIONER ROSENBAUM: Essentially there will be sort of a less concern about what I cover versus what you cover and more looking at the functionalities of the care system in relation to the patient.

MR. PARK: Right, that is the hope.

COMMISSIONER ROSENBAUM: With a budget for --

MR. PARK: That is the hope that, you know, the plan is not going to think this is a Medicare dollar so we shouldn't, you know, use that on the Medicaid side and vice versa.

COMMISSIONER ROSENBAUM: Okay.

COMMISSIONER HOYT: I had one kind of actuarial editorial comment on the chapter. I thought it was really good and covered a lot of ground, hit a lot of good states.

The minor piece or add I would have would be an additional reference just to the size of the rate cells being so small creates a lot of challenges for actuaries to set these rates and drives the need for the risk corridors or reinsurance or something else that's distinctly different from doing acute care. So just you can pick, you know, where to weave that in.

MR. PARK: Right.

COMMISSIONER HOYT: But that's a real significant challenge. It's been common in PACE. You know, you might have a group of 100, 150 people, and how do you set rates for that?

MR. PARK: Right.

COMMISSIONER HOYT: So there's that.

Then I had a comment here that also ties to a thought I had after the presentation yesterday as well. I really think we should give some serious thought to making a recommendation that the Secretary, CMS, come out on the record around managed care principles both in this environment as well as acute care yesterday. To me, that's, honestly, just inexcusable to be 15, 20 years into managed care contracting in states and have the actuary yesterday more or less kind of shrug and go, no, we don't really know specifically what the impact of managed care is on the use of the hospital, the ER, referrals to specialists, the trend line. You know, there's a number of different things that have been discussed, and there's all sorts of assumptions made about that in approving waivers and putting those in place, and here in this instance in doing demonstrations.

So here I would like to maybe have them spell out what do you think -- what are the assumptions that are implicit in these rates about the impact of managed care? And then after that, what are you going to do to measure that? You know, what data will be collected? That's sort of the plus side of smaller rate cells or fewer people, fewer things to track. But tell me specifically what you think the impact of managed care is and then can we prove that out? We've made such a huge movement nationally to enroll people under managed care. It just seems ridiculous to me that we don't have -- we're not at a point and don't seem to be moving towards a point where we would be able to quantify is it efficient, is it effective.

CHAIR ROWLAND: Mark, I'm taking that as a comment that could be embedded into this chapter but is a much broader comment for our general work on managed care.

COMMISSIONER HOYT: Yes.

COMMISSIONER CHAMBERS: Well, I'd certainly compliment staff and the draft chapters because, as Mark said, this is a very difficult issue and has really framed it appropriately.

As someone who runs a managed care plan and is, you know, up to my eyeballs in working on my state's financial alignment demonstration and implementation sometime in 2013, the rate-setting for this demonstration is so significant, and it's not just, you know, from worrying about bottom-line profits. It's really is the viability, I think, of all the players in these demonstration programs is that, you know, we're talking traditional managed care for TANF populations is, you know, the risk is pretty low and it's pretty straightforward in figuring out as a player and delivering services is to, you know, what your ultimate risk is.

There is not a lot of experience across the country. You know, some states have dipped their toe into integrating long-term care services and capitating plans, but we're talking significant dollars, particularly when you get into states that are going to fully put plans at risk for nursing facility care. I mean, some states are going to, after a certain period of time, is nursing home residents then go back to fee-for-service responsibility for the state. But in California's design, for instance, the plans are going to be a full risk for

nursing facility care for custodial long-term care services, and there's really not a whole lot of experience.

And so what I just fear is if the rate setting isn't done properly is the risk it puts on the managed care industry and delivering services not only for this population but the plans that are participating in the demonstration programs deliver services to the rest of the Medicaid population. And it's -- there's many places in the country that managed care is delivered by nonprofit organizations and public organizations. I think California has an extensive network of public health plans that operate that don't have the kinds of financial resources, as, you know, with mistakes that are made in managed care -- excuse me, in long-term care service management, you know, mistakes can ultimately be financially disastrous to a managed care plan.

