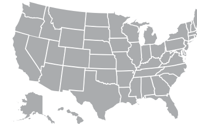
MACPAC

Medicaid and CHIP Payment and Access Commission



Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

Horizon Ballroom
Ronald Reagan Building and International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

Tuesday, February 12, 2013
11:03 a.m.

COMMISSIONERS PRESENT:
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ROBIN SMITH
STEVEN WALDREN, MD, MS

ANNE SCHWARTZ, PhD, Executive Director

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1 P R O C E E D I N G S [11:03 a.m.]

2 CHAIR ROWLAND: If we could please reconvene. Welcome to this session of the Medicaid
3 and CHIP Payment and Access Commission. We're very pleased to be opening with this panel on
4 Medicaid and public health and have a Medicaid leader and a public health leader working together and
5 demonstrating that.

6 This is a session that our Vice Chair, David Sundwall, has begged us to do for at least the last year,
7 so we are glad that we are finally putting it together and we are very sad that David, who really wanted to be
8 here, for whom this session meant a great deal, had an unfortunate family accident that requires him to be in
9 Utah. So he sends his greetings and we send our best wishes to him and his wife.

10 But I know that this session will not be the last on integrating Medicaid and public health. We
11 have just had a great discussion with some of our Hill staff about the importance of looking at Medicaid as
12 more than a financing program, trying to figure out how Medicaid can do more to assure that when
13 someone gets a Medicaid card, they get connected to real health services and how these services can work
14 together. And we know that this session will give us a lot of insight into some best practices that have
15 gone on in the State of Washington and we are very interested in learning more about how your experience
16 can be translated to broader coverage in other States and in other ways to the Medicaid program.

17 So we welcome both of you. Your bios, I know, are in the book, and I'm not sure what order you
18 want to do your presentation. I've been told that you've done this before and it's a very great presentation,
19 so please begin.

20

1 #### MEDICAID AND PUBLIC HEALTH: WORKING TOGETHER

2 * MS. SELECKY: Well, thank you very much, and I'm Mary Selecky and I'm the Secretary of Health

3 in Washington State, having the pleasure of serving my now third Governor and also having great

4 colleagues, like David Sundwall, so let me just start out with that.

5 As a member of the Association of State and Territorial Health Officials, we see people come and

6 go, and while they are State health officials, really, we learn from each other, and David taught us all a lot

7 and continues to do that.

8 And just a little bit on how we ended up here. At our -- my national association fall meeting,

9 David was there, ever present. Doug and I did this presentation because, really, I think we're all dealing

10 with how do you integrate public health and medicine -- you might use that as a title -- but it's really about

11 how do you influence the outcome so that we have a healthier population. We come at it from very

12 different angles, but we all have the same goal in mind, which are healthier folks, cutting the cost curve, all

13 those kinds of things, using all the mechanisms.

14 So David kind of beelined us and said, would you come to MACPAC? We talked about dates, and

15 so it turns out, here we are. I've already sent David a note, once I heard that they were dealing with a

16 health emergency.

17 And, Doug, you might want to say some things.

18 * MR. PORTER: Good morning. Mary is awful good at these kinds of presentations all by herself,

19 but she is even better when she has a straight man, and that's my role here.

20 [Laughter.]

1 MR. PORTER: I had the privilege of working with Mary for, gosh, ten years, I guess, in the State
2 of Washington, and found her to be a great ally and a great resource. As you'll see in our presentation, we
3 jointly did everything we could to get our staff together, as good a relationship as Mary and I have been able
4 to forge over the years. We'll wait and see how sustainable that is, now that we're both departing from
5 State service.
6 MS. SELECKY: And to that note, last week, I announced that I will leave State service. We're at
7 the front end of Governor Inslee's term, and recognizing this is my 15th year in the job, it was time for
8 somebody else. It doesn't mean I'll be gone from public service or health issues, for sure, but -- so this is
9 one that even is a little sweeter, as Doug said, because it's what happens when you've got two folks who
10 have been there a long time aren't there, and I don't think either of us are worried about that at all in terms
11 of continuing, and I think you'll see why.
12 So this is really about a long and windy road. It leads to better outcomes and better bang for the
13 buck. But it is about forging partnerships, understanding each other's history, to some extent,
14 understanding what drives each of you, the public health system and the Medicaid system, and what your
15 common interests are.
16 For me, I've been in public health now 34 years and I was one of those local public health people
17 who went to the legislature back in 1989 because our birth outcomes were lousy. Women were getting
18 into prenatal care way too late. There wasn't much coverage for low-income women. I was in a very
19 rural part of Washington State, and what would happen is no prenatal care. They'd show at the delivery
20 room and the doctors said, "What are we going to do?" There had been some Federal dollars available for

1 us to help a few women in the community, but the collective impact of us in public health identifying the
2 problem, taking it forward to the legislature, and having them expand to what we called the First Steps
3 Program really, I think, was one of those markers in terms of what would make a difference in health
4 outcomes. And I think you'll hear a few things like that.
5 In 1994, we moved to covering all kids up to 250 percent of poverty. We were an early State that
6 did that. We moved on to do things on immunizations that we'll talk about a little bit that also had to do
7 with mailings to families who had babies that took care of the Medicaid requirement and informing those
8 families about what was available to them.
9 So little things like that were really foundational for what we've been able to do in the future.
10 MR. PORTER: This rather odd-looking design or diagram up on the screen is -- POG stands for
11 Priorities of Government, and it was an innovative approach to a very deteriorating economic situation in
12 our State, a huge budget problem, and I thought it was timely, actually, given all the talk currently about
13 sequestration. We had been a State, like other States, that have done traditional give me your two, five, and
14 ten percent across-the-board cuts from each of your departments. The Governor would ask for that, and
15 in each of the silos, the departments would come up with best to worst case scenarios for budget
16 reductions. And then you go sit in front of the legislative committees and present those cut proposals and
17 be embarrassed by all the ripple effects that would be felt by other departments who you hadn't talked to
18 yet.
19 So in this case, what we did was sat down for, gosh, maybe six months --
20 MS. SELECKY: Oh, at least, and this was in 2002 and 2003, not recent, 2002 and 2003.

1 MR. PORTER: We had public health, we had the Health Care Authority, which was in charge of
2 the public employee benefits program, we had what -- Labor and Industries, or what you would normally
3 understand as a workers' comp organization, you had the Medicaid program from DSHS, all kind of locked
4 in a room together and presented with one pot of money that the five of us were going to have to divvy up
5 and be able to justify and the best way of allocating those resources.
6 And what was odd, we were never really told what the reduction was. They took all of the money
7 from all the different departments, put it all together from what we historically had spent, reduced it by
8 some amount, and then said, here is your bucket of resources. Figure out where the biggest bang for the
9 buck is. And this, for me, was something that I was pretty skeptical about on the front end. When it was
10 all over, I was a big convert to how much better a way this was to go about doing your budget than the
11 traditional way.
12 And I tell this story on a number of different occasions and I'm always surprised by how much more
13 enthusiasm I have for it in telling it historically than I did when we were actually going through it.
14 [Laughter.]
15 MR. PORTER: It was a lot of sitting down together and really trying to understand what the other
16 departments were doing with their resources and their staffing, what their priorities were and how they did
17 or didn't line up with what you were doing. A big learning process, pretty unwieldy, but it really paid off in
18 the end.
19 MS. SELECKY: So the POG work that we did really had a goal, and it was improve the health of
20 Washington, and we were to bring to the table -- and then there actually was, I would call it, like a court,

1 where we had to show them what we knew and why we would invest the money.

2 So it would be, show me your evidence, so I would prepare for these meetings and I'd come in with

3 Health People 2010 or the books that showed you the return on investment, and there's not a lot of public

4 health research, but there's some out there. We keep begging for more. But it would be, like, well, if you

5 put babies in car seats safely, here are the injuries that don't happen. You know, we're always having a

6 hard time of proving what doesn't happen.

7 And at some point in that event, Doug, sitting way on the other side of the room, said, "So, as the

8 Medicaid Director, I should be writing checks to her?" Well, I thought my work was done and I should

9 just go home for the rest of whatever in my career, but it really was about that basic understanding, that

10 plain talk kind of way of talking about what difference it made when we strapped kids in cars or used

11 booster seats or dealt with prenatal care so kids weren't in the NICU, in the neonatal intensive care unit, and

12 show those actual pieces.

13 This became the star of POG, or the Priorities of Government, under Governor Locke because

14 nobody else came up with a map quite like we did about what impacts held, what you need to invest in,

15 where the money should be spent.

16 The other thing is, Peter Hutchinson is a man who wrote a book called Price of Government, and

17 this map is in it and the whole description of Washington State. He was known, and those of you who

18 might have ever read Governing magazine and things like that, for going out to, if I remember correctly,

19 Sacramento, California, turning the city around in that. He was a school superintendent in Minnesota.

20 But that's where the idea came from, was to try to adapt that in State government. And, actually, what was

1 determined was here's a set amount of resources the Washington State Government has to spend, and your
2 programs were either above the line or below the line, and going to the legislature that year, if you wanted to
3 pull up a program below the line, you better figure out what's above the line to pull down. And so that
4 technique was used for a number of years in terms of how budgets were presented, but really grew into
5 future policy discussions about, again, what's the best bang for the buck, how do you do that impact work.
6 So when we look at -- and this pie chart is only from 2002, so we didn't have it in front of us, and
7 this is Mike McGinnis and Bill Fahey, big public health giants, came up with this and got talking about, you
8 know, let's really talk about what influences our health and where do we put our money.
9 Well, Doug made it simpler than that when he said, "So I should be writing checks to her?", but it
10 became a whole research project, and given the magnitude of your budget, you might want to focus on that.
11 MR. PORTER: Yeah. Actually, this was my wake-up call. Intuitively, I knew that we were
12 spending a disproportionate amount of money on acute medical care in the Medicaid program relative to
13 what was being spent in public health, but this really snapped it into focus and made me -- well, actually, I
14 think what I actually said to Mary was, I should give you as much money as you could possibly spend over
15 the next two years because I can spend money a lot faster than you can. And so whatever you need, you
16 should get, and I'll take what's left and I'll spend whatever they give me, anyway, just on the status quo.
17 But this, looking at the ten percent that health care really has an impact on on someone's health
18 status, given the almost 95 percent of expenditures that go there, was a sobering statistic.
19 And I have to say, I also related this to -- I'm a big fan of the Dartmouth Atlas, and the talk about
20 evidence-based medicine, and I'm having to confess in this group setting that according to Jack Weinberg,

1 maybe ten to 15 percent of what Medicaid spends out there can be tied back to evidence-based medicine.

2 The rest of it is patient preference and provider preference. When you look at the world of public health,

3 there's a lot more evidence-based activity out there that you can really go to and determine what the return

4 on investment is for things like immunizations and prevention. So I'm a big convert to how Mary should

5 be spending the taxpayers' dollars rather than people like Doug Porter.

6 MS. SELECKY: So, again, Doug earlier said, hindsight of the POG process is a wisdom teacher.

7 Well, the same thing as we sit here and think about the journey we've been through in terms of wisdom

8 teachers. And maybe the focus on this slide really should be on the word "partnership."

9 And while Medicaid in Washington State was looking at new ways to deliver services, because what

10 are you doing about the biggest cost driver in State government, at least in our State, and I think most, you

11 know, how are you going to be more cost effective? What is going to be -- rather than patient preference,

12 how do we get them to the right stuff at the right time in the right place? And we were all being held more

13 and more accountable in different ways, very different ways. It wasn't, how many clients did you serve.

14 What's the outcome? What's the measurement? Have you met that measurement?

15 And we also had some opportunities, and you may be familiar with a variety of States across the

16 nation, but our governors and our legislatures have really been very supportive of us making sure that folks

17 who are low-income, lower educated, have access to health care, sometimes around specific services,

18 sometimes around specific diseases, but really, over -- starting in actually the late 1980s, I would say, with

19 the coming forward of HIV and AIDS and then many other things, over these last several decades.

20 And we had to improve outcomes. And in those months that we were together with POG, Doug

1 needed data and was discovering that the Department of Health had data about the six-plus million people
2 in the State while he was focusing on his million.
3 MR. PORTER: The other thing I would add to that is that this period in time really coincided with
4 many States, including the State of Washington, making the shift from being an insurer and a bill payer to
5 being a purchaser and paying more attention to what it is you are buying rather than how much you're
6 buying or just what the unit costs were.
7 MS. SELECKY: So we got looking at kinds of collaborations that we might do, and I already
8 mentioned First Steps. That was our prenatal care program. It had, at that time, wrap-around services
9 that had to do with nutritional. It had to do with getting people into treatment, as appropriate. It had
10 home visits by public health nurses and community workers to help get families ready for the birth of this
11 child. Services like family planning available to the new mom for a certain period of time. Coverage for
12 the baby for the baby's first year of life. Make sure we get this healthy start at the beginning.
13 Back in 2000, the Breast and Cervical Treatment Act was promoted, and again, that relationship
14 between Medicaid and public health, where we had a program that would go and do the identification, let's
15 have screening programs in the community -- and again, I was running the local health department -- and
16 then what? So we found something wrong, so we'd go to the local doctors and beg, can they pay on time?
17 What can we do?
18 Well, when the availability of Medicaid match funds, it really did, then, make a program that was
19 seamless between our two agencies and really had to have staff who knew what each other were doing. So
20 as I said earlier, it's about those partnership things. It was getting staff engaged in those kinds of pieces.

1 Family planning, Title X has been around for a long time. Medicaid eligibility for women who are
2 a little above low income wasn't very available, but again, Medicaid stepped up. The 1115 waiver, I think,
3 took us to new heights.
4 On immunizations, I think Doug has got a great story about that, about our common goals.
5 Tobacco, I will drill down on that one a little bit more, and a few of these other pieces. But it gives you an
6 idea, and we'll just say a few words more about each one of those.
7 MR. PORTER: Immunizations was another wake-up call for me early on in my tenure in
8 Washington State. I would meet monthly with the Secretary at DSHS, would present the metrics that we
9 were following in our program, one of which was immunization rates and well child visits for kids in
10 managed care programs. And I didn't get halfway through my charts when Dennis Braddock, the Secretary
11 then, said, "How much has the immunization rate improved over the last five years in your managed care
12 organizations?"
13 And I had to go back and dig up the past five years' worth of statistics in order to report back to him
14 that the needle hadn't moved at all. There was no statistically valid change from one year to the next over
15 the last five years. And when I gave him that update, he said, "Do me a favor. Either change the
16 behavior of the managed care plans or stop reporting on this. Quit measuring this data if you're not
17 managing it."
18 And so, again, partnering up with Mary and talking some straight talk with the managed care plans,
19 we put in a withhold of, I think, just one percent, and said, until you improve the -- and Washington State,
20 as Mary will explain, has an abysmal immunization record when it comes to the entire population, including

1 the Medicaid population -- and by working together with the Department of Health and using a fiscal stick

2 as well as a carrot, we were able to start dramatically improving the rate of immunizations for kids in

3 Washington.

4 MS. SELECKY: So just a few things on that. Again, our staff is working together, and as

5 Medicaid was moving to the managed care plans, the credibility of our immunization staff and our State

6 Health Officer meeting with the medical plans' medical directors and getting them focused on it made a

7 huge difference. We have an immunization registry and do share that data back and forth seamlessly.

8 We're actually growing the registry into all immunizations, not just around kids, but it was an absolutely

9 important tool for us to have. We do mail-outs to now all children born in the State of Washington

10 through the time they're age six. And together, our two agencies decide what's going to go in these

11 mail-outs. They're timed for developmental. They're timed for the immunization schedules.

12 Ten years ago, I was in front of the Senate Health and Long-Term Care Committee in our

13 legislature, and what I recognized was my partner was not being held to the rate of immunizations that were

14 done by age three, age appropriate, it was I. Well, gosh, he was paying for the office visits. I mean, and

15 my staff would say, no, no, we make sure they have vaccine. I said, no, I think we have to figure this out in

16 a very different way.

17 And so, really, it needed to become collective impact from all of us, including our private sector.

18 Now, in Washington State, most immunizations are given in the private sector. We made that shift in the

19 early 1990s, but the role that some of us felt is if we didn't run immunization clinics, it was those people --

20 we gave them the vaccine, it must have been their fault, something that went on at that end. And we really

1 had to shift the culture on that when the accountabilities really started to become more serious.

2 We were rated at that time, I'm sorry to say, about 46th in the nation in the rate of kids at age three

3 who were all immunized up to the schedule at the time. I am proud to say we are now at about number

4 16, but it took a heck of a lot. And those of you who would be living in the world I'm in or paying

5 attention to it know that in the last many years, we've also been dealing with pop media stars who speak

6 against immunizations, and that was a complicating layer, which means we had to shift our messages, shift

7 the way that our private sector talked to parents about immunizations, recognizing we were accountable for

8 the outcome, but the inputs were happening by very different folks.