So just a long-winded way of saying how important the rate-setting process is. You can do risk corridors as you lay out options, but even in risk corridors, before you can make up particularly on the loss side is you have to lose money before you actually have some recovery.

So, again, I'm really beating probably a dead horse as how critical this is. I think it's going to be important for both the federal government and states to be very nimble and be willing to make mid-course corrections on assuring that there's, you know, appropriate resources in the system. I'm fearful as what happens on the non-institutional long-term care side, which is mostly, you know, home and community-based services, is what will happen with -- you know, the traditional question is the woodwork effect, is what happens if suddenly when managed care plans are providing appropriate services for all of these very complex members is when you have fixed payments is, you know, how you're going to make sure to assure access to all those quality services.

So just I hope that MACPAC will pay close attention to this because if this does not work, is we're going to set ourselves back in the Medicaid program, is finding solutions, is for the most vulnerable folks in the system, is to be able to make sure that it works.

So I compliment the work that has been done, and I think this is going to be a really critical piece of looking at this very complex program going forward.

CHAIR ROWLAND: Thank you.

COMMISSIONER HENNING: At the risk of sounding stupid, how do we treat people that are in assisted living centers? Is that considered institutional care, or is that in the home and community-based services bucket?

MR. PARK: I think that might depend on the states and their classification of how, you know, they put things into different types of services. But it also will depend on how the state creates their programs. They might carve out certain populations. You know, some states might take out the home and community-based waiver populations since they're already receiving some services, and they might consider that a different program.

Overall, it might not really matter as to whether that is considered institutional or home and community-based services because the idea of the capitation payment is to say this is what we think the population will need, it is up to the plan to decide what's the most appropriate setting to deliver the services to that person. So they may decide that, you know, the assisted living center is the appropriate setting, that that's the most cost-effective place, regardless of how it's classified as institutional or HCBS.

COMMISSIONER COHEN: More questions rather than comments. I'm interested in Richard's comment about the need for course corrections, the multi-year savings targets, but I think the piece that I don't know -- and I'm not sure how these things all come together -- are the rates set in a multi-year kind of way? Because I do think that one common misperception about rate setting for managed care and the incentives of managed care is that the thought is there are things that we can do to invest in the health of people up front that may result in savings down the road, care coordination, care management, prevention, maybe more community-based services to prevent hospitalizations, things like that. And they may result in

savings, but typically states -- those savings don't really accrue to a plan unless the savings are achieved within the year, and, of course, unless the person is -- their tenure in a plan is long enough to make that difference, because typically states adjust the rates, their rates every year for plans. And so the plans' incentives can be sort of watered down to some extent.

So I guess I'm just sort of curious about the interaction of these things. You know, there's multi-year savings targets, presumably multi-year, therefore, projections on where the costs would otherwise go. There are rates set that are supposed to be multi-year or not and can they be changed and under what circumstances. I mean, what do we do if we find out that, you know, the rates are set high and there's much higher savings? Does that mean the rates go down or the savings just -- the savings go to the state and the federal government but not the plan?

Anyway, I'm just trying to understand how that all fits together.

MR. PARK: Right. So far, through the Massachusetts and Ohio memorandums of understanding, it looks like the baseline targets are going to be set in the beginning and that they've already set the 1, 2, and 4 percent savings over the years of the demonstration. CMS does have language in those memorandums that the states and CMS can always revisit the rate-setting process on the Medicaid side to take into account either increased -- you know, updated data. Maybe you would want to include some of the plans' actual experience to help update the rates in the latter years. You know, as you mentioned, you know, CMS and the states see some drastic change in the program. That might require a rate change, that they'll always be open to redoing their rates. But there's no definitive timeline where they'll like reconsider, you know, changing their rates. But it's kind of an ad hoc process where, if it's necessary, then they'll look into it.

COMMISSIONER COHEN: So the rates are actually set for -- what is it, a four-year period or a five-year period, presumably with some sort of inflators, and then sort of like see how it goes?

MR. PARK: That's the way it looks like so far. You know, all the details are not in the memorandum, but it seems like they've kind of established the baseline targets for the demonstration years, and they've established the savings targets. But, you know, there's always opportunity, as more updated data comes in, that they would revisit that and make some corrections on the Medicaid side.

The Medicare payment will kind of be updated every year as the Medicare Advantage rates are updated, so that process is more established on like an annual basis.

COMMISSIONER HOYT: I'm not current or fully conversant on these demos. I do know from some of the waivers we worked on with long-term care, you'd have to lay out a budget as to what you're going to spend for two or five years, but I never saw any MCOs or any kind of capitated arrangement where you'd agree to more than one year's worth of rates at a time. And in some instances, where you've got risk corridors, like you describe in the chapter, because the risks are so unknown when you initiate contracts like this, I've certainly seen states get permission from CMS to advance funds to, call it, and MCO or a capitated entity because the dollars could be pretty significant, and if you're off, they can't wait until six months after the year's over to get, you know, the final accounting for exactly where things landed, so you can measure 25 percent of this or whatever the agreement is around the risk corridor. They won't make it.

So by mutual agreement, you would push money to the plan and then include that as part of the reconciliation when you're done, remember, I gave you $10 million in July, or whenever it was, just to help work your way through this so that it's reasonable for everybody involved.

CHAIR ROWLAND: All right. Well, I think that Chris can reflect some of our discussion in the revisions to this chapter, but that we're going forward with being able to put out at least the nice comparison that isn't included in here of Ohio and Massachusetts just so that people actually can begin to understand what's going on, at least at that level in these demos. So thank you very much.

MR. PARK: Thank you.

CHAIR ROWLAND: And we're going to turn now to a discussion of cost sharing for low-income Medicare beneficiaries, a draft report chapter, and Jim Teisl and Molly McGinn-Shapiro are going to give us some background on the chapter and then your comments on how it should be shaped or could be reshaped.

Jim, are you going to lead off, or Molly -- Molly is going to lead off. Okay. And again, we're at now Tab 9.

REVIEW OF DRAFT MARCH REPORT CHAPTER ON MEDICAID COVERAGE OF COST SHARING FOR LOW-INCOME MEDICARE BENEFICIARIES

* MS. McGINN-SHAPIRO: Thanks, Diane.

So in our last Commission meeting, Jim discussed the results of our analysis of State Medicaid payment policies for Medicare cost sharing and the interaction with Medicare bad debt policies. So based on your feedback and discussion yesterday, particularly on the partial-benefit duals in Session 5 that Ellen mentioned, we have provided more context for Medicaid coverage of Medicare cost sharing in our draft chapter, which we will discuss today.

So along with the session brief for this session, you have also received our draft chapter on Medicaid coverage of cost sharing for low-income Medicare beneficiaries. In this session, we would like to review the issues covered in the draft chapter, which includes an overview of the Medicare savings program, which I will present, and Jim will discuss the results from our analysis of State Medicaid payment policies for Medicare cost sharing as well as a discussion of several policy questions related to this issue. So we are especially interested in your feedback and comments on the chapter.

Just for a quick review, similar to private health insurance, the Medicare program requires cost sharing for many covered services. For example, in 2013, the average premium for Part B coverage is $104.90 per month for most Medicare beneficiaries, and many Part B services require a 20 percent

coinsurance. These cost sharing requirements can potentially impact low-income Medicare beneficiaries' access to needed services if these cost sharing amounts are too burdensome.