9 So, again, realizing what might help them to spend more time with families who walk in with this

10 from the Internet and say, prove it to me, really doesn't ever show up in data. It really shows up in the

11 kind of work you do.

12 And just as a side note, we in Washington State have the unfortunate distinction in 2012 of having

13 the greatest rate of whooping cough cases. I declared an epidemic in the month of April. It was

14 widespread across Washington State. We're ending the year with more than 4,800 cases of lab-confirmed

15 whopping cough. We have not seen numbers or a rate since -- for 70 years like this. I'm pleased to say

16 our immunization rates got boosted as a result of that. I am sad to say we did lose a baby in 2012 in the

17 month of December, but it really perhaps helps us with another culture shift about the fact that

18 immunizations actually save lives, but it also protects your child from being so, so sick.

19 A few other immunization teamwork kinds of things is that, actually, this is where staff did the work.

20 Doug said, "I didn't know this was going on," and Mary said --

1 MR. PORTER: I find out about this as the presentation, as Mary was talking about. I had no
2 idea that this was something we had done.
3 MS. SELECKY: So Medicaid identified a problem. You know, in our State, we have a lot of
4 Russian-speaking residents and their immunization rates were abysmal and impacting what was going on
5 with Medicaid rates. So our staffs talked to one another, and because we have the skills of going out and
6 having focus groups and health promotion kinds of things and work together on this, some of the Medicaid
7 staff got together with us, did an interagency agreement. We went down and looked at what we could
8 learn from these Russian-speaking families about what was going on.
9 And what we learned was they are highly suspicious of government. We have to address the
10 cultural mistrust of doctors and vaccines. We need to use a strong social network in the community, you
11 know, I mean, that's usually, gee, should have had a V-8. And they're very church-based. And
12 Washington State is not like some other States that are very church-based States, you know. So for us to
13 discover a population that was English-as-a-second-language, if that, who really were causing concerns for
14 both of us, showed that there's something now embedded in all of this work together, and I think that's
15 really important. But, again, it's understanding those common goals.
16 MR. PORTER: In our State, as well, the Medicaid population disproportionately consumes
17 tobacco products, and it was one of our goals to invest more to get our folks -- I think at the time, we only
18 paid for a smoking cessation benefit for pregnant women and decided we really had to expand, given the
19 rates of smoking in our population, to the whole Medicaid population. We put in a State plan amendment
20 to do that and it was disapproved, basically.

1 It was kind of a bureaucratic glitch inasmuch as most of -- I think the entire rest of our State plan
2 only authorized payments to licensed medical staff, and here, we were talking about funding a quit line with
3 people who were not medical providers in the traditional sense, and it wasn't until Don Berwick -- and I
4 want to give a big shout-out to Dr. Berwick for coming to visit with our State -- spent some time asking
5 what was working, what wasn't working, and I was able to bring to his attention that it looked like the
6 Federal rules and regulations weren't really keeping up with state-of-the-art practice out there. And he
7 listened quietly for a good five minutes and said, "We'll take care of this." And I think within three
8 months, not only did our State plan get approved, but I think there was a provision put into rules that now
9 made this available to any State that wanted to use that 50-50 match to institute this intervention.
10 MS. SELECKY: So you see that we're spending investment on prevention of about $1.8 million a
11 year for our Medicaid population, but we had been spending over $651 million a year in publicly-funded
12 health care to tobacco-related illnesses. And that doesn't count kids in smoke-filled homes, and our State
13 pays more than 50 percent of the births, so it shows you the lower income, and these kids are then covered
14 by Medicaid in our Second Steps, or our now Apple Health Program.
15 And showing a legislature, just like showing Congress, that prevention pays off, but it takes a while.
16 So, I mean, we've got to look at these numbers and be able to talk about return on investment in very
17 different kinds of ways.
18 MR. PORTER: On the health homes, I don't know how many other States adopted this sort of
19 label, but we were trying to incorporate, and actually, this was happening in our agency at DSHS, behavioral
20 health was being combined. I, for about three-and-a-half years, had mental health and substance abuse

1 also in my portfolio along with acute medical care as we were trying to integrate three very different cultures

2 under a single governmental organization. And we were trying to allay the fears basically of the mental

3 health and substance abuse folks that we didn't want to adopt a strictly medical model as we were trying to

4 better integrate care and make them subservient to the medical provider dictates.

5 So we called it health homes, and here again is a case where we had an agenda in Medicaid to

6 improve care, better coordinate care, and save some money, frankly. And in order to sell this, it was

7 helpful to be able to turn to Mary Selecky and her crew to go out there and train folks on what was a health

8 home and have kind of a party once removed from the Medicaid folks who also had a track record of

9 working with the University of Washington dating back to the early days of what we called the Diabetes

10 Collaborative, working in conjunction with Ed Wagner out at UW. A very good model, had a lot of

11 credibility and it was something that I thought was a critical ingredient in order to mute the skepticism that

12 we were putting this label of health home on something that was kind of a secret managed care effort to

13 take more money out of the system.

14 MS. SELECKY: So here we are in a time when the Affordable Care Act has passed and our State

15 is on track to implement, I can't presume all the outcomes from the legislature, but implement everything

16 that we're going to need to implement. And in Washington State, public health doesn't run public clinics

17 like FQHCs. That's not what public health is in.

18 So what's that role you have in the clinical stuff that needs to go on? Well, again, it's in terms of

19 the knowledge we have of looking towards evidence-based and best practices, because a lot of this is not

20 evidence yet and we've got to work that through, but what can we do with the private sector in terms of the

1 shifts in how they approach our patients. And we had gained credibility around single diseases -- diabetes,
2 around dealing with children with special health care needs. Then we started to talk about general health
3 kinds of things and, really, our private medical system in Washington State, health care system, does trust us
4 to come in and say, if you look at your practice in this different way, and working with giants like Ed
5 Wagner on doing these kinds of things, so you see that we're already committed to be working with clinical.
6 We've gone from bringing everybody together from around the State in these practices, away from
7 their offices, to being able to be much more electronically-based and much more available as a technical
8 resource, different teaching, different showing, different modeling kinds of methods that have gone on.
9 And we're very appreciative of the kinds of funds that we get through the chronic disease programs, Centers
10 for Disease Control, that are allowing us to shift as to how we use these funds to impact health overall, not
11 disease by disease, which if you look at the Federal budget, there are all those line items -- and I understand
12 how they got there -- and all of those folks.
13 MR. PORTER: This is a real success story and I'll lead with the lesser of the impacts here. We
14 have clients in the Medicaid program, they're kind of the five percent of the Medicaid clients who drive
15 about 50 percent of our expenditures who are frequent visitors to emergency rooms, higher than average
16 hospitalization costs and a lot of it can be tied right back to overuse or abuse of prescription drugs,
17 specifically narcotics.
18 And we had some data in Medicaid paid claims data about what we were paying for, but it wasn't
19 until we came late to the party of Prescription Monitoring Plan and we're now able to capture all of the
20 expenditures that Medicaid clients were generating, including payments made by cash or credit cards for

1 medications outside of the Medicaid Claims Data System.

2 In the first month we were able to detect about $60,000 worth of prescription drug purchases that
3 were off our radar previously, and we're able to enroll those clients into our lock-in program or patients
4 requiring restrictions so they would only have one primary care doc who could prescribe narcotics, they can
5 only go to one pharmacy, and then we had to be extra vigilant about emergency room because you really
6 can't restrict people to one emergency room.

7 But more importantly than $60,000, or I think in the first six months we calculated about a half a
8 million dollars when the program got ramped up for cost avoidance, but the really important story here is
9 that as much as Washington State is a leader nationally when it comes to a progressive look at healthcare
10 reform, we were also a leader in the number of deaths due to narcotic overdoses. And our Medicaid
11 program was in the top five states in the country for deaths of Medicaid clients because of overuse of
12 narcotic prescription drugs.

13 And this is an effort here that is paying off huge dividends, not just in savings and dollars to the
14 Medicaid program, we're actually saving lives of Medicaid clients out there by getting them into a treatment
15 programs and getting them off of these high dose narcotics.

16 MS. SELECKY: Separate and apart from, but clearly related to his knowing that about clients, it
17 was our Epidemiology Staff and our Injury Prevention Program who said, "You know what? We just
18 crossed over from the leading cause of unintentional injury deaths is not motor vehicle crashes anymore.
19 It's prescriptions." And this got to be six or seven years ago and it hadn't gotten caught up on the general
20 radar.

1 There were some states that were seeing it, my colleagues in Oklahoma, but we were independent at
2 seeing things; Kentucky, a number of other places. Some states were the leader in putting together
3 Prescription Monitoring Programs before the rest of us and it usually had to do with funding more than
4 anything else. And I'll put a pitch in for that at some point if you can influence it and have Medicaid help
5 us out with that with Match or something.
6 There was the pitch.
7 But, those numbers just kept going up and the Medicaid Medical Director was using our
8 epidemiology data about the population overall, and then sorting out what was going on inside the Medicaid
9 population. But it's not just Medicaid folks, it's general population also.
10 So, with the help of federal grants, we were able to start up the program in October of 2011. We
11 have a full year of people still coming on, more than 10,000 providers are enrolled. We have millions of
12 records. When you go into a pharmacy in Washington State and you have a prescription you're picking up,
13 immediately your name is entered and as my rural pharmacist said, and I had one of those guys that I knew
14 was a frequent filer, that I was able to say, "No. I can't give this to you. It won't allow me. you're
15 done."
16 And it's a very interesting kind of -- you hear it at the community level, we're starting to see it not
17 only in economic savings, but life savings. And, in fact, we're able to share with the public that the number
18 of prescription medication deaths has dropped by 26 percent in the last three years.
19 So, it takes a combination of things.
20 The other thing I would add is this wasn't it alone, this is something that really impacted costs and

1 lives. But we also have common prescribing guidelines between all of our prescribers in Washington State.
2 All of those healthcare professionals who have these prescription authorities are using common guidelines,
3 pain management guidelines. I just recently talked to my colleague in Vermont and shared everything with
4 him, my colleague in Alaska, but that was yeoman's work because like most other states those are
5 independent boards or commissions. But in Washington State they're all under me. They have
6 independent authorities, but we house together all the health professions, all 83. Not all 83 are prescribers.
7 But it's work to get the folks who regulate the independent commissions together to say let's have this
8 common set.
9 The other thing was that our state Medical Association and our Medical Quality Assurance
10 Commission really did step up and take some extra time to make sure the providers were well educated and
11 what this really meant. This was not about stepping in on their practices; it's about giving them guidelines
12 for better outcomes as a result.
13 It takes all of those things to do it.
14 But again, a lot of these folks are on Medicaid, we're trying to figure out how to continue to fund
15 this. You know, and maybe something can help us out in the future.
16 So, as we look at this work together it really is about coordination and collaboration and, you know,
17 sometimes I think Washington State is spelled with a big "C" because that's what we're expected to do
18 when we sit at the Governor's Cabinet. Those are the measures that we're held to. Under Governor
19 Christine Gregoire, we had accountability sessions in front of her with the press present, with the public
20 watching to talk about our outcomes. "Mary what did you have to do with that thing that Doug has

1 dropped down on? Or Doug, how can you help Mary improve this, that, and the other thing?"

2 I mean, our public expects that from us, but we've got mazes that we need to go through to get

3 there.

4 So, here's some lessons learned.

5 MR. PORTER: One of the things that I think was useful for us was to take the stereotypes of our

6 respective departments and debunk them. I think it's fair to say at the staff level there was an attitude on

7 the part of the public health folks, that my people wore all green-eye shades, wore wingtips and counted

8 beans day in and day out. And whereas my folks thought, these are a bunch of granola-chomping,

9 Birkenstock-wearing, prima donnas who did only God's work and we really had to work at many, many

10 areas where we had common interests and come to respect the cultures and the fact that we serve different

11 federal masters and we did have slightly divergent agendas when it came to population-based health versus

12 just looking at the Medicaid clients, but the leadership here, I think, really plays a huge role.

13 It's one thing for two cabinet officers to tell the Governor that we'll have our staffs work together.

14 There are ways that you can talk to your staff to say, "I really want you to sit down with Mary's folks and

15 solve this problem. I don't want you defend our turf. I don't want you to adopt an adversarial posture.

16 I really need you to get along as well as Mary and I get along."

17 MS. SELECKY: I guess my closing comment would be that one that said different federal

18 influences and sometimes it doesn't help us when our federal colleagues aren't talking the same language or

19 think they have different outcomes or held to different standards, because when it comes down to the

20 people in our communities and in our state, it's about what helps them make good choices for themselves.

1 Where do they get the best information they can? What is it that helps them open the door to make that
2 choice? And it's going to take all of us to do that.
3 So, we really appreciate being able to share our story. Doug already is in a different role and not
4 the Medicaid Director. I'll be moving on in some future time when they name a new Secretary and both of
5 us are convinced that this will stand the change of leadership and the test of time and we'd be happy to
6 answer questions.
7 CHAIR ROWLAND: Well, your presentation really shows your integration and I think is a really
8 fantastic contribution to our understanding. And if David were here he would be saying, "This is why I
9 have been trying for a year to get you to have them come in and be here." So, on his behalf I thank you
10 for coming and I'll open it up to questions and comments from the Commission members.
11 Sara, Burt, Andy, and then Patty.
12 COMMISSIONER ROSENBAUM: This is a terrific presentation and I think your model -- I
13 mean, I assume because you present through ASTHO, I assume through the Medicaid Directors it has
14 spawned more working relationships and I actually, I think, a very interesting issue is that the CDC and
15 HRSA and CMS simply have not grown this kind of working relationship.
16 And, it's been a special focus of mine for many years of my practice because I've tended to work on
17 issues that are on both sides of this divide and it's much more likely to find collaborations in states than it is
18 at the federal level. And so, I think our writing about this issue and about its importance in being reflected
19 in federal policymaking would really do a service.
20 And I just wondered from your experience now and having so many different points where you

1 have formed a collaboration whether you have noticed, just like when the Preventive Benefit definition

2 came up, are there other areas that you or somebody on your staff might point us to? In terms of specific

3 things, this goes to both of you, either having to do with what is an allowable medical assistance or

4 administrative expenditure, the kinds of allowable arrangements that you can create for provider practices.

5 Anything that you would like to see us make recommendations around where existing policies -- and

6 typically, I should just -- I'm going to stop. But that most of these changes don't require legislative

7 correction in my view. It's things like the Preventive Benefit definition, which turns out is a badly drafted

8 role over many, many years.

9 So, I'm just wondering from your practical experience if you have found other areas that you would

10 like to recommend to us.

11 MS. SELECKY: I have one.

12 MR. PORTER: I'll let you start.

13 MS. SELECKY: Well, again, because Public Health isn't the primary provider yet we're the ones

14 who identify the need. I'm not saying exclusively. There are CBOs, community-based organizations and

15 all kinds of folks but I'll speak from my seat.

16 So we have to identify the folks. We have to hook them up and then make sure they stay

17 connected. And sometimes Medicaid Match rules for that work done in community become very tough

18 for communities to be able to continue to do that with where the individual is.

19 You know, there's no simple thing like a family planning visit. It's full of other kinds of things.

20 Or a WIC visit, Women, Infants, and Children. Or having a family come in, and fortunately in our state, it

1 used to be that the Public Health Nurse would barter sometimes with eggs with folks to see that baby with
2 an ear problem. Well, when we expanded our Healthcare for Kids it was a gift, a gift to help the door get
3 open. Well, we have lots more of that kind of stuff out there.
4 Our population has doubled since I moved there in 1974 and its continuing to grow. While I'm
5 watching the state from which I came, Pennsylvania, reduce in population. So we have some different
6 dynamics than other states in terms of all kinds of density. I'm not saying the West is special, but it sure is
7 pretty. But I think that is one of the pieces from where I sit immediately.
8 MR. PORTER: This is a little awkward. And I'm not sure if it lends itself to the kind of solution
9 you're looking for, but I'll say that there's a pendulum that swings between the states and the feds and I've
10 been around the Medicaid program long enough to appreciate the abuses that states have indulged in
11 maximizing their federal revenue, some creative financing efforts that have effectively shifted the Match rate
12 in states given one economic situation or another.
13 And then, I've also been there when CMS or before that, HCFA, would catch on and crack down
14 and force us to clean up our act. And so, I guess I have to acknowledge that up front, that there has been
15 a tension in the federal-state partnership there that has had unintended consequences from time to time.
16 And here's a good example. I mean, back when Richard Chambers and I were working the
17 Medicaid shift in California, I thought we had some pretty creative solutions in our managed care
18 organizations. They were handing out child safety seats upon the birth of a child. They were
19 encouraging folks to sign up and giving out bicycle safety helmets to kids. In our state when we had our
20 Chronic Care Management Program, we were providing clients with scales to detect water retention in

1 patients with congestive heart failure. And it was, you know, not too far into that endeavor when, I believe

2 it was Dennis Smith was in charge of the program, where he said "Well, that's not a medical piece of

3 equipment, that scale. We're not going to give you the federal share for that. Bicycle safety helmets are

4 not something that we should be paying for. We're giving Managed care Plans too much money, so let's

5 start pulling federal dollars out of things that really aren't strictly a Medicaid service."

6 So, if I have an appeal it's to the federal government. It's "Okay, we promise to not go overboard

7 and abuse our flexibility this time."

8 But we really could use more flexibility to be more creative with how we try and integrate, for

9 example, behavioral healthcare and physical healthcare. SAMHSA comes out with guidelines for best

10 practices and evidence-based approaches for mental health and substance abuse treatment. Medicaid

11 doesn't have a code for that. And so, we don't pay for it. I think those are all things that really should be

12 on the agenda for reform.

13 COMMISSIONER EDELSTEIN: I think you have really helped highlight for us how improving

14 health can address healthcare costs and I want to congratulate you on something that you didn't get to

15 mention today but you're with the Commissioners, the work you've done on oral health. Both your

16 inclusion of comprehensive dental benefits for pregnant women as part of your prenatal package and also

17 the ABCD Program, ABCD.

18 MS. SELECKY: Access to Baby and Child Dentistry.

19 COMMISSIONER EDELSTEIN: Thank you.

20 MS. SELECKY: You're welcome.

1 COMMISSIONER EDELSTEIN: That really is focused on the causes of the epidemic of early
2 childhood tooth decay rather than all the money that goes to cleaning up after it. So, Washington has been
3 a tremendous leader on those. What's next on oral health and integration in Public Health?
4 MR. PORTER: I would hope it would it be restoring the Adult Dental Benefit that we cut during
5 the 2008 recession.
6 MS. SELECKY: And I know on several legislators radar screen it is, number one, anything we can
7 "save" from somewhere else it goes into that. The impact of the Affordable Care Act in the expansion to
8 139 percent of poverty basically -- for example, for my department looking at breast and cervical and what
9 state dollars we put into it. We're making some assumptions about getting people into coverage with
10 Medicaid, with our HIV/AIDS Program, again, doing the same thing.
11 So legislators are saying okay, if we're going to be able to "capture that," where can we put it and
12 Adult Dental is the most recent. I mean, most stated that I hear.
13 And just for a moment on that ABCD program. University of Washington School of Dentistry
14 recognized that a lot of the dentists in the state weren't comfortable with little kids in their seats, number
15 one. Number two, there is always an issue and I think it's nationwide about Medicaid payment for dentists
16 and dentists opening up their practices to that. Well, Medicaid made it much more attractive by upping the
17 reimbursement for kids, to get them into the chair. So it took a combination and it's taken a number of
18 years but the ABCD program has paid off and it's got now about -- pushing a 20 year history.
19 COMMISSIONER COHEN: I want to thank you so much for your presentation, it was great, it's
20 a great topic. I work in the New York City Mayor's Office and I work and am a liaison to both our public

1 hospital system and our City Department of Mental Health and Hygiene and I admire so much of what you

2 have done and think that that kind of, you know, sort of cross collaboration between like the delivery

3 system and Public Health -- not just the money, but it's the techniques is so important and I want to thank

4 you.

5 So Sara asked my question and then in the course of answering it, thank you so much you actually

6 kind of addressed what is my other question, which is -- if you have any more to say about it, I would love

7 to hear it. What are some ways that public health techniques, you know, funding programs, other things,

8 can be used in the behavioral health space? Do you have any more sort of thoughts about that? Besides

9 doing our best to kind of, you know, align recommendations from to sort of align agencies policies and

10 recommendations at the federal level, are there other things that you would suggest in that arena?

11 MR. PORTER: More clarity around what parity means would be a huge help for states like ours.

12 And again, under full disclosure, we went to a managed care 1915 waiver for our mental health services,

13 which is why when you look at the CMS data it looks like a 100 percent of our Medicaid clients are covered

14 by managed care, that's really the Mental Health Benefit they're talking about.

15 Unfortunately, we instituted what's called an Access to Care Standard, which is a more stringent

16 level or threshold to clear than just medical necessity when it comes to getting mental health services. So

17 our regional support networks, I think it's about 13 of them around the state, they screen out all but the

18 most seriously mentally ill folks and when it comes to prevention, I think we're sadly lacking in our state and

19 I would imagine others and I would think a Public Health attitude or perspective could be very useful in

20 defining parity for behavioral healthcare.

1 That's off the top of my head, what I would look for.

2 MS. SELECKY: The other thing you might expand on is we did get one of the dual eligible
3 projects and we talk about health homes and really some strong feelings, particularly by our
4 community-based mental health providers in looking at how do we get medicine, looking at mental health as
5 part of what they're doing. And one of the first knee jerk reactions by the Medical Association was,
6 "You're trying to turn our docs into mental health providers and psychiatrists." No. It's about let's look
7 at this whole piece. Let's work on the community to make sure there is connection outside the clinic room
8 for example.

9 COMMISSIONER GABOW: I came from a system where the Public Health Department was
10 part of the acute healthcare system, and I wondered, I thought that worked pretty well for integration.
11 And I wondered if in your state there were any examples where county health departments were part of
12 community health, DSH hospital, you know, an integrated delivery system across the whole continuum and
13 if there were such places can you comment about whether you have any data that that actually facilitated
14 better integration of care at the patient and community level?

15 MS. SELECKY: There are a couple of examples, I mean, Public Health Seattle, King County, is an
16 exception to what in terms of are delivered by other health departments in our state. There are only 35
17 local health jurisdictions covering 39 counties and, of course, that's our largest metro. They actually run
18 two primary care clinics. And they share space with also an FQHC, and so, they move people back and
19 forth. One might have oral health, one might do the prenatal. So they'll move them back and forth and
20 have Public Health Nurses who will then go out and look. But this is again urban setting.

1 There's a very rural county called Lincoln County. Lincoln County is just outside of Spokane.

2 those familiar with -- it's a wheat country. It's your bread basket of the United States. And they're in the

3 same geographic location as the critical access hospital. So you've got two administrators who have very

4 limited pots, who are 35-40 minute drive from a tertiary healthcare center. So, understanding that, for

5 example, getting stroke victim to the right place at the right time and you have a better outcome, Health

6 Department data. That the hospital worked with the larger urban hospital in Spokane, so that they've

7 come up with a unique way that as they come into the ER and they identify what's going on, there's a team

8 waiting for them in Spokane. So a stroke system and we've taken that concept and moved it through our

9 EMS and trauma system.

10 But in terms of -- and I have to tell you, having been 20 years at the local level, we always felt like we

11 got swallowed up by that because the big bucks went to the primary care and less went to the Public Health.

12 So maybe if we were on our own and were complementary, you know, the way of the future looks very

13 different.

14 My colleagues in the State of Tennessee, they run many of the FQHCs in the communities; my

15 colleagues in Alabama, in Arkansas, in Mississippi, I mean, very different set ups across the country. The

16 West is much more about local health departments not doing as much primary care, doing some of the

17 traditional public health when you just look across the country.

18 And I would never say one is better than the other, given the experiences I've had.

19 COMMISSIONER HOYT: I second what other people said about great presentation on how to

20 make these programs more efficient and effective.

1 You mentioned the need to sell legislators or maybe the feds on the ROI argument. I just
2 wondered, now several years down the road have you made some measurement, the ROI -- savings to
3 Medicaid or overall to the State of Washington? What is that?
4 MS. SELECKY: We in Washington State were very fortunate that Christine Gregoire was the
5 Attorney General and one of -- she was called Tiger Ladies on the Tobacco Settlement. So and she and
6 Governor Gary Locke at the time did make sure that we had a very robust Tobacco Prevention Program.
7 And we were able to hold onto that program funding until the Great Recession hit us and we're still in it.
8 We're dealing, again, with another state budget deficit. Again, another state budget deficit. it will be
9 our 11th reduction since February of '09.
10 Well, the Tobacco Prevention Program is now a tiny little quit line, continues and some federal
11 dollars focusing on smoke-free housing in public housing and those kinds of things. Because we had 10
12 years' worth of data and because we had coordination with our Medicaid program and looked at healthcare
13 costs overall, there is a peer-reviewed article that shows that the number of hospitalizations due to heart
14 issues and pulmonary issues has dropped and the cost avoidance is hundreds of millions of dollars in terms
15 of what hospitalizations were 10 years ago and are now.
16 So we do have that and we'd be happy to send a link to Anne.
17 CHAIR ROWLAND: That would be great.
18 MR. PORTER: If I could just add. The threat here is that -- as Mary and I have said, you have to
19 have some patience when you're looking at these prevention efforts and you have to be able to have a
20 longer view and by that I mean five to 10 years of what the payout's going to be and you can show that.

1 But as Mary says, when you're looking at a billion dollar shortfall and still a huge resistance to any kind of
2 increase in taxes in our state or even closing tax loopholes in our state, you still come back to "I know it will
3 save us money five years from now, I need to cut X-number of hundreds of millions of dollars today."
4 And we won't see the effect of the cut for three or four years, so we'll come back, "I promise, we'll
5 restore your funding later, but right now we have to end these programs even though you've called out what
6 the benefits are to them."
7 In my last go around in the budget, the only way I could hit the target that was laid out for my
8 agency was to propose the elimination of prescription drugs as a benefit for the Medicaid program.
9 Everyone knew that was ridiculous, but it worked with the math when it came up to "I need $486 million of
10 State General Fund savings." that will get blown away in a heartbeat, as soon as our state hospital fills up
11 with people who aren't getting their antipsychotic medications, which Medicaid buys a lot of. But that I
12 think is the tension. is that you can have all of the research and show the success stories that we've talking
13 about here, but when politicians are held, you know, their feet to the fire to come up with a budget that has
14 no new taxes, a lot of the stuff is in jeopardy.
15 CHAIR ROWLAND: Richard.
16 COMMISSIONER CHAMBERS: Yeah, I'd just like to join my colleagues in complimenting you
17 both in such a great collaborative partnership at the state level. As Sara said, having been at the federal
18 level and having and trying to get CMS to coordinate with HRSA is often times very difficult. It's the
19 Birkenstocks versus the wingtips, I think, carrying on the same -- but the initiatives are all very exciting and I
20 think it is something I hope we can advertise for other states to pick up.

1 For me, as running a health plan in California, is part of the waiver that the state got several years
2 ago is to prepare for 2014 and the bridge, they called it The Bridge to 2014, and picking up on the option to
3 early enroll the medically indigent population who are going to be on Medicaid in 2014, and we have seen
4 the struggles of primary care physicians in our clinics that we run through the health plan itself is dealing
5 with this population. Particularly on the medication side and substance use and abuse and seeking.
6 And, it is certainly stuff that you have pointed out as what you did in Washington is how when that
7 population transitions, I think we as Medicaid health plans or Medicaid agencies are going to see even
8 tougher struggles in trying to control that use and abuse of, you know, narcotics and where you can really
9 connect it with pain management that is going to be key in those populations.
10 But I just had two quick questions. I just had on the health homes you mentioned long-term care.
11 I'm just curious if you could talk for a second about what that specifically looks like. And the second thing
12 was, is you mentioned the Medicaid Managed Care during 2012 and '13 as Transitional Healthcare Service
13 Program, and I'm just curious if you could just briefly talk about those two to see how that could inform us.
14 MR. PORTER: Sure. We started, I'm going to guess it's seven or eight years ago now, a pilot
15 project in Snohomish County whereby we contracted with one of our Healthy Options plans, which was,
16 oddly enough, Molina, to accept capitation payments from our Aging and Disabilities Administration, from
17 our Substance Abuse and Behavioral Health Administrations and DSHS as well as the acute medical care
18 payments and to consolidate all of those payments to a single entity and make them accountable for
19 long-term care, acute care, behavioral health care. It was called the Washington Medicaid Integration
20 Partnership, or WMIP.

1 And I would say it has been a success, overall. We've done an evaluation of it. Largely, the goals
2 that we had called out were goals that have been met. The trickiest piece has been the long-term care
3 piece, and actually, when -- and we phased this in. First, we had acute care and substance abuse. We
4 added mental health as a benefit, I think, a year later, and about three years after that, we finally added the
5 long-term care piece in.
6 And when we did that, when we added that final long-term care piece, because -- and this may be
7 peculiar to Washington State -- because so much of our home- and community-based care is rendered by
8 individual providers who are alarmed that this managed care entity would come in and only contract with,
9 say, large home health agencies, where you had a lot of individual contractors out there, some of whom
10 were family members, there was a huge out-migration -- and this was a voluntary program because there was
11 only one plan, so you could opt out of this pilot -- and I'm going to say when we started we had 15,000 to
12 20,000 clients enrolled. As soon as we added the long-term care piece, enrollment dropped down to
13 something like 3,000.
14 And so that's an area. I don't think we have yet figured out how to sell clients who are very reliant
15 on long-term care services that those services can be managed. I think the consumer-directed aspects of
16 long-term care and home health care are such that they will resist an incorporation. We're hoping that we
17 can learn from some of those lessons and be better prepared for the duals pilot that we're looking to put
18 into place in Snohomish, and I think now King County, as well. But work with those providers and have
19 the plans work with those providers to calm them down about the prospect of what integration of care
20 holds out as a promise versus a threat of managed care.

1 CHAIR ROWLAND: Okay.

2 MR. PORTER: And I can't remember what the second was you wanted me to talk about.

3 COMMISSIONER CHAMBERS: It was the managed care with transitional health care services.

4 MS. SELECKY: That was part of that same project, and the role, again, with us was to work on
5 the health home concept and continue to learn and upgrade what it is we've learned from the pilot. But we
6 were committed to do this arm-in-arm.

7 And, again, not knowing other States, we have an initiative that was passed -- we are strong initiative
8 States in the West -- an initiative that was passed to get all of the home care aides in Washington State
9 registered as a health care professional. Well, we're going through fingerprint checks, et cetera, but we're
10 talking tens of thousands of independent people, unlike many States that might have, you know, Catholic
11 Charities covers most of it or Area Agencies on Aging or whatever. So I don't know if we're different than
12 other States, but it's a dynamic that's growing.

13 CHAIR ROWLAND: Okay, Denise, last word.

14 COMMISSIONER HENNING: Oh, good. I always like the last word.

15 [Laughter.]

16 COMMISSIONER HENNING: I was just curious -- actually, I have two questions. One,
17 coming from a State whose governor used his line-item veto to keep pregnant women from getting a Tdap
18 vaccine, I was wondering if your Medicaid program actually pays for the Tdap.

19 MR. PORTER: Do we?

20 COMMISSIONER HENNING: Yeah.

1 MR. PORTER: Okay.

2 [Laughter.]

3 MS. SELECKY: Yes, and we're encouraging all pregnant women to get Tdap.

4 COMMISSIONER HENNING: Well, so is the CDC --

5 MS. SELECKY: However, not all Medicare programs cover Tdap. I mean, the first ones who
6 wind up, when we said, adults, get your booster shots, were grandmas and grandpas who wanted to protect
7 their precious little babies. And the first sets of calls that I got, even personally, were about my Medicare
8 program does not cover this. How silly that we have a Medicare program that if you're on A or B or D --
9 I'm that age, but, I must admit, not familiar -- but that it covers these four and not the rest? A little help
10 from my friends would be great on that.

11 And the other one, the other population we heard from were adults who had no coverage at all.
12 And so, really, we were able to work with vaccine companies to first access through their programs, our
13 local health departments and community clinics got vaccine, but then our Governor kicked in and CDC
14 freed up some money for us, so we were able to provide vaccine for those who had no coverage.

15 But Medicare isn't as generous as Medicaid. Never has been.

16 COMMISSIONER HENNING: And I'm not sure which one of you might want to speak to this,
17 but I was just curious about the participation and the environment for midwifery in the State of Washington
18 as far as helping to provide prenatal care and access to prenatal care and if there are any barriers there that
19 you can identify.

20 MS. SELECKY: Sure, there are barriers, and they're cultural, but they're also really -- some of the

1 toughest, and I license them, are the bad outcomes, you know, and we have more on a rate sometimes of

2 bad outcomes and unintended kinds of situations and it will cause a pale every time that happens.

3 I think there are movements to say -- and I know that there's an Institute of Medicine committee --

4 Dr. Maxine Hayes, our State Health Officer, is on that -- looking at today's practices, not 20 years' old stuff

5 that people are basing today's decisions on. What's going on today? What are we seeing in terms of

6 outcomes and results? And how can we best use the variety of health care professionals that are available

7 to help with those situations?