So as Medicare cost sharing amounts continue to rise, potentially impacting more low-income Medicare beneficiaries and their access to services, Congress established the Medicare Savings Program, which was first enacted in 1988 with the Qualified Medicare Beneficiaries Program. So the MSP has required that Medicaid pay for certain types of Medicare cost sharing. The MSPs have incrementally expanded over the years and now include four different programs that cover certain Medicare cost sharing for dual eligibles at different income levels.

There were 7.4 million duals enrolled in MSPs in fiscal year 2009. Two-point-two million are dual eligibles who are only eligible for Medicaid coverage of Medicare cost sharing and not full Medicaid benefits. This means that they have income and resource levels that qualify them for the MSP program, but their incomes are too high to qualify them for their State Medicaid program. We often refer to them as partial-benefit duals. The rest of the 5.2 million are dual eligibles who are enrolled in MSPs and also receive full Medicaid coverage, such as coverage for long-term services and supports.

So I'll just run through a quick overview of the four MSP programs and their populations.

As mentioned before, MSPs were first established with the enactment of the Qualified Medicare Beneficiary Program in 1988. The majority of the duals are QMBs, at 5.9 million enrolled in 2009. Medicaid is required to cover Medicare premiums, deductibles, and coinsurance for QMBs who are duals with incomes up to 100 percent of the Federal poverty level. The State receives a Federal match for the payments made for QMBs. And just to note, every dual under poverty is a QMB, but not all duals under poverty receive the same Medicaid benefits. So depending on the State eligibility levels for full Medicaid benefits, an individual may only receive Medicaid coverage of Medicare cost sharing, often referred to as a QMB-only, or be eligible to also receive the full Medicaid benefits, which are often referred to as QMB-plus

duals.

OBRA 1990 expanded the MSP program to include specified low-income Medicare beneficiaries, or SLMBs, who are dual eligibles with incomes between 100 and 120 percent Federal poverty level. Similar to QMBs, the State receives a Federal match for payments made for SLMBs, and also there are some SLMBs who only receive Medicaid coverage of Medicare cost sharing, SLMB-onlys, while other SLMBs also receive full Medicaid benefits, or SLMB-plus duals, and they generally qualify for Medicaid in their State by spending down with their medical expenses to meet the criteria for the State's medically needy category.

The third category of MSPs is the Qualifying Individuals Program, which expanded the MSPs to include duals between 100 and 135 percent of the Federal poverty level. Like SLMBs, the Medicaid coverage is limited to Medicare Part B premiums. Unlike QMBs and SLMBs, the QI program is 100 percent Federally funded with annual allotments for each State. So if a State goes over its annual allotment, the State is fully responsible for the additional QI expenses. CMS makes the allotments to States based on the number of individuals potentially eligible to enroll in the QI program in each State. Because of the annual allotments, Congress permits States to impose restrictions on enrollment policies for QIs, including limiting the number of QIs in a given year. Enrollment in the QI program is typically based on a first come, first served basis, and each enrollee must reapply to the QI program every year.

And the fourth category of the MSPs includes the Qualified Disabled and Working Individuals Program, which, as you can see, is very small, with less than 200 enrolled in fiscal year 2009. This program covers individuals with disabilities who have lost their SSDI and Medicare coverage as a result of returning to work. So in order to ensure that they have access to health insurance coverage, they can purchase Medicare Part A and Part B and States are required to cover the Part A premiums for those individuals who are under 200 percent of the Federal poverty level.

While there are Federal requirements for the MSPs, the State Medicaid agencies administer the

programs and, therefore, play a significant role in determining eligibility and benefits available to low-income Medicare beneficiaries. States can use their own methods for accounting for income and resources as long as it is not more restrictive than the Federal requirement. Thirty-nine States had at least one less restrictive policy when accounting for MSP eligibility in 2006.

And as mentioned before, States also have the flexibility in determining who is eligible for full Medicaid benefits in their State, including dual eligibles. So using SSI determination, poverty level option, or medical needy option eligibility categories are often the primary methods. Dual eligibles are eligible for full Medicaid benefits in their State, although they are State options and, therefore, vary by State.