8 But there are also folks who jump to, that's a solution. Let's understand the outcomes first, is what

9 I say, and then make smart decisions, regardless of who pays for it.

10 COMMISSIONER HENNING: I'm not sure what bad outcomes you're talking about, but I

11 know that nurse midwives have excellent outcomes.

12 MS. SELECKY: Yes, they do. No, I'm talking about if somebody has -- there are always bad

13 headlines when a baby dies.

14 COMMISSIONER HENNING: Right.

15 MS. SELECKY: Okay, and then the costs --

16 COMMISSIONER HENNING: But you don't hear about those in the hospital.

17 MS. SELECKY: Yeah. No, and there are always bad outcomes, and when families are aggrieved

18 and things like that. So this is not about data. I'm talking about culture impressions, and you've got all

19 kinds of culture impressions. So we're looking at what the science, and we're hoping the Institute of

20 Medicine will say, here is what we know today, so that we can move on with good discussions about that.

1 CHAIR ROWLAND: Well, I think you have offered us a terrific discussion. Along with my
2 other Commission members, I want to thank you for both coming, for sharing your experience, and for
3 showing us what great collaboration can occur between a Medicaid Director and a Secretary of Health.
4 And I really hope that we can stay in touch with you, because we are trying to look at where there are best
5 practices, where there are instances in which we can make the program on the ground work better for the
6 residents of the State, not just the people on the program. So thank you very much and we will be in
7 touch.
8 MR. PORTER: Thank you for the invitation.
9 CHAIR ROWLAND: And now we're going to turn, since we've talked a little bit in this session
10 about the importance of the payment rates and what happens to payment rates for providers, we're going to
11 now turn back to an update from Ben Finder on our MACPAC staff on what's going on with the primary
12 care payment bump.
13 But, again, thank you to both Doug and Mary for joining us.
14 Ben, you have a hard act to follow.
15
16 **#### UPDATE ON MEDICAID PRIMARY CARE**
17 **PHYSICIAN PAYMENT INCREASE**
18 * MR. FINDER: Thank you. I'll try to do my best. Jim has not only passed the torch to me of
19 talking about the Medicaid primary care bump, but also this coveted spot, speaking just before lunch.
20 [Laughter.]

1 MR. FINDER: So I'm very excited to be here today. Thank you again for the opportunity.

2 So as I mentioned, this session will build on our November meeting in which Jim discussed the final

3 rules for the primary care payment increase. So in that session, we mentioned that we were conducting a

4 survey among different stakeholders to better understand what the implications of their decisions about

5 implementation might have. In this session, we'd like to share some of the preliminary findings from that

6 survey.

7 So we'll first briefly recap the Federal requirements related to the payment increase. Then we'll

8 move on to an overview of the survey, and we'll conclude with some of the preliminary findings from the

9 survey.

10 So you'll recall from the November meeting that the primary care payment increase is a requirement

11 of the Affordable Care Act that requires State Medicaid agencies to pay at least the Medicare rates for

12 primary care services. The rate increase is contingent upon a combination of eligible providers and

13 procedure codes. The services that make up those procedure codes are defined in statute amongst a

14 specific set.

15 The final rule also answered the question of who is eligible and which providers. Increased rates

16 are limited to providers certified in family medicine, general internal medicine, and pediatric services. The

17 rule also allows for providers of subspecialties recognized by the American Board of Medical Subspecialties,

18 the American Board of Physician Specialties, or the American Osteopathic Association.

19 Alternatively, for providers who are certified in a different specialty, like surgery or dermatology,

20 they can qualify for the increased rates if their scope of practice is defined as primary care, and the way that

1 they attest to that is if 60 percent of their Medicaid billed codes in the previous year were primary care
2 services. And, again, that's from the specific set of codes that are established in the statute.
3 And for claims that meet both of these criteria, the Federal Government will reimburse 100 percent
4 of the difference from the Medicare rate and the rate from the State's fee schedule as of July 1, 2009.
5 In order to better understand how States and other stakeholders were approaching the
6 implementation. We conducted interviews with State policy and technical staff as well as representatives
7 from Medicaid and managed care organizations and different provider organizations within each State.
8 These respondents represent six States and the District of Columbia, and overall, 24 interviews were
9 conducted between November and January.
10 It's worth noting that when we started the interviews, it was in the weeks just prior to the release of
11 the final rule and in the weeks just after with the State policy officials, so many of them then were still in the
12 very early implementation stages and many of them told us that they were waiting for the final rules to see
13 how they would unveil -- how they would implement the provision and how they would unveil their plans.
14 And so with that in mind, when we did speak to them, they were in the early stages of implementation and
15 were focused mainly on implementing the provision among their fee-for-service programs.
16 Most States that we spoke with planned to adjust their fee schedule annually and pay the Medicare
17 rate, the increased rate, as each claim comes in. However, two of the States told us that they plan to make
18 supplemental payments and they offered two reasons for doing this.
19 First of all, the States believe that the supplemental payments may help increase awareness of what
20 the provision was or why providers were getting these increased rates. So there was this feeling among

1 States that with all of the other payment reforms going on, that this kind of might get lost in the shuffle.

2 And so they felt that by making these supplemental payments, that might help increase provider awareness

3 of why they were receiving the increased payments.

4 And on the flip side of that, States were also a little concerned -- these two States that planned to

5 make the supplemental payments were a little concerned about the perception of what happens after the

6 provision expires. And so they felt that by making supplemental payments, the providers may be less

7 sensitive to when the provision expires and the increased rates might have to be rolled back.

8 So it's also worth noting that States mentioned that this would require MMIS modifications, that is

9 modifications to their claims payment systems, and they reported this to be a major challenge. Specifically,

10 they will now have to pay two separate rates for the same code, which some States have done in the past

11 and others have not, and they'll also have to identify eligible providers within the system, which is something

12 that some States mentioned they don't have experience doing in this particular way, and that is defining

13 them through these specialties, subspecialties, or these self-attestations.

14 With that in mind, they also noted that the administrative expenses of making these changes were

15 not eligible for the enhanced match, and that was somewhat of a barrier or a challenge for them in

16 implementing the provision.

17 However, on the flip side, they appreciated the fact that the final rule allows flexibility for site of

18 service adjustments and physician self-attestation.

19 So States also -- another underlying theme that emerged from the States was how to implement this

20 in light of the other payment reforms, and so I mentioned that a little bit in terms of the awareness. I

1 think States were concerned with whether or not this would get lost in the shuffle of implementing bundled
2 payments, medical and health homes, Accountable Care Organizations, and payment reforms of those
3 nature.
4 States were also concerned with how to implement this among their managed care programs. Most
5 of them were working with an actuary and awaiting additional guidance and technical assistance from the
6 Federal Government for how to implement this among the managed care organizations. So while many of
7 them didn't have a methodology in place yet, they did note that a lot of them had put placeholders in their
8 managed care contracts which would require amendment in order to implement the payment increase.
9 States also reported two underlying data challenges in sort of the monitoring and oversight of the
10 managed care -- how this would be implemented among managed care organizations. The first is that
11 many of the providers that are enrolled with managed care organizations might not also be enrolled with the
12 Medicaid agency in their fee-for-service program. And so in trying to ensure that these payments are made
13 to the managed care providers, we have a little bit of a problem of who is in that world, and the State
14 fee-for-service program might not have all of those providers enrolled, all of the managed care providers
15 enrolled in their system.
16 They also noted that the managed care fee schedules have previously been proprietary in some
17 States, and so they have another added burden of trying to determine what the difference is between the July
18 1, 2009, and the Medicare rates.
19 So we asked States and other stakeholders how this provision might affect provider recruitment and
20 participation to get a baseline. Half of the States that we interviewed said that there was a primary care

1 shortage in their State. And among these that said that there was a primary care shortage, most of these
2 States mentioned that many of the Medicaid providers were not accepting new patients, and that was
3 contributing to the shortage. One State also pointed to a specific geographic location, specifically rural
4 areas, that lacked an adequate number of primary care providers.
5 Many stakeholders agreed that the temporary nature of the increase would likely inhibit provider
6 recruitment, and this hearkens back to what we said about the supplemental payments, what States told us
7 about the supplemental payments. Stakeholders were concerned that this might inhibit recruitment,
8 mentioned that the increase and the timeline might not be sufficient incentive, and they were concerned that
9 providers may lack the awareness of the provision and may confuse it with some of the other payment
10 reforms that were going on.
11 One State also added that they did not observe an increase in participation among their physicians
12 when they previously increased their fee schedule to 100 percent of Medicare.
13 Finally, provider organizations noted that, aside from rates, administrative hassles and patient
14 noncompliance also contributed to low Medicaid participation.
15 When we asked about beneficiary access, there was no consensus among respondents on whether
16 the payment increase would have an impact on improving beneficiary access to care. Stakeholders were
17 concerned that some sources of primary care were not eligible for rate increases and they talked a lot about
18 -- and this again calls back to the shortage area in rural areas -- that a lot of their beneficiaries and enrollees
19 were getting primary care from rural health clinics, FQHCs, and nurse practitioners, and these are not
20 providers that are eligible for the primary care increase. However, many States were optimistic that the

1 increase would provide enough incentive for providers to begin seeing more Medicaid patients, for them to

2 increase their volume of Medicaid billing.

3 We did ask about beyond 2014. We asked States what they think will happen once the provision

4 expires, some of the anticipated effects and unintended consequences. Most States were uncertain that the

5 rate increase would continue after the provision expires at the end of 2014, and in one State, the legislature

6 had passed a bill requiring rates to revert to the pre-2013 rates after 2014. Other States had noted that

7 their budget situation is unclear for 2015 at this point, and so they were really uncertain what would happen

8 at the end of 2014. They were still in the midst of planning to implement this provision now and hadn't

9 really looked ahead to what would happen afterwards yet. There was concern among States that the

10 expiration of the rate increase would be perceived as a rate cut, and several stakeholders hoped the

11 enhanced Federal match would continue beyond 2014.

12 Again, we were still really in the early stages of implementation, so most States had not developed a

13 methodology or plan to evaluate the effect of this increase. They noted a couple of challenges in

14 conducting an evaluation, that few resources are available, both in terms of financial resources and the

15 bandwidth of their staff, State staffs and technical support. They noted that we might not see -- because of

16 timely filing rules with claims, that claims lag would present a substantial challenge to conducting an

17 evaluation. That is, that the claims come in afterwards, and so we might not be able to begin to evaluate

18 this until 2016 or 2017. They also noted a challenge in isolating the effect of the increase given other

19 payment reform initiatives that were going on at the same time.

20 So while they didn't have a lot of ideas for methodology or for developing a plan to evaluate this,

1 they did mention to us several data sources that they believe they'll turn to in order to evaluate it, and that is
2 their provider enrollment data, their administrative claims and encounter data, and in two States, they
3 conduct workforce surveys. In one State, the medical society does it, and in another State, the State itself
4 conducts the survey, and they would turn to these as resources to measure the effect of the payment
5 increase.
6 So with these preliminary findings in mind, they raise some questions as we move forward, questions
7 like what are the lessons learned from the implementation of this provision and what are reasonable
8 expectations for the effect of the payment increase on enrollee access and provider participation? How
9 will CMS and States systematically evaluate this policy change? And what other systems changes might be
10 needed to assess access to care for primary care services for Medicaid enrollees?
11 So those are the preliminary findings. We anticipate having a final draft later this month or early
12 next month. And with that in mind, I'll turn it back to Diane and I look forward to your questions.
13 CHAIR ROWLAND: Thank you.
14 Denise, Judy, Sarah.
15 COMMISSIONER HENNING: Mine isn't so much a question as just a comment, and that is the
16 road to hell is paved with good intentions, and that really seems like the whole primary care bump was a
17 good intention gone terribly awry. I mean, as far as who it applies to and who it doesn't, it covers some
18 neonatal surgeons but it doesn't cover people like me who provide primary care to women and annual GYN
19 health exams and pap smears. So it just -- it doesn't make sense. And, if I worked for a family practice
20 physician, it would cover me at 100 percent and I would get the bump-up. But since I work with an

1 OB/GYN, it doesn't.

2 CHAIR ROWLAND: Comment well taken.

3 Judy.

4 COMMISSIONER MOORE: It may be that I don't remember the answer to this question, but

5 perhaps an update if, in fact, it's been discussed before. Do we have any information beyond the survey

6 about entities that might be planning to do formal evaluations of this, ASPE, AHRQ, academic institutions,

7 that sort of thing, because, frankly, it's hard for me to picture in the economic circumstances that most

8 States are in right now that States are going to be leading the charge to do a serious evaluation and

9 look-back of how this affected -- now, to the extent they can do something more readily, looking at data and

10 so forth, that's one thing, but a sophisticated health services research type evaluation, I wouldn't expect to

11 see from States. So I'm kind of curious about other entities that might be looking at this in terms of

12 evaluation post-2014.

13 MR. FINDER: We definitely know that there's a lot of interest out there in how to do this, and I

14 think a lot of the conversations right now are sort of what are the metrics that we would use to evaluate

15 whether or not this had any effect on the population. And, secondly, not to call back to the survey too

16 much, but how are we going to isolate this in light of some of the other effects that are going on, notably

17 the expansion, some of the payment reforms that are going on.

18 COMMISSIONER MOORE: In order to deal with those kinds of questions, it ought to be

19 underway in terms of design right now and funded right now, it seems to me as an observer of research

20 rather than a researcher, and it doesn't sound like we really know of folks who are heavily involved in that

1 right now, other than maybe us.

2 CHAIR ROWLAND: The regulations call for a survey, didn't they?

3 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. Well, we did have a conversation back in

4 December with folks at ASPE who are doing a number of sort of preliminary pieces to it. I don't think

5 we've talked with them since about how that's progressed, but, I mean, they were talking about something

6 that's well beyond the scope of what we could do and we would expect that's the place within the

7 Department that would happen.

8 COMMISSIONER MOORE: Yes.

9 CHAIR ROWLAND: Sara.

10 COMMISSIONER ROSENBAUM: Sort of building on some of the prior comments, it seems to

11 me that as we look at what other people are doing and think about what we are going to do, I think that it's

12 really important that we ask a few basic questions. One is whether, in fact, in pediatrics the result is very

13 different from the result for adults, because there's a very different history in pediatric participation in

14 Medicaid versus adult participation -- versus the participation in adult medicine. And I think it may play

15 out very differently in terms of advising the Federal Government how to make investments in Medicaid to

16 show that you get results in pediatrics that may not be an increase in participation because pediatricians

17 participate, but it does other things for their practices that are good, to have the extra revenue. So that's

18 number one, and it may be the same for adults.

19 I also think it's very important, going somewhat to Denise's comment, that in our work for Congress

20 we consider the cost of this investment in relation to its purported goal, which was obviously to increase

1 access, and be able to indicate whether other kinds of investments might have, in fact, yielded Congress

2 more. I think that just answering the question of whether more patients were seen in a private physician's

3 office by age is not as valuable as letting Congress know, in retrospect, at least, what some of its options --

4 what some of the alternative options might have been and how the same expenditure might have played out.

5 COMMISSIONER CHECKETT: Sara, do you mean other expenditures for the same purpose?

6 You mean the program restructured, in other words, to clarify.

7 COMMISSIONER ROSENBAUM: For example, in another part of the Affordable Care Act,

8 Congress made an investment in nurse managed clinics. So one of the things that might have been actually

9 a more solid investment would have been, you know, to combine whatever they spend here or separately or

10 in the alternative a very clear push toward incentivizing payment to nurse managed clinics.

11 COMMISSIONER CHECKETT: Got it. Thank you. I just wanted to clarify. Excuse me.

12 CHAIR ROWLAND: Robin was next.

13 COMMISSIONER SMITH: Ben, under the provider participation, and we've talked about this a

14 little bit before, that the provider organizations said that it was administrative hassles and patient

15 noncompliance was one of the reasons that there was such low participation. Do we know if that is a

16 perception or is there any type of documentation or follow-up or -- I mean, is it a stereotype or do we know

17 that there actually is amongst Medicaid users, if there is actually a history of noncompliance?

18 MR. FINDER: I think in this sense, noncompliance partially means not showing up to

19 appointments in addition to sort of going along with the care. I am not very well versed in sort of that

20 research and we can look into it and get back to you.

1 COMMISSIONER SMITH: I think that's going to be -- if that's a barrier to access, then I think
2 that's definitely something we need to kind of flesh out and find out what's going on.
3 CHAIR ROWLAND: Burt.
4 COMMISSIONER EDELSTEIN: Ben, can you tell us more about the anecdote of the State that
5 reported that it didn't get a response to its fee increase?
6 MR. FINDER: Right. So in order to protect their anonymity, I can't mention which State it was.
7 But there was a State that did implement a fee schedule increase a couple of years ago that went up to 100
8 percent of Medicare -- yes. Their Medicaid rates were equal to the Medicare rates. They maintained that
9 for a couple of years until the budget hit and then had to go back down. They just mentioned that they did
10 not see an increase in their provider rolls, provider enrollment or their provider participation.
11 COMMISSIONER EDELSTEIN: Do you have any idea how sophisticated that analysis was?
12 Did they look at pediatrics versus -- as Sara mentioned, did they look at the types of services for --
13 MR. FINDER: I don't think they cut either the populations or the provider specialties or
14 subspecialties.
15 CHAIR ROWLAND: Sara.
16 COMMISSIONER ROSENBAUM: Just back to Robin's point, one of the ways that we might
17 illuminate this question of behavior versus structural barriers is to look at the research into open access
18 modifications. The changes are pretty dramatic for practices that have moved from scheduled
19 appointments to open access in terms of eliminating the problem of high volume of last-minute missed
20 appointments. It's certainly not limited to poor people, but open access has a big effect. And so we

1 might want to couple, in terms of thinking about how we look at the access question, we might want to

2 think about drilling down on what could be called system behavior issues as opposed to individual behavior

3 issues to sort of open this issue up a bit more. I think she's quite right to raise it.

4 CHAIR ROWLAND: Richard.

5 COMMISSIONER CHAMBERS: I'd just like to say, Ben, just from someone who's on the front

6 lines of trying to deal with this in a delivery system as a managed care organization, I think the results from

7 your interviews are pretty spot on as to what we're seeing. I think since this was enacted, I have not had

8 any provider approach me and say, "Gosh, can I sign a contract with you?" What I get is, "When am I

9 going to get my money for the contract I have today?" So I think it's all these issues we're talking about,

10 you know, as Sara and Robin were talking, on the issues, just the inherent issues in getting providers to

11 participate in the Medicaid program.

12 It makes me think back in the early 1990s when there were issues about access to OB/GYNs, and as

13 I recall, a lot of States moved to global payments and ways of making it easier for OB/GYNs for billing and

14 reimbursement and, I think, had the same results when they looked at it several years later, is you had the

15 same providers getting paid more, but you didn't have new providers being entered into the system.

16 I just hear over and over again as providers say, even with all these other hassles, is what's going to

17 happen when it disappears? You're just going to cut my rates, and you're not paying me enough now, so --

18 or you're not going to pay me enough now. So I think, again, as, I think, the results from your interviews

19 are pretty spot on as what at least we're seeing in the front lines, those of us who have to figure out how to

20 make this actually happen.

1 COMMISSIONER GABOW: I think one point about a two-year window for payment that hasn't

2 been brought up is that I think part of the reluctance of providers to take on a patient where they know that

3 the payment for that is going to go down is once you've developed a relationship with the patient and you

4 have a mutual sort of contractual/trust relationship, that then to -- not that it doesn't happen, we know it

5 does -- that people are reluctant to say I can't see you anymore. I mean, we know they do that.

6 But I think the doctors who are most likely to come into this kind of relationship are the ones who

7 also are most sensitive to the issue about will we have to abandon this person two years from now?

8 And I think that makes people -- it's not just that the dollars are going to get cut, it's that there's a

9 relationship that could be cut. And I think there are a group of providers who are very sensitive to that,

10 and are probably the ones who would generally be open to these populations.

11 CHAIR ROWLAND: Any other comments?

12 Well, thank you, Ben, and we'll look forward to continuing this discussion and to the report.

13 With that, we're going to adjourn until 1:30 p.m.

14 [Whereupon, at 12:38 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

15

AFTERNOON SESSION [1:41 p.m.]

CHAIR ROWLAND: Okay, if we could please reconvene.

In our work, we have long identified the fact that one cannot make policy without adequate data, and that one of the responsibilities of MACPAC is to really look at whether we have the appropriate information to make policy decisions and policy recommendations, and to actually do the analysis that is important to inform choices going forward on how to operate the Medicaid program, as well as how do you potentially evaluate changes to it.

So we're very pleased to bring CMS back again to talk with us about where they are in their data development work. Julie Boughn is with us as the Deputy Director of the Center for Medicaid and CHIP and really looking at how we have progressed since Penny Thompson visited with us I think over a year ago.

So, if you would both introduce your colleagues and offer your insights to us on where we are in the data development process and how you see moving forward in the future.

CMS INITIATIVES TO IMPROVE DATA FOR PROGRAM OPERATIONS AND EVALUATION

* MS. BOUGHN: Thank you very much.

I think I'm okay if I just have one microphone on, right?

My name is Julie Boughn and we are very pleased to be here today because we are incredibly excited about what we're really kind of -- at the junction that we're at in our efforts to improve Medicaid and CHIP data at CMS at the Federal level.

The folks that I brought with me are just people who I wanted one, to see you and understand the

work that you do a little bit better; and two, for you to know who they were.

Elaine Olin, on my right, is the Director of our Data and Systems Group. And she has really basically all of the Federal information technology that we have in place to run Medicaid and CHIP programs, and also one of the divisions in Elaine's group is the division of state systems. And they're responsible for all of the IT systems that we fund in the states for the Medicaid Management Information Systems and, right now a big focus of our attention is eligibility and enrollment systems in the states, as you might imagine.

To my left is Loretta Schickner. Loretta is a Division Director in Elaine's group. The division is -- we always call it DIATA which is -- say what it is?

MS. OLIN: Division of Information Analysis and Technical Assistance.

MS. BOUGHN: Thank you.

So Elaine's division is responsible for what we lovingly refer to as MSIS these days, and also you'll hear a little bit more about the Transformed MSIS project that we are engaged in very actively right now.

Just to introduce myself a little bit, I'm very new to the Medicaid and CHIP world. I joined CMCS in August of 2011, so I have about a year-and-a-half under my belt. What I always tell everybody now is that Medicaid rocks.

But where I came from, I have a very long career in information technology. The last 11 or so years of it have been at CMS. Up until late 2010 I was the Chief Information Officer for CMS and then I moved into the sort of more policy program areas. But I still have a very big focus on data and analytics and information technology within CMCS.

1 So that's sort of where I come from and that's sort of the perspective that I bring to this.

2 What we are going to talk you through today is -- I know when Penny was here, she basically
3 probably echoed what you just said, which is that it's really hard to run a $400 billion a year program when
4 you don't have the data and information that you really need to understand what's happening, who's paying
5 what to whom for what services, who's getting enrolled, who's being covered for what benefits. I mean,
6 just all of the kind of basic things. And let alone -- we get requests all the time for much more complex
7 analyses than that.

8 So we're going to talk to you a little bit about where we are with our data programs. Let me just
9 sort of leap into the slides so we can get through them, because I'm sure you guys have some questions.

10 This slide is really to set the stage for what we're going to talk about. Cindy Mann, who is the
11 Director of CMCS at CMS, she likes to say can anybody name another $400 billion business anywhere in the
12 world that tries to run itself with this dearth of data and information about it.

13 When I asked that question one time, somebody said oh yeah, Medicaid. I said besides Medicaid --
14 we don't want to, you know -- we're basically trying to fix that problem.

15 But Medicaid, in the not to distant future, is going to be much bigger; right? It's going to be even
16 bigger than $400 billion; right? We're projecting it to go out to $500 billion, to be 80 million beneficiaries
17 give or take. We can all argue about those numbers, and you probably have numbers that you guys like to
18 use for MACPAC purposes, but they're all in this vicinity.

19 So this is a very, very, very large chunk of the Federal Government's budget every year.

20 So not that I have to convince you that there's a need for change, but -- and this slide probably

1 echoes a lot of what Penny said when she was here. We were thinking that it might have been even closer

2 to two years ago that Penny was here, but it was certainly a while ago.

3 That the dataset is incomplete, it's not contemporary. We're still working with some states to get

4 their 2010 data submitted. And the way that health care is moving right now, just generally, data that

5 comes from 2010, most of us are just going to go oh, really? Who cares? Right? Unless you're a

6 researcher looking at some longitudinal study.

7 From a technology perspective, what we have at the Federal level is wholly inadequate to the task

8 that we're trying to do. We don't have the data in modern databases. We don't have modern business

9 intelligence tools connected to it so you can do sort of basic kind of canned reporting, let alone drill down

10 and things like that. And so we're working on all angles of that.

11 What happens to day -- and I'll echo this again in a slide a little bit later in the presentation -- is that

12 whenever we present some information that comes from our data, people want to basically question it as

13 opposed to accept it. Right? You want to say how old is that data? And what was that state doing?

14 All those kinds of things are called into question so we sort of question the validity of the results instead of

15 looking at the information as a way to help inform the work that we're doing in terms of running the

16 Medicaid and CHIP programs.

17 I don't want to belabor that too much more.

18 So where are we headed? We're headed to this arena that we call actionable business intelligence.

19 Now this slide up here is important because it's context setting. We are working on our data, data

20 improvements. We've got four different arenas. The first area is -- and I'll start at the bottom of this

1 kind of circle -- is program data. Today, state plan amendments, waiver submissions, even the documents

2 that we use with states to manage their IT -- which we call Advance Planning Documents, or APDs -- are all

3 paper-based. The data is largely unstructured. Yes, there are some templates that we use for some

4 aspects of these things, and we've moved a little bit of this stuff online. But the data is still very much

5 unstructured.

6 So trying to understand even what benefit packages the state has or who they cover, those types of

7 things, is really challenging to do. And so we're working on that, and I'll talk a little bit more about that.

8 Moving up to the top of the circle, operations data, that's MSIS. The big effort we have underway

9 right now is to implement Transformed MSIS. I'm going to talk in more detail about that, so I don't want

10 to belabor that.

11 I don't want to leave the other two arrows out of the conversations though, although I'm not going

12 to spend too much time on either one of these. But on the left side you see quality data. So a lot of work

13 in health care today is around what is the quality of the health care that's being provided? What are the

14 outcomes that we're getting? Are people getting the services that we need? Those types of things.

15 So we do have work going on in the quality arena. Largely what we're doing is working at the state

16 level, though; right? Aggregate at the state level and say giving us aggregate reports about the quality of

17 care that beneficiaries are receiving. And so we're going to work to be improving that over time.

18 The other arrow is one that we have -- actually, we're just at the very beginning stages. We put out

19 an RFI recently on this one called performance indicators. So with performance indicators, what we're

20 trying to look at is timeliness and accuracy of business processes. How long is it taking beneficiaries to get

1 enrolled? What's the provider experience, in terms of getting enrolled to become a Medicaid provider?

2 That type of information we don't really do anything with today and we're going to be moving out

3 that in the future.

4 So what we expect to achieve is we expect to deal with all of the problems that we presented two

5 slides ago with the work that we have underway. We're looking to have a complete contemporary set of

6 operational data. We're looking to have structured data about the programs that states are running at the

7 state level. We expect to put it on much different technology and to make more of the data available

8 outside of CMS than we do today, through public use files and by providing opportunities for -- states in

9 particular, is who we're thinking of in this arena, but we certainly could think about this with other folks --

10 to come into our environment with their own data and work with what we in the IT world like to call

11 sandboxes to do more sophisticated analyses than you can do with just our data.

12 We expect to be able to calculate a lot of the aggregate reports. I know one of the questions that

13 you specifically had was about EPSDT reporting which today we do as an annual state calculated report.

14 We expect to be able to do a lot more reporting like that off of the contemporary complete dataset that we

15 will have as we're working with states to get T-MSIS implemented.

16 We are looking basically to have -- I'll go back to that last slide -- actionable business intelligence.

17 It's going to be an interesting world in CMCS because we've not been used to having data to support

18 decisions or to help inform decisions. It's going to be a cultural change, I think, for us as we're going

19 forward here.

20 So let me spend a little bit of time talking about the program data side of that actionable business

1 intelligence area, MACPro. MACPro is -- simplistically you can think of it as an online form for state plan
2 amendments, for waivers, ultimately for advanced planning documents, and basically all of the business of
3 our states. But today our business with the states, which is largely around these documents, which are
4 critically important, is paper-based and completely unstructured.
5 What it does is the work flows that are associated with that -- we did this work under -- Penny, I'm
6 sure, told you about the acronym MACBis, Medicaid and CHIP Business Information Solutions Council,
7 that we started at CMS. She and I started that together when I was the CIO.
8 The initial work that they did around studying the work flows, they found 17 different business
9 processes supporting the processing of state plan amendments and waivers and APDs inside CMCS. We
10 thought we could probably do that a little bit more efficiently and effectively.
11 So that was one of the first things that MACPro did was develop a common work flow for all of
12 those types of things. And then let's develop online structured data templates for submitting these things.
13 So MACPro is actually in very, very active development and testing right now. We're expecting to
14 release the first release of it to production -- I'm going to have to say the spring because it's like any IT
15 project, it's having a little bit of fits and starts as we get near the end here. But we are very imminently
16 going to go with release 1. We will follow very soon after that with a second release.
17 The idea being that we will be able to do our business with the states around the 2014 Affordable
18 Care Act implementations. They have to do state plan amendments to change their eligibility and they're
19 also going to have to do state plan amendments for their alternative benefit plans. So we are going to do
20 those online, through this MACPro system.

1 And then we have a release schedule going out for two years that will bring in all of the other
2 authorities that we're talking about with MACPro.
3 We expect, with MACPro, to -- well, obviously the key benefit is standardizing the data. What you
4 finally are looking at, even the operational Medicaid and CHIP data that we have today, it's not meaningless,
5 but it's difficult to interpret if you don't understand the program that's associated with what produced that
6 data.
7 For example, if you're looking at a state's fee-for-service data, right, and it adds up to some total but
8 you don't have in your mind that that state is actually 85 percent managed care? Right, 85 percent of their
9 beneficiaries are in managed care. You're not getting a very complete picture by just looking at that
10 fee-for-service data.
11 And you need to understand that context in order to be able to draw any meaningful conclusions
12 from the operational data. So we're going to be standardizing that program data.
13 We're really looking at reducing cycle time. A large chunk of these actions that we do as states are
14 routine business. They're things that states are allowed to do in the Medicaid and CHIP program. So we
15 really don't need to spend a lot of time reviewing them.
16 There's other ones that are more complicated and have bigger policy implications and will probably
17 need some more attention. So MACPro is going to help us to sort through which ones are which and
18 make sure that we're using our time and attention on the ones that are really important.
19 We're also going to have accountability because states are going to be able to see into this system as
20 well and they're going to know where they are on what we call "the clock" because our business processes

1 require that we review things usually within 90 days, although some of the things are different. So states

2 are going to be able to see where in the review cycle their actions are. And they're going to be able to, I

3 think, hold us accountable and we're going to be able to hold them accountable for things that they need to

4 provide to us, too.

5 So that's kind of MACPro, which is, I think, important to you all but probably not as interesting and

6 important as Transformed MSIS. So let me turn to Transformed MSIS a little bit.

7 T-MSIS, as we call this, is really aimed at addressing three big problems that are in operational data

8 today: timeliness, reliability, and robustness, or sometimes "completeness" we call it. We often have a lot

9 -- we actually do get MSIS submissions from all 50 states. Some of them are relatively timely. We are

10 actually working on some 2012 data files right now. Not as many as you would think, given that it's 2013,

11 but some. And so we're working on those things.

12 But the data only comes in every quarter. There's a lot of back and forth because the manual

13 quality checking that happens is all manual. Like we're looking at the data, literally people's eyes are on it,

14 to say whether it's good or not. So there's a lot of back and forth to the states and that sort of affects the

15 timeliness that we have for putting the data in.

16 But probably the biggest problem with the data, in addition to the timeliness, is that it's not

17 complete. Some states aren't sending all of their encounters. There's lots and lots of reasons why that

18 happens. Or we don't have a complete view, for example, into home and community-based services

19 sometimes. Those are the types of things or issues that we have with the data.

20 So the first thing we did with T-MSIS is we did a pilot. We worked with -- we called it the Ten

1 State Pilot, although two additional states joined the pilot later on. We still kept the name because

2 otherwise we would get ourselves confused.

3 So we did this pilot with 10 states where we asked them to produce this T-MSIS dataset that we had

4 worked on internally and with some other stakeholders to define from their systems. We were really trying

5 to, with the pilot, answer kind of three questions. First, and sort of most important questions, how hard is

6 it to get this data out of the state systems? It turns out, it's really hard. I'll come back to that in a second.

7 The second question is is this the right data to meet the business needs? The people who say they

8 need Medicaid data and CHIP data, are we going to have the right data to meet their needs? Because

9 everybody talks about the MSIS files being -- there's all kinds of euphemisms we use, but basically not good

10 enough. And so we wanted to make sure -- what I didn't want to do was do a multi-million dollar IT

11 project, work really hard with all of the states to get the data out of the systems and people still say this data

12 is no good.