Therefore, in one State, an individual may qualify as a QMB-plus and receive full Medicaid benefits in addition to the Medicare cost sharing, while in another State, the same beneficiary may be eligible as a QMB-only, entitled only to Medicaid coverage of Medicare cost sharing.

And, finally, enrollment in the MSPs has been historically low. For example, CBO estimated in 2004 that only 33 percent of eligible duals were enrolled in QMB programs, although this varied by State. A lack of awareness about the programs and the complex eligibility enrollment processes are often seen as barriers to enrollment in these programs, although a recent GAO study found that several provisions in the Medicaid Improvements for Patients and Providers Act of 2008 that aimed at eliminating barriers to MSP enrollment, such as additional funding for States to perform outreach for the programs, have resulted in growth in the MSP enrollment rate for each of the past five years. Enrollment rates among those Medicare beneficiaries eligible for MSPs vary across States and often depend on a State's eligibility and outreach activities.

So I'll now pass it on to Jim, who will discuss our analysis of State Medicaid payment of Medicare cost sharing.

* MR. TEISL: Thanks, Molly.

So, as Molly just presented, State Medicaid programs are required to cover cost sharing for most individuals that are dually eligible for Medicaid and Medicare. As you'll recall, the Balanced Budget Act of 1997 gave States explicit authority to pay cost sharing, and here, I'm talking about deductibles and coinsurance, only up to the standard Medicaid payment amount, such that the total amount of payment that a provider received wouldn't exceed the amount that they would receive if Medicaid was paying for the service alone. Providers are required to accept Medicare and Medicaid payment as payment in full and can't seek any unpaid cost sharing from the individual enrollee.

States do typically limit the payment of cost sharing to what we term the "lesser of," and that means the State pays the lesser of the full amount of the Medicare deductibles and coinsurance or the Medicaid rate minus the amount paid by Medicare, again, ensuring that the provider doesn't receive more than they would have had Medicaid alone covered the service.

I won't go through the examples again.

So, as Molly indicated, we did some research to identify State payment policies for Medicare coinsurance and deductibles. We looked at the 50 States and the District of Columbia's payment policies across four services -- inpatient, outpatient, hospital, skilled nursing facility services, and physician services -- and for each of the services that we looked at, about 40 States limit their payment of cost sharing to the Medicaid payment amount. Thirty States limited payment for all four of the services examined, while only four paid full cost sharing across the board.

As you'll recall, some providers can claim unpaid cost sharing amounts as Medicare bad debt. For dually eligible individuals in fiscal year 2012, Medicare reimbursed 70 percent of bad debt to hospitals and 100 percent of bad debt for dually eligibles to nursing facilities. However, recent legislation reduces bad debt reimbursement to 65 percent for all institutional providers beginning in 2013. In the case of nursing facilities, which were at 100 percent, they will phase down to 65 percent by 2015. Also, as a reminder,

providers that are paid on a fee schedule basis, and this includes physicians, are not able to claim bad debt through the Medicare program.

Some important policy implications of cost sharing payment policies. Interactions between Medicaid coverage and Medicare cost sharing and Medicare bad debt clearly can lead to some cost shifting between the programs. There's a couple examples here. If States reduce their Medicaid payment rates for hospitals and nursing facilities, then, necessarily, they will reduce their amount of payment for cost sharing and Medicare bad debt payment would increase. On the other hand, if Medicare increases cost sharing requirements within its program, Medicaid spending on cost sharing in the Medicare program would increase.

It's possible that Medicaid policies to limit payment of Medicare cost sharing could affect access. Obviously, bad debt payment may mitigate the effect for some providers, and understanding the effect would really require further information and analysis.