13 So we had to -- we're trying to do that. So do we have the right data to meet our business needs?

14 And then thirdly, what should be our technology platform for hosting and managing this data and

15 getting the files in and out? The answer to the technology platform I'm not going to dwell on, that's an IT

16 question and we like to talk about that kind of stuff but it's probably not so important for this forum.

17 The right data to meet business needs? We think yes. There are going to definitely be some

18 analyses that people want to bring other data to the table, but the Medicaid and CHIP data will be fairly

19 complete. And by other data, some people might want to bring, for example, private payer data. Or a

20 state might want to bring its Census data. Or you can imagine some places like that, where you want to

1 bring some other data to do a particular analysis.

2 So what does it take to get this data out of the state systems? Well, it turns out that's sort of the
3 crux of this. You'll see on a later slide that T-MSIS is 800 or so data elements. Most of those data
4 elements are not directly like one-for-one you can map them from a state system to T-MSIS. So there's
5 some analysis that has to go to derive the data. And so that project, in and of itself, in every single state is
6 going to be an IT project.

7 So we've spent a lot of time since the pilot, which concluded in June, this has been Loretta's main
8 task since she joined CMCS in August, to derive a tool kit that helps states to do that. I'll talk a little bit
9 more about that, as well as obtain technical assistance, so that we will have contractor support to help the
10 states as they're approaching this project.

11 What makes T-MSIS better? This is sort of like this quid pro quo because what we don't want --
12 T-MSIS will not be successful if it only answers the mail for CMS. If it's only good for CMS, then we will
13 not have done our job and it's almost like it's not worth doing it if that's the case.

14 We want to improve the data situation for states. We want to go for them fewer times, asking for
15 aggregate reports or one-off data files. We want to have, obviously, more timely data. We want to be
16 able to do fraud, waste and abuse, better analyses around that.

17 And lastly, and I think most importantly, we want to be able to provide expanded access to the data.
18 So we want to provide abilities for not just us to do reports and analyses at CMS but for states to do it and
19 for other important stakeholders -- I don't know, maybe like MACPAC -- to be able to analyze the data and
20 use it to help inform the work that we all do around the Medicaid and CHIP programs. And we'll only be

1 successful if we manage to accomplish and pull off that.

2 This next slide is just sort of like the -- it's the as is and the to be for where we're trying to get with

3 operational data. We tried to do a little bit more detail about what T-MSIS is. You can see that it's

4 800-plus elements.

5 One thing I want to note here is that if we do T-MSIS well, a lot of the reports that we get today

6 that are aggregate reports from the states where we ask them to report annually, for example, on EPSDT --

7 but we have several other, as well -- we'll be able to calculate those off the T-MSIS file ourselves. If you

8 have the right set of operational data, you can just create the report.

9 As a matter of fact, we've speculated that we might even be able to change some of our business

10 requirements around this because some of the business requirements would have been formed because I

11 don't have the operational data so I've got to ask for it from the states, and here's the way I can get it from

12 the states so I'm going to ask for it that way.

13 So we're thinking that that will be something that's important as we're going forward is that we'll

14 have more accurate reports about those types of business processes.

15 The other thing that T-MSIS has in that 800-plus data elements is it has a complete set and a

16 requirement for encounter data. Now encounter data is incomplete for lots and lots of reasons, not the

17 least of which is that sometimes states don't even have the encounter dat from their plans. And so we're

18 going to be working on that kind of at all different levels here to make sure that this dataset is complete

19 because you can't fix something at the back end that has a front end problem. So we're going to be

20 working throughout all of the businesses processes of CMS to make sure that this data is complete.

1 T-MSIS will also have a complete set of information about the beneficiaries that are covered in a

2 particular state, as well as the providers that are participating. And providers are very important when

3 you're looking at fraud, waste and abuse issues, for example, that you have solid, good provider data.

4 I think that's all I want to say about that.

5 So we're getting near the end of my prepared presentation so we can move on to questions here, so

6 be thinking about what you want to ask.

7 So where we are with T-MSIS right now is that Loretta's team is putting the finishing touches on the

8 data dictionary. We're doing one last round of checking with people who are going to be users of the data,

9 stakeholders to say is this the right dataset? Because we're going to go out to states with it, we're going to

10 say this is it.

11 It's not that we're never going to be able to change it, because we're being very open with states and

12 ourselves that it's going to change over time, but we're going to have to put that in a change management

13 process. So we're not thinking that changes are going to be more frequent really than annual, given the

14 amount of IT work that has to go into changes.

15 And then the whole toolkit that Loretta's put together that has things, for example, like sample

16 project plans for how you do the project plan. There's lessons learned from the pilot on the mapping of

17 the data from the MMIS systems to the T-MSIS file. And we're also working with the vendors of the

18 MMIS systems in the states to make sure that they understand what the data is that they're supposed to be

19 producing.

20 We're currently going to be onboarding states. Loretta has just finished a conversation with every

single state in the country, with the exception of one who's working on a very intense MMIS project right now, to kind of assess their readiness, of how ready they are to produce the T-MSIS file.

I will tell you, by and large -- there's a few exceptions to this. By and large, states understand that they need to provide the data. You guys have talked about the issues with data. OIG, GAO, we have lots of people who have talked about the issues with Medicaid and CHIP data. Everybody gets it and knows that we have to get to a better place. And so they're, by and large, ready and willing to work with us to make that happen.

They would also tell you that they're very busy. They have a few things going on right now. And so they're not exactly sure how they're going to fit it in, but they were willing to sit down with Loretta and talk about it.

And so we think, our overall goal is that states would be submitting T-MSIS data to us on a monthly basis from January 1st, 2014 forward; right? Now some states can come in earlier, we'll be ready earlier to take it. But that's sort of our mark in the sand, that we want to be getting T-MSIS.

One of the interesting things, a by-product of the conversations that Loretta has been having with states about T-MSIS, is that she also asked them about MSIS, which has almost organically improved the MSIS data submissions by all measures. They're coming in more often, they're coming in closer to the end of the quarter, they're passing quality checks a little bit better. So by almost all measures, the MSIS data is just kind of organically improving, we think, just because it's being paid attention to.

I'm going to go back to that access, accessing and using the data. It's critically important to me that as we start bringing in this data that we actually do start using it, and that it's very visible that we're

1 using it. We're doing things like putting state profiles on Medicaid.gov. We're just making it very well
2 known that we have this data and that we're using it to understand the policy and what's happening in the
3 states.
4 In my experience, nothing improves data quality like transparency and use. Oh, you're actually
5 using that data? Well, I'd better make sure it's good data. So we're going to take advantage of that.
6 So both MACPro and T-MSIS really kind of are on the precipice of becoming real, live projects that
7 are moving out of PowerPoint and into the real world. So I'm very excited to talk to you a little bit more
8 about it and I'll take any questions that you have now.
9 COMMISSIONER GABOW: This is probably a very -- so bear with me if it's completely stupid.
10 Would it be cheaper, higher quality, more efficient if the places that the state is getting the data from came
11 directly to you and then you distributed it back to the states? So that instead of having 56 entities building
12 the ability to orchestrate the data in appropriate format, there was one, but that commitment was to analytic
13 and appropriately sharing.
14 So again, I apologize if that's an overly naive --
15 MS. BOUGHN: No, no, no. I think -- you know, we actually have talked about that, and I'll give
16 you a specific example that we've talked about, that encounter data. Right? My background is in
17 Medicare. I mean, when you work at CMS, you know, even in the IT in CMS, you spend a lot of time on
18 the Medicare program.
19 And Medicare encounters, Medicare encounters are submitted to CMS from the plans. Right?
20 The plans that are processing the claims right from the providers. And so, we thought, Wow. And, you

1 know, there's some exceptions to this, but the plans are the plans. Right? They have Medicaid plans,

2 they have Medicare plans, you know. So could the Medicaid -- you know, could the plans who are

3 submitting Medicare encounters just submit their Medicaid encounters at the same time, right? And we

4 could have -- and, you know, we looked pretty hard at that issue. It sounds, you know, from an -- I'll tell

5 you.

6 If you just have an IT hat on you go, Well, of course, that's how I want it. Right? The challenge

7 becomes with that, in Medicaid, what we really want of Medicaid at the Federal level is an authoritative

8 source of data, and meaning that if I were to use this data, for example, to look at how a state had set its

9 payment rates for managed care, or I wanted to look at it from the perspective of just what's happening in

10 the state, right? And the state's not sent me that data, then it's less authoritative, right? From the

11 perspective of that.

12 There's an opportunity for the state to question. Well, that's not the right data. You're not using

13 the correct information. So there's that sort of challenge.

14 And so it turns out that a similar kind of like challenge happens across all the business lines. Right?

15 The states make the eligibility decisions, right? They determine who's eligible for this Medicaid programs.

16 The states also enroll providers. They're responsible for enrolling providers.

17 In the fee-for-service world, they are responsible for paying the claims. They pay the claims

18 through their MSIS systems. In other words, any particular state has the authoritative data about what's

19 happening in their program. So it doesn't become, you know, I don't think more efficient necessarily.

20 You essentially have Medicare but replicated for Medicaid if you carry this out.

1 You know, there's still millions of providers who are submitting claims. They're either submitting
2 them to plans or they're submitting them to states to process the data. You know, we have looked at,
3 Could we leave the data in the state, right? And access it with, you know, business intelligence tools, right?
4 They can access data anywhere.
5 You have the same problem of the mapping. You still have to understand where the state stores
6 the data and how they store it, what their business processes are. And so, that is actually in some ways
7 more challenging than saying to the state, You figure this out and give me this data that's authoritative once
8 a month. I'm going to take it. I'm going to aggregate it at the Federal level and use it.
9 So, you know, we have looked at a lot of those alternatives and, you know, we've just always sort of
10 bumped up against some dead-end and we keep coming back to the best way to go about this is to ask the
11 states, Write us the standard data set they can stand behind and is authoritative about what's happening
12 there.
13 CHAIR ROWLAND: Mark?
14 COMMISSIONER HOYT: So the use of managed care contracting now is pretty much
15 ubiquitous? It's used all across the country, almost any kind of population. A lot of the larger states have
16 done it for 10 or 15 years. If I was a state treasurer, a senator who sits on the Finance Committee, where
17 would I look, who would I talk to to answer the question of, So managed care contracting, does it save
18 money? If so, how much? If it doesn't, maybe that's okay. How much did it cost me? What did I get?
19 What was the improvement?
20 MS. BOUGHN: Yeah, and that actually turns out to be a bigger question because you don't want

1 to answer just the cost question in isolation. You also want to make sure that the beneficiaries got -- that

2 they have access, right, to health care and that the health care was of some at least baseline quality. Right?

3 So there's a lot more to that question.

4 You know, where you would go if you were in a state right now, the answer is, you know, to a

5 ceratin extent it depends on which state you're sitting in. There are some states that are quite sophisticated

6 in their management of encounter data, and use their encounter data for purposes of rate setting.

7 And so, there's -- they create almost an incentive for the plans to give them a full set of encounter

8 data. There's other states that aren't quite so sophisticated in terms of using encounter data to manage

9 their managed care plans.

10 I'll tell you, at the Federal level what we're trying to do is look around the country and say, you

11 know, what are the best practices in this arena? And, you know, we -- for example, we have a role in

12 approving managed care contracts. Right? When states want to do a new managed care contract and,

13 you know, we can say some things about what those contracts contain.

14 And so, again, we're looking at all those types of things to make sure that we have that. You know,

15 if I was the treasurer in the state and, you know, needing to submit the budget, I'd be definitely sitting down

16 with the state Medicaid Director and saying, Can you do this analysis?

17 I would tell you that in some states, they could do that analysis. They could say, What has

18 managed care done for us, you know, in our program. Other states probably not so much.

19 CHAIR ROWLAND: Judy?

20 COMMISSIONER MOORE: Hi. A couple of questions. If memory serves, it was probably

1 eight or ten years after MSIS was required before we started getting all the states. Now the world has

2 moved along a fair ways since then, but I'd be curious to know what your estimation is about how long it

3 will take all the states and whether there will be a lot of states involved, you know, complying January 1,

4 2014 versus only a few who kind of drag along later or just how long it will take to get to that 100 percent

5 mark.

6 And the second question is, to what extent will all this information that we've been talking about

7 today be transparent in terms of open public to anyone and everyone, both T-MSIS and the MACPro stuff?

8 MS. BOUGHN: Okay. So the first question is?

9 COMMISSIONER MOORE: How long it will take.

10 MS. BOUGHN: Yeah. And I'm trying to decide how to answer that because my big wild card in

11 that, of course, is the states. And, you know, we are preparing ourselves at the Federal level to be able to

12 accept the data from all the states and be able to do that this year.

13 Now, the best information that we have is the work that Loretta has just completed on the

14 assessments. And, you know, I don't want anybody totally holding me to this, but we're looking like the

15 number of states that seem like they can meet the goal will be about half the beneficiary population in the

16 country. Okay? With another, I would say -- and I'm forgetting the percentages exactly -- but another --

17 the next quarter, right? Sometime in 2014.

18 So we're sort of looking it like that. What's the population of the coverage of the country that we

19 can cover. I'm not going to -- you know, there could very well be stragglers. You know, what we're

20 looking at is, in the past, we've largely only used the, Oh, please, you have to send this MSIS. Right? As

1 our lever.

2 And Cindy Mann is very serious about improving the data and information that we have available at

3 the Federal level. And she -- we are very actively looking at what all of our levers might be. Right? You

4 could sort of think of it almost as progressive discipline, but, you know, the BBA is the first law that had

5 MSIS. That was in 1997, if I have that right, or 1999. I can't --

6 MS. OLIN: They started submitting in 1999.

7 MS. BOUGHN: But, you know, the lever that's basically in the statute there is MSIS funding.

8 That's $2.4 billion a year that we send to states to do their IT projects. That's, you know, not a bad little

9 lever to just sort of think about using that.

10 The next law is the Affordable Care Act which talks about encounter data and actually, you know,

11 ding the FMAP. It's a little challenging to think about how would you do that. How would you take

12 away money based on data that you don't have when you don't know you don't have the data?

13 So it's a little circular, but nevertheless, there is some statutory authority saying, you know, we will be

14 able to say in the big picture, does it look like we're getting encounter data for this big part of the

15 population, to your earlier point or not.

16 So from a time perspective, I'm not really -- I'm dodging just a little bit, but we think -- I mean,

17 given -- the states do seem committed to working with us on this. So I don't think this is going to be

18 another ten-year project and I think we'll be getting most of the data, you know, kind of within the next 18

19 to 24 months, but maybe not all of it.

20 And the second question -- remind me what the second question was.

1 COMMISSIONER MOORE: Transparency.

2 MS. BOUGHN: Oh, the transparency.

3 COMMISSIONER MOORE: Will it all be available to all of us?

4 MS. BOUGHN: So you might know that CMS created this new Office of Information Products

5 and Data Analytics. It's not part of CMS. It's a separate stand-alone office. And their function is,

6 essentially, making sure that we are -- you know, I'm going to, you know, use a trendy term here, but

7 prioritize our data.

8 So, you know, like any individually identifiable data, which this is going to be, right? You know,

9 there's Privacy Act protections, there's all kinds of protection around, so we're not going to just let anybody

10 waltz in and start using it or take it away and use it someplace else.

11 But the Director of that office is Niall Brennan and, you know, his job is basically to understand the

12 data that we have and to understand the needs of data users and to create products that are maybe

13 aggregated or public use files or those types of things that might be helpful.

14 But, you know, we're intending to bring this data under that rubric, that one of our roles in the

15 health care, you know, sector is to make our data and information available for purposes of innovation, so

16 this would be no exception.

17 CHAIR ROWLAND: Steve?

18 COMMISSIONER WALDEN: Thanks. As somebody that does health IT, I understand the

19 complex -- I start to understand some of the complexity. So my next question is more about kind of

20 looking to the future because I know this hasn't been done quickly or cheaply either.

1 But as we've started to talk about from a policy standpoint from payment to looking at value-based

2 payment, so with managed care you're starting to talk about getting that encounter data which is still kind of

3 traditional fee-for-service encounter-based, not really quality-based.

4 But you're starting to talk about bringing in the quality measurement from meaningful use, and then

5 I'm assuming, too, also the PQRS process. In those, in the meaningful use, there's discussion about

6 bringing the data in as an aggregate, so as a provider here is my, you know, quality measurement for my

7 diabetics.