There was a report to Congress in 2003 which found that access to outpatient physician visits for dually eligible beneficiaries was reduced relative to non-duals in States that limited their payment of cost sharing. But a more complete understanding of the effect of these policies on access in individual States would require more information on the actual difference between Medicaid and Medicare payment in each of those States and for each of the services as well as the number of providers that serve dual eligibles and the use of services among duals. Further research could also provide some insight into the extent to which these "lesser of" policies affect the total amount of payment to providers when you account not only for the Medicaid payment rates, but, as we've discussed before, supplemental payments and other things.

With that, we thank you and look forward to your comments on the draft chapter.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: One observation and one question. So on the observation

front, a couple of years ago, we looked at the presence of low-income older people at community health centers in actually some work for Kaiser and, very interestingly, in the period from 1997 to roughly 2009, the number of low-income elderly people doubled. And you can't explain it by neighborhood shifts or where the health centers were. They didn't suddenly go into neighborhoods with only old people. The shifts were out of all -- there was no relationship between that shift and the rise of the low-income elderly. I mean, there's nothing to explain it other than the fact that I've always assumed that following the cost sharing changes in 1997, you begin to see a much steeper rise relative to any other population in the presence of elderly people at health centers.

So I flagged that not to say that they're not well cared for at health centers, but I flag it because I think it provides a little bit of insight as to what might be happening in some communities and it might be worth, at some point, raising this question with health centers whose UDS data show this steep historical rise.

Health centers, of course, are insulated from the impact of this because of the special payment rate. So in many ways, it's sort of a logical response in the financial world to what went on here.

My question is what's the interaction of this with the Affordable Care Act's primary care payment bump? So in the Affordable Care Act, of course, now for primary care services furnished by primary care professionals, the rate is, for two years, the Medicare rate. So doesn't that take -- does that trump the States' discretion to pay cost sharing at the Medicaid rate?

MR. TEISL: Well, it doesn't exactly trump it. I mean, the "lesser of" policy still stands. But to the extent that the Medicare payment level is equal to the Medicare level --

COMMISSIONER ROSENBAUM: Right. I mean --

MR. TEISL: -- then the State would end up paying --

COMMISSIONER ROSENBAUM: -- the practical effect --

MR. TEISL: -- the full 20 percent.

COMMISSIONER ROSENBAUM: -- is that it's --

CHAIR ROWLAND: For those providers.

COMMISSIONER ROSENBAUM: For those primary care services --

MR. TEISL: Those providers and those services --

COMMISSIONER ROSENBAUM: -- furnished by those providers.

MR. TEISL: And it is eligible for the 100 percent Federal match.

COMMISSIONER ROSENBAUM: And so the question is, should we be flagging this specifically and following it at all in terms of whether it has any influence, any effect on providers' decision to participate in duals programs. I don't know how you would get at it. In theory, it should be of some help. In reality, if providers have just generally wholesale gotten out of the Medicaid business, if they're in internal medicine and seeing older people because there's no reason to participate anymore, I don't know that this would bring them back. I'm not sure that that's going to -- that there's going to be a big payoff for anybody other than family practice and pediatrics from the pay bump.

CHAIR ROWLAND: But it could be useful to look at whether there's any shift in the source of care for the dual eligible population.

COMMISSIONER ROSENBAUM: Exactly.

CHAIR ROWLAND: And probably the duals, also, have more established patterns of care that are not quickly going to change.

Any other? Judy and Andy. Andy waved a little earlier than Judy.

COMMISSIONER COHEN: I just wanted to reiterate a question or suggestion that I've made before. I do think for purposes of the dual eligible demonstrations, for purposes, you know, for these cost sharing purposes, I just think some analysis on our part about where dual eligibles actually receive their care,

different categories of care -- outpatient, I think, probably most, outpatient primary care probably of most interest -- would just be a really relevant addition to policy debate. You know, if there is a little struggle over identity, I think that underlies our dual eligibles. Basically, Medicaid beneficiaries, basically Medicare beneficiaries, and what change would having governance of an integrated program in one place or another affect them, and I do think it would be interesting just to understand what the delivery systems really look like for dual eligibles because I think there's a lot of assumptions and, frankly, I can make a wild guess, but I have no idea, and I suspect --

CHAIR ROWLAND: That was actually a question in some of our discussions with MedPAC about whether the dual eligible population had a different source of care or a different utilization pattern in terms of what kind of providers they used and where they went to their care. Were they more reliant on academic health centers or on clinics than other Medicare beneficiaries? So I think that would be an interesting piece to look at.