8 How are you guys thinking, or are you thinking about how T-MSIS data and that quality starts to

9 come together? Because with the current quality measurement, you're not able to pull out who is

10 Medicaid, who is Medicare, and some of those type of things.

11 So what's been thoughts about starting to try to commingle that as we look next down the road?

12 MS. BOUGHN: So with the caveat that we are really kind of in the nascent stages of looking at

13 quality data, there are some quality measures that you can calculate off of administrative data. Right? So

14 where that's possible, you know, we would probably look to doing that.

15 You know, we've started to have some conversations with our colleagues in CMS who work in the

16 quality side of Medicare and they're having some of the same, you know, challenges, although the one that

17 we have that they don't have is from a quality perspective, are we measuring a state and the performance of

18 a state's Medicaid program or are we measuring providers? Right? And the quality of various providers

19 for Medicaid. Okay?

20 And I think the answer is going to end up being it depends on which thing we're sort of looking at.

1 What we're trying to do with quality data as CMS now is minimize burden on providers. Right? And it's
2 almost an analogy to what we talked about with the states earlier where they have to provide us with so
3 many reports.
4 Providers have a lot of places they have to report quality data, a lot of payers they have to report
5 quality data to. I can't necessarily fix all the other payers, but we can certainly look at the Medicare and
6 Medicaid programs.
7 And so from -- back to quality, what we're going to try to do is work with our other colleagues in
8 CMS and get as many of the quality measures we can through the common mechanisms. To the extent
9 that there's a desire to look at Medicaid and Medicare separately, and certainly there's certain types of
10 providers that don't have each other's -- you know, those two programs in their beneficiary population --
11 you know, we will have to look at ways that we can bring in the data separately.
12 And then the next question becomes, do we bring it in at the state level or do we really bring it in at
13 the provider level and then aggregate to the state? And I don't know that all those questions have been
14 answered. This is sort of like new area, I think, for all payers.
15 One of the things that I find most interesting about Medicaid is that variable, the state being added
16 in. And, you know, it really, I think, comes to bear here in this whole notion of quality. And, of course,
17 as CMCS, our oversight is of the states, right, and their Medicaid/CHIP programs and they're running the
18 Medicaid/CHIP programs, that they're following the law and the regulations and things like that.
19 But quality measurement tends to be a provider thing. That's how we think of quality
20 measurement. So it's going to be really interesting, I think, to see how those things come together, and if

1 you guys have thoughts about that, we'd certainly appreciate them, especially at this stage of our work.

2 CHAIR ROWLAND: You know, in terms of our work, we're supposed to look at the cost and the

3 administrative burden of any of the changes that we might be recommending as a Commission. So how

4 do you evaluate what the changes, in terms of both cost and administrative responsibility for the states, to

5 go from a 400-element to an 800-element data set?

6 MS. BOUGHN: So, you know, this is where I'm just going to put an IT hat on, right, a little bit.

7 We think there is a -- I mean, we certainly think there's an effort on the states' part to produce this data set.

8 I don't know that it's so materially different from MSIS, right? Other than it's a bigger data set, right, so

9 I've got to go produce some more elements, but I basically have to do this mapping to do that one time and

10 the development of the software to do it one time. Right? And then I have to -- obviously with some

11 modifications as you go through time.

12 And then I, you know, I run it. Right? I run the software, it creates a file, it sends it in. You

13 know, there's replies back and forth. So I don't know that the overall administrative burden for producing

14 MSIS versus T-MSIS is vastly different, although we absolutely acknowledge that there's a one-time effort

15 for sure and that's what, you know, we've been working with. Loretta's been working to produce this

16 toolkit and the technical assistance and all that stuff to try to help us phase through that process.

17 We've also done an expedited APD process so that states can get IT funding to do it, the 90 10

18 funding to do the work that they need to do on our IT systems. So, you know, I just go back to, this is a

19 $400 billion a year program becoming a $500 billion a year program. You know, if we need to spend, you

20 know, somewhere in the vicinity of, let's just say, if it was $75 million to $100 million IT investment, you

1 know, to get us into a reasonable world of having -- a reasonable access to data and information to run that

2 $500 billion program, it strikes me as a reasonable investment to make.

3 CHAIR ROWLAND: And when you're finished, you think that in 2013, we'll have data from

4 2012, 2013? How close to --

5 MS. BOUGHN: Oh, our intent is that the files are submitted monthly, so as a state is, you know --

6 we're just going to be arrears by, you know, somewhere between 30 and 60 days, maybe 90 days in some

7 cases. That's our intent, that we're not working on 2012 and 2011 in 2013.

8 MS. OLIN: I want to just add one more thing around the cost to states, particularly. So we've

9 been working very closely with our colleagues across CMS who have a need for Medicaid and CHIP data,

10 the Duals Office, the Medicare/Medicaid Modernization organization, the Program Integrity folks, our

11 Office of Financial Management. All sorts of folks have a need for Medicaid and CHIP data.

12 And so, what we're trying to create is what we're calling this authoritative source or the gold record

13 of Medicaid and CHIP program from the states' perspective that everybody can use as their foundational set

14 of data, so that they're not going off -- going back to a state for one off request.

15 So today, a state can be getting requests from three, four, five, six, seven, eight different places in

16 CMS for different needs to meet different parts of their program. And so, we've been working very hard

17 with our colleagues to say, This needs to be the gold record for Medicaid and CHIP and we need you to

18 come together with us to create this authoritative source and once it hits our front door, have at it. You

19 can all have the record to do whatever you need to do for your individual programs, but let's stop asking the

20 states to do it four, five, six, seven, eight times because they have limited resources in pulling that data for

1 us.

2 CHAIR ROWLAND: Thank you, Donna.

3 COMMISSIONER CHECKETT: The very last point you made, as a former state official I'd say
4 hear-hear. I think people will be thrilled to say, Ask your colleagues, which leads to my question actually.
5 So who will be able to access this data?

6 MS. BOUGHN: So the data is going to be in a database that we manage, you know, federally, and
7 we're going to have tools there. Right? What we're working on is providing access, basically, through
8 portals for state users to use so they can analyze their data. It's sort of like they're going to be able to see
9 their MACPro data, of what they've entered there, and they're also going to be able to decide in MACPro
10 who else can see their data, whether other states can see it, even whether we can see it. Right? Because
11 it's there.

12 If you've got a state plan amendment in process, you don't necessarily want us to be able to see it
13 while it's raw, while it's being worked on. So, you know, those are kind of our initial things, and obviously
14 people at the Federal level in some other agencies.

15 CHAIR ROWLAND: And that includes MACPAC?

16 MS. BOUGHN: We're certainly going to make sure that we can do -- do what we need to do to
17 address your needs, yes. Now, this is where the work of that new office at CMS is going to come into be,
18 because what we're looking at is trying to, over time, creating ways as CMS for external users of our data to
19 analyze it in place, right, as opposed to taking extracts and, you know, taking it off to somebody else's data
20 center.

1 You know, again it really kind of depends on the need there, right? And what the sort of frequency

2 is and whether it makes more sense to do that, to be something like

3 the census does, right? Where your people can come to the census and sit at terminals and do their work.

4 You know, we have ways of thinking about doing that virtually.

5 But we are -- we want to, for the most -- as CMS, I mean, generally have people access our data and

6 using it in place. That helps with information security and privacy and a bunch of other things like that,

7 but there are plenty of users that are going to need to just take it. And so we'll do our usual process with

8 data use agreements. But certainly we're going to be working closely with MACPAC.

9 CHAIR ROWLAND: Sharon?

10 COMMISSIONER CARTE: How are you factoring in separate to programs that might not

11 currently report census?

12 MS. BOUGHN: So in the most generic sense, I will tell you that we consider CHIP right there

13 with Medicaid, right? With T-MSIS it's all about Medicaid and CHIP data. There's some nuances to

14 CHIP financing that are going to make that maybe just a little bit more challenging, but we think we need

15 CHIP data just as much as we need Medicaid data.

16 CHAIR ROWLAND: Andy?

17 COMMISSIONER COHEN: And how about -- I'm going to ask, I'm sure, I'm going to ask this

18 question badly because I'm so not an IT person, but like what about alignment with other data sets? And

19 forgive me if I use that wrong, but, you know, Medicare stuff coming out of the exchanges, data being

20 reported out of exchanges and thing like that. What will be the sort of ability to use Medicaid data

1 alongside or with those other data sets? Is there sort of any effort to make them -- I know it's data so it's

2 not interoperable, but you get the gist of my poorly worded question?

3 MS. BOUGHN: Yeah. Because, you know, the big challenge about that is essentially how the

4 different sort of original systems identify things that are in the system like people, right? And, you know,

5 there's all this queasiness around using things like Social Security numbers, right, which are pretty standard

6 and ubiquitous, but nevertheless they don't exist in a lot of the systems that we're talking about. So unique

7 identifiers are a challenge when you're trying to map data.

8 But let me answer the question more specifically. One of the, I think, key objectives of our Center

9 for Program Integrity at CMS is to be able to analyze for fraud, waste and abuse purposes Medicare and

10 Medicaid data together. So as Elaine mentioned earlier, they're definitely at the table with us as we were

11 creating this T-MSIS file.

12 And so, they're going to be creating techniques and ways of -- merging the data is too strong of a

13 word, but being able to analyze it side-by-side. But, you know, it's an effort to look at disparate data

14 sources and understand how I could tie them together, right? And understand that this record over here

15 and this record over here are about the same person, or the same provider submitted them. Right?

16 Providers is a little easier because now we have the National Provider Identifier, so that tends to be

17 okay, but it's not always okay, as a way to sort of look at people across disparate data sources.

18 As far as the exchanges go, I honestly have not thought about that, and so I don't know that I could

19 give you a very intelligent answer about how we would do that. But, you know, that general -- that's the

20 stuff that Niall Brennan at CMS has to think about, how we're going to put all these data sets together and

1 use them for interesting purposes.

2 CHAIR ROWLAND: Well, thank you. We do appreciate that you're going to make it easier for

3 us to understand the Medicaid program and what's going on. I think that one of our priorities has always

4 been, and we started at one of our very earliest meetings, to talk about, how do we improve both the

5 administrative data and, on the other hand, what kind of survey data do we need.

6 And so, looking at how to mesh that administrative data that you're creating with some of the

7 surveys is also a priority of ours. But we appreciate you sharing with us your progress to date and we hope

8 that the next time you come back you'll have a data system up and running.

9 MS. BOUGHN: Well, we appreciate you being an advocate for the work that we're doing. So

10 thank you so much for having us here today.

11 CHAIR ROWLAND: Thank you, and thank you all for coming.

12 And speaking of an area, as we move on to our next discussion, where Medicaid and Medicare data

13 together are necessary and needed and where two programs try to intermingle, we have a discussion at your

14 request last time to talk about the partial dual benefit -- the partial-benefit dual eligibles, those who are

15 covered by both Medicare and Medicaid but don't get the full scope of Medicaid benefits, and so Molly

16 McGinn-Shapiro is going to try and address the pathways and your questions about this population.

17 #### **OVERVIEW OF PARTIAL-BENEFIT DUAL ELIGIBLES**

18 * MS. MCGINN-SHAPIRO: Thanks, Diane.

19 So as Diane just mentioned, at last month's meeting, the Commission requested more information

20 specific to partial-benefit dual eligibles, which I will present today.

1 So in this session, I will provide you an overview of partial-benefit dual eligibles, including certain
2 characteristics of the partial-benefit dual eligible population, the role Medicaid plays in providing their
3 coverage, and policy questions related to Medicaid coverage of partial-benefit dual eligibles for the
4 Commission to consider.

5 So, first off, who are the partial-benefit dual eligibles? Just to recap from last month's meeting,
6 partial-benefit dual eligibles are enrollees whose only interaction with the Medicaid program is limited to
7 their Medicaid coverage of their Medicare premiums and cost sharing and through their enrollment in the
8 Medicare savings programs. So they have incomes that qualify them for one of the four categories of the
9 MSPs, but their income and assets are too high to qualify them for full Medicaid in their State. There were
10 2.2 million partial-benefit dual eligibles in 2009, or around 23 percent of all dual eligibles.

11 There are four categories of partial-benefit dual eligibles who are enrolled in MSPs, each with
12 different levels of Medicaid coverage that is based on the individuals' incomes and assets. So in the
13 materials provided for this session under Tab 4, there is a memo on the partial-benefit dual eligibles that
14 provides further detail of these different categories, including the number of enrollees, the Federal eligibility
15 income and asset levels, as well as a description of the Medicaid benefits provided for each category of
16 beneficiaries.

17 And also, just as a reminder, we are going to have a more extensive discussion of the different MSPs
18 in our cost sharing chapter in the forthcoming March report. So just --

19 CHAIR ROWLAND: MSPs refers to Medicare Savings Programs.

20 MS. MCGINN-SHAPIRO: Correct. Yes. Sorry.

1 In general, partial-benefit dual eligibles are more likely to be age 65 and older, female, and have
2 incomes under poverty with few assets. However, the QDWI dual eligibles look slightly different than the
3 other groups of the Medicare Savings Programs in that they are more likely to be slightly younger.
4 And just to give you a picture of the enrollment of this population by State, here is the State
5 enrollment of partial-benefit dual eligibles as a share of total dual eligibles for each State. The share of
6 partial-benefit dual eligibles in a State can range from two percent of all dual eligibles in a State like
7 California up to over 50 percent of all dual eligibles in Delaware. Some of this variation in the enrollment
8 of partial-benefit dual eligibles is likely due to the variation in State Medicaid eligibility criteria.
9 As for all dual eligibles, the State plays a critical role in determining eligibility in enrollment. The
10 enrollment of low-income Medicare beneficiaries into the MSPs is through an application process
11 administered by State Medicaid agencies. States have flexibility in developing the application process and,
12 therefore, the process varies by State. Some State options in the application include screening individuals
13 for MSP eligibility when they are applying for Medicaid or offering a separate streamlined application to
14 apply specifically for enrollment in the MSPs, and also automatically enrolling beneficiaries whom the Social
15 Security Administration has determined to be eligible to receive SSI benefits, and more than half of the
16 States use that option.
17 Enrollment rates for MSPs have been historically low, including estimated rates that range from 13
18 to 33 percent of eligible beneficiaries across the program. Documentation of assets may contribute to the
19 complexity of the enrollment process and may be a potential barrier for beneficiaries applying for MSP
20 coverage. And administering the MSPs' application, including verifying income and assets, obviously

1 requires State resources, and some States have reported administrative savings from eliminating the asset

2 test for their MSP enrollees.

3 In 2009, average Medicaid per capita spending for partial-benefit dual eligibles was around $2,300,

4 which compares to almost $20,000 for full-benefit dual eligibles. Total Federal and State Medicaid

5 expenditures for all partial-benefit dual eligibles were $4.4 billion in 2009, which was around one percent of

6 the total Medicaid program spending. And just to note, we are continuing to analyze the State-level

7 spending on partial-benefit dual eligibles. We're still looking into that.

8 Medicaid payments for premiums and cost sharing for QMBs, SLMBs, and QDWIs are eligible for

9 Federal financial participation at the State's regular FMAP. However, Medicaid payments for premiums

10 for the QIs are 100 percent Federally funded through allocations to States in one-year increments.

11 So Medicaid's coverage of partial-benefit dual eligibles introduces several policy questions for the

12 Medicaid program, including such questions as what are States' concerns regarding partial-benefit dual

13 eligibles and their administration of the MSPs, and are there more simplified methods of providing

14 cost-sharing assistance for this population, and what role Medicaid would have in these methods.

15 CHAIR ROWLAND: I think there's undoubtedly more simplified ways to provide it.

16 [Laughter.]

17 MS. MCGINN-SHAPIRO: Right. Thank you for your time.

18 COMMISSIONER COHEN: If memory serves, and it might not, but when Part D, when the

19 low-income subsidy was developed, Medicare Part D, there was some discussion about the role when an

20 individual would fill out a low-income subsidy application that might indicate the person might also be

1 eligible for Medicaid or one of the Medicare Savings Programs. There's supposed to be a process where, at

2 the Social Security Administration, would sort of forward that application to States. And I think maybe at

3 some point there was some thought that, with a great deal of outreach around the Medicare Part D

4 low-income subsidy program, that it might sort of beef up the enrollment and the uptake of people onto the

5 Medicare Savings Programs. What's the -- I mean, I saw the estimates of uptake are really old. Like, what

6 is -- do we know anything about what that experience was?

7 MS. MCGINN-SHAPIRO: Right. Well, there hasn't been any -- I wasn't able to find any more

8 recent estimates of, among the eligible beneficiaries, how many are enrolled in MSPs, but, actually, the

9 Medicare Improvements and Patient Protection Act had those requirements, where the Social Security

10 Administration for LIS applications is required to send those applications to the State Medicaid agency if

11 they seem to be eligible for the MSP programs in their State, and then the State is to use information from

12 that to start the application for an MSP. And the GAO had a recent study in September that looked at

13 whether some of those types of provisions have -- and enrollments have -- they found that enrollment had

14 increased in the last five years, from 2007 to 2011. But in terms of looking at it out of the estimated

15 eligible, I haven't found anything that shows the rates increase.