Judy was first, and then Richard.

COMMISSIONER MOORE: Partially channeling Patty, who had to leave early this morning, I would love for us to look at and think a little bit more about and describe the pros and cons, ins and outs, an analytic look at what might be done to change the responsibility for covering these special groups of dual eligibles through Medicare rather than Medicaid. I know from Diane's caution to us that this would be a responsibility of MedPAC in terms of making formal recommendations, but I think it would be something we could look at and work with MedPAC on over the next year or two and get some cost estimates, know what it would mean further.

CHAIR ROWLAND: I just think, as a quick follow-up, the material that Molly presented about QMBs and QMB-pluses and SLMBs and SLMB-pluses, the more we can tease out how many people are just purely there for their cost sharing help and how many people are there because of other services, even

within those categories, would be very helpful so that we know more about who the partial dual population is as well as the full dual.

COMMISSIONER MOORE: Yeah, and I think the partial dual population should be highlighted for our concern and analytic look, yes, in that way.

CHAIR ROWLAND: And in our goal of simplification, all four of those categories are up for simplification rules, as well.

Richard, I'm sorry.

COMMISSIONER CHAMBERS: No, that's okay. I just wanted to go back to respond to Andy's question about duals' access.

I can only speak from one health plan that's had a special needs plan for a number of years, and it is a plan that's Medicaid focused, so has no commercial business. But the providers, the primary care providers, particularly, are willing to contract to see the dual members, will not see straight Medi-Cal members.

And so, pretty much, at least in our experience in California, is the duals have access to the Medicare delivery system as opposed to having only have access to Medicaid sort of focused providers who are not in the mainstream. So they actually have better access, at least in our system. There's more choices, because then they have all the Medicaid and clinic options, but they have options to providers that the straight Medicaid population don't have.

COMMISSIONER ROSENBAUM: And they don't care that they're not getting potentially the full State of California --

COMMISSIONER CHAMBERS: Correct.

COMMISSIONER ROSENBAUM: They're willing to take the discount --

COMMISSIONER CHAMBERS: I mean, they're taking 80 percent --

COMMISSIONER ROSENBAUM: Yeah.

COMMISSIONER CHAMBERS: -- and it's even the traditional Medicare Advantage IPs, which they're getting 100 percent with the copays, they're willing to take duals at the 80 percent.

CHAIR ROWLAND: Okay. Other comments?

I think this is a critical chapter, and as you know from the discussion yesterday, substantial interest in both teasing out within the dual population those who rely on Medicaid mostly for the cost sharing and the premium assistance versus those who are full duals, and I think this is a very important addition to our work and I thank you both for your contribution and for this chapter that I know will be well read and well done. Thank you.

MR. TEISL: Thank you.

CHAIR ROWLAND: At this point, if there is anyone in our audience who wants to offer a comment or has a point that they would like to raise, please come forward.

PUBLIC COMMENT

* [No response.]

CHAIR ROWLAND: We appreciate your coming to our sessions.

Seeing no one rising to run to the microphone, we have had a full day and a half and have, I think, covered a lot of territory in terms of laying out the report that will be issued in March. We will be reconvening in February to go over some of our draft recommendations as well as to finalize some of our chapters and begin to prepare materials for our June report.

So with that, we will adjourn this session and look forward to continuing to work on these issues as we go forward. Thank you.

[Whereupon, at 11:54 a.m., the meeting was adjourned.]