16 COMMISSIONER COHEN: How much did it grow in the last -- I mean, like, did it grow by a

17 very -- the enrollment -- by very substantial amounts over that period, which would have been the period

18 when people were kind of -- large numbers of people enrolling --

19 MS. MCGINN-SHAPIRO: Right. It depended upon the State. But I remember looking at

20 some of the States that they looked specifically at that enrollment -- the enrollment rate doubled, but I think

1 it depended.

2 CHAIR ROWLAND: Patty.

3 COMMISSIONER GABOW: I have a couple of questions. When you made the comment that

4 the majority of partial duals are over 65 and mostly female, it raises the question, are they mostly widows?

5 You know, there was -- there have been previous studies that the men are dying -- sorry, guys --

6 [Laughter.]

7 COMMISSIONER GABOW: -- men die earlier and that when widows are left, they tend to be

8 quite poor, and it's exaggerated as you go down the income scale. So it would just be an interesting

9 question if we know the answer. I don't know that it would create a policy difference necessarily, but it

10 may be interesting.

11 The second question was --

12 CHAIR ROWLAND: Patty, it could potentially, on your theory, also deal with the change in their

13 Social Security benefits --

14 COMMISSIONER GABOW: Right.

15 CHAIR ROWLAND: -- when they go from being a couple to being an individual, which then

16 drives their income low enough to put them on --

17 COMMISSIONER GABOW: Right, which would have a policy -- I have two other questions.

18 CHAIR ROWLAND: I know.

19 COMMISSIONER GABOW: This comment that California is two percent of all the duals are

20 partial, but in Delaware are 54 percent, and you sort of said that was due to State differences, but that's like

1 a 30-fold difference, almost. It's pretty spectacular. Can we dig into this variability a little bit more to

2 understand it, because that seems quite startling to me.

3 And my final thing is really a comment. As you know, I'm hot on the issue that Medicare should

4 do a sliding fee scale for premiums, and when I look at this little table that you have here, Table 1, that goes

5 up the, you know, from QMBs to SLMBs to QIs, it's a beautiful sliding fee scale and makes it -- it just like

6 the sliding fee scale we used to have at Denver Health for payment. And when you talked about the QIs

7 being 100 percent Federal payment, that even makes it a stronger point that this really should just be a

8 sliding fee scale premium payment in Medicare. And I'm going to perseverate on this for the duration of

9 my time on MACPAC.

10 [Laughter.]

11 CHAIR ROWLAND: That's fine.

12 COMMISSIONER HOYT: That's a warning.

13 COMMISSIONER GABOW: Yeah, that's a warning.

14 CHAIR ROWLAND: Okay. Mark.

15 COMMISSIONER HOYT: I was curious whether you know, has any kind of a cost-benefit

16 analysis ever been done on this program? Other presentations got me thinking about data, I guess. Do

17 we know how many full-benefit duals were partial-benefit duals before? Could you parse the full-benefit

18 duals out that way and try to measure some impact of the program you presented on?

19 MS. MCGINN-SHAPIRO: I haven't looked into that, but, I mean, we could try to see if you can

20 track how Medicare enrollees become full-benefit. I mean, I guess if they spend down far enough, they

1 maybe qualify, so we could look into that and try it.

2 CHAIR ROWLAND: Judy.

3 COMMISSIONER MOORE: One of your policy questions says -- queries what State concerns

4 are regarding partial-benefit dual eligibles in administering MSP. Is there -- I don't mean to be flip about

5 this, but are there States that would like to continue to do this? I mean, is there -- if given an option,

6 would a -- that is, if States were given the option of continuing to do what we're doing now or going to

7 something like Patty has suggested, which is making this into a Medicare program with a sliding fee scale but

8 a Medicare-only program, would States opt to continue doing this, because I don't know why. I can't

9 understand why that would be, but maybe there are reasons.

10 MS. MCGINN-SHAPIRO: Right. There are, you know, some incentives and disincentives, I

11 think, for States. We haven't had a chance to really talk to States particularly about the partial-benefit dual

12 eligibles, so we could follow up more on their particular thoughts --

13 COMMISSIONER MOORE: Yeah. I'd actually be curious --

14 MS. MCGINN-SHAPIRO: Okay.

15 COMMISSIONER MOORE: -- to hear some conversation about what the, at least even the

16 association would have to say about it.

17 CHAIR ROWLAND: I think there might be, also, a sliding scale for the States, that they don't

18 really usually talk exclusively about the partial-benefit duals only. They talk about why should they be

19 paying the Medicare premium, which they have no control over as that premium goes up or whatever. So

20 I think that there's obviously a broader issue there, but at least for this population, where the only payment

1 is into the Medicare system, and the complexity, of course, was not set up by State options. These were
2 categories set up by the Medicare side of the equation as each iteration came forward.
3 Andy.
4 COMMISSIONER COHEN: Just kind of to follow up on my earlier question, what do we know
5 -- and, I'm sorry, this is a little bit out of scope. If you don't know it, I understand. But what do we
6 know about the take-up rates for the Medicare Part D low-income subsidy? It was a very simplified
7 national application with a goal of really getting many people on it. I don't know that take-up rate is, like,
8 the only thing that we should care about when it comes to a benefit, but, obviously, if your goal -- if you've
9 made a policy decision that you want to provide a benefit to people in certain circumstances, having a really
10 incredibly variable and pretty low take-up rate is, I think we can acknowledge, not necessarily a good thing.
11 So I'm just sort of curious, what else can we learn about the Medicare Part D experience and what was sort
12 of good or potentially replicable about it in this context.
13 MS. MCGINN-SHAPIRO: Right. You know, I looked a little bit into comparing the LIS
14 program with the MSP program, but, again, Medicare is -- you know, LIS is a full Medicare program. And
15 so it's my understanding, though, with the LIS, there are those that are deemed automatically eligible and
16 enrolled into LIS and then there are those that have to enroll themselves. And so you have to look at it --
17 I guess the better comparison would be among those that have to enroll themselves with the MSP
18 compared to the population. And I haven't seen -- I haven't looked into as many of that comparison. I
19 don't think -- obviously, it's definitely lower than the ones that are automatically enrolled, and I'm not sure
20 it's that high, but I would have to look into that further.

CHAIR ROWLAND: Other questions, comments? I think that this obviously fits, too, with our broader discussion of the dual population, generally. But this is really useful information and the more we can dig into it and understand exactly how this program works, and I think Andy's comment about seeing how the other side of the Medicare equation works, because these programs were really all put into place before Medicare introduced any kind of means tested approach to its programs and so there's a lot to be learned that may help instruct how to make this simpler, whether it's to totally move it to be a Medicare responsibility or at least to simplify within the way these categories work, how it works. So thank you, Molly.

And speaking of other duals -- so we've gone from the partial dual population for whom Medicaid provides mostly the premiums and some cost sharing assistance but no additional benefits to Ellen is now going to take us back to the broader dual eligible population that gets a wider scope of benefits and services from the Medicaid program in addition to their Medicare benefits.

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

* DR. O'BRIEN: All right. Thank you.

CHAIR ROWLAND: And we're at Tab 5, as I believe.

DR. O'BRIEN: Thank you very much, and this is going to be really brief, so hold on to your hats.

I just want to give a very brief update on the revisions to the draft chapter that you saw last month on dual eligible beneficiaries, highlight very briefly the key findings from the chapter, and take your

1 comments and suggestions for future work.

2 So, first, in terms of how we've revised the chapter, you'll see that it's shorter and focuses on the

3 population profile, specifically the profile of all-year full-benefit dual eligibles, and four subgroups within

4 that population that vary in terms of their use of Medicaid-financed long-term services and support.

5 The sections in the draft chapter that discussed, very briefly, some available indicators of the need

6 for program improvement for dual eligibles and approaches to program improvement in managed care and

7 in fee-for-service have been removed and will be reserved for further development and use in a future

8 report to the Congress. These sections, as they were drafted, and as you saw last month, provided a

9 general overview, but perhaps were not as developed as you would have liked to see, and so we will focus

10 our attention on those sections and come back with more concrete information about what kinds of policy

11 approaches make sense for distinct subgroups of dual eligibles.

12 As it is currently drafted, the chapter has four major sections that focus on the population, and the

13 chapter concludes now with a new section called "Looking Forward" that signals that the Commission is

14 going to come back to the policy discussion to evaluate proposed policy approaches for duals.

15 So just to briefly review the chapter as it's currently drafted, it makes three key points, that duals are

16 a diverse population with widely varying needs and patterns of Medicare and Medicaid services and

17 spending. We look at the overall level of spending in Medicare and Medicaid across these distinct

18 subgroups and show that it varies quite widely.

19 The roles of Medicare and Medicaid for each of these groups also varies widely, with the majority of

20 dual eligibles of all-year full-benefit duals, fully 60 percent of those duals not using long-term services and

1 supports in Medicaid and relying largely on Medicare services. And, in fact, only a small percentage of
2 those duals, those non-LTSS users, receive any Medicaid wrap-around services, like non-emergency
3 transportation or dental care.
4 In contrast, duals who need long-term services and supports rely much more heavily on Medicaid,
5 so that 40 percent who use any long-term services and supports in Medicaid are relying on Medicaid, on
6 average, with Medicaid accounting for two-thirds of their combined Medicare and Medicaid spending.
7 And then we have in the chapter, then, this final point, that in light of this diversity, it seems that
8 different approaches will be needed to target solutions to the diverse needs of these distinct subpopulations.
9 In the concluding section, then, the "Looking Forward" section to the chapter, a few key areas of
10 focus for the Commission are highlighted. These, again, are expressed at a very general level, and we'd
11 certainly like your feedback on how to make this more specific and concrete and hear about what you want
12 to look into.
13 The broad areas, though, for future work are further analysis of the populations. The profile
14 provided in the draft chapter begins to illustrate the diversity of the population in terms of their service use
15 and spending, but evaluating approaches to reform for duals will depend on a richer description of dual
16 eligible subpopulations than the one provided in the chapter. We had some data limitations. We couldn't
17 include, for example, at this stage anything on the functional status of duals, or on their health status. We
18 looked briefly at age, but we would like to look at that a little more closely. We'd like to look at diagnoses
19 and health conditions, the living situation and family supports of dual eligibles, especially those who need
20 long-term services and supports, and so we propose to continue to make this a richer description of these

1 populations.

2 For example, since the fastest-growing segment of the dually-eligible population is the non-elderly

3 population, those under age 65 who come into Medicare on the basis of a disability, more attention may be

4 needed to understand Medicare's role for these duals, including people with intellectual disabilities, people

5 with mental health disabilities and a wide range of physical disabilities and chronic conditions who need

6 ongoing health care and supportive services.

7 And so we'll look, then, for each of these distinct subgroups at indicators of need for program

8 improvement, indicators of need in terms of their access to services, the quality, clinical quality of care they

9 receive and the quality of the supportive services they receive.

10 The second broad area in the "Looking Forward" section indicates that the Commission will

11 describe and evaluate approaches designed to lower costs for duals. We'll look at what has been tried, on

12 what scale, and for whom, and we'll take another stab at really evaluating what has been learned about what

13 works and what still needs to be learned, since improving care for duals is complicated and hard work.

14 Here's where we can dig in on the long list of initiatives you saw in the previous version of the

15 chapter, including PACE, fully integrated special needs plans for duals, initiatives designed to reduce

16 hospitalizations for nursing home residents, and care management programs in fee-for-service, and we can

17 -- we will try to again deepen that analysis and come back to you with more concrete ideas about what we

18 see about what works.

19 Finally, the "Looking Forward" section indicates that we'll take a closer look at State variation, since

20 this profile has focused on the national picture. The analysis presented in the chapter focuses on national

1 estimates of dual service use and spending to highlight the distinct subgroups. But Medicaid programs

2 vary widely in terms of covered benefits and payment policies and other program design features that may

3 affect access to care and quality of care for duals and their service use and spending, including their

4 Medicare spending.

5 The section indicates that, as a first step in understanding the extent of an impact of State variation,

6 the Commission will undertake an assessment of Medicaid policies for paying Medicare cost sharing and

7 their impact on access to care. Previous studies have shown that access to care for dually-eligible

8 individuals is lower in States where Medicaid payments or Medicare cost sharing is lower, with especially

9 large gaps in access to mental health providers in States that do not pay Medicare cost sharing in full, and

10 the section indicates that the Commission is interested in an updated assessment of the impact of those

11 Medicaid payment policies. That is just one example that is called out in the section.

12 And that's really all I have to say, so I look forward to your comments and suggestions on how to

13 improve the chapter and how to move forward with this analysis.

14 CHAIR ROWLAND: Okay. Patty, Mark.

15 COMMISSIONER GABOW: Thank you. I have three comments. One is sort of maybe a

16 little touchy-feely, which is, I know, atypical for me --

17 [Laughter.]

18 COMMISSIONER GABOW: -- but since we're going to be talking a lot about dually-eligible

19 people going forward, I wonder if we should adopt some nomenclature that is consistent. Sometimes we

20 call them "duals," which doesn't seem very respectful. Sometimes "dual eligibles." I mean, they are still

1 people. So I just wonder if we should think about the nomenclature that would be consistent.

2 So past that, you mention that many States have waiting lists for the home and community-based

3 service waiver. Do we know how many States actually have a wait list and what the magnitude of that wait

4 list is? I mean, is it 20 people, a thousand people? And, actually, I think it would be important for us to

5 understand that, what the sort of need is that we may not be aware of. So I don't know if that's data that's

6 even accessible.

7 And my last comment is, there's a closing part here that says that there may be little room to reduce

8 expenditures in the top, in the group that is spending the most. I don't think we have the data to conclude

9 that, and you would sort of generally guess that the most expensive do have room to reduce expenditures.

10 I think we need to be very careful about assuming where costs can be reduced and where they can't if we

11 don't have solid information about that. So those are my general comments.

12 DR. O'BRIEN: In terms of the wait list, there are people -- I'm not sure, actually, what the status

13 of CMS information is on wait lists, but I know that there are researchers out in California who have for

14 years tracked those waiting lists. And I think you raise an interesting point. We don't know, for example,

15 about that subgroup that we looked at, of people who are not using long-term services and supports, we

16 don't really know yet what their needs for those supportive services might be. So when we add in the

17 information on their functional status, their ADL limitations and say, well, geez, how many of these people

18 really do have a need for service and aren't getting it? How many of them, in fact, may be on waiting lists

19 for waiver services because in their State there is no personal care option, for example? So we will

20 definitely want to look into what the needs are and the extent to which they're being met by these services,

1 since this profile here today just focused on those who are receiving services, not the gaps in need.

2 In terms of ability to reduce expenditures at the top, that statement, maybe we can take a closer look

3 at. But we certainly also want to look at people who are persistently high cost, people, say, who have a

4 disability from birth, who are in the Medicaid program and are in the Medicaid program year after year after

5 year and what are those long-term services and supports that they're receiving, what are the costs of those

6 services, and what are the goals of those services. You know, for many of these people, this is

7 fundamentally about community integration, about supports for living. It's not about health care as much

8 as it is about basic support for life, life's daily activities. So I appreciate the point, and hopefully, we can

9 get into data analysis in the future that looks at duals over time.

10 CHAIR ROWLAND: Mark.

11 COMMISSIONER HOYT: I can't remember whether we discussed this before or not. If we

12 did, then you can just smack me, or I'm sure Sharon would be glad to do it. She's closer.

13 DR. O'BRIEN: I'll move closer to your chair.

14 [Laughter.]

15 COMMISSIONER HOYT: I'm thinking about our brothers and sisters across the ocean in

16 MedPAC. Were we going to have a break-out box or any kind of summary statement of what they've done

17 or said about duals and when they said it and recommendations they made to sort of link the two together?

18 DR. O'BRIEN: I don't -- we can certainly do that. They themselves have done it in their report.

19 I know I saw one recently where they went back over the history of several reports and said, here are the

20 kinds of things we've looked at with respect to duals in the past. We could certainly do it. We also are

1 working with MedPAC on these issues in terms of developing a data profile on duals in joint work.

2 COMMISSIONER HOYT: Well, then maybe it could be -- I mean, if people agree, then there'd

3 be some reference to what's been done and maybe a mention in the "Looking Forward," too, of what we

4 would anticipate coordinating with them going forward. I think the optics of that would be good with

5 some of the audiences we write for.

6 CHAIR ROWLAND: Richard.

7 COMMISSIONER CHAMBERS: Yeah, just a couple comments. When we talk about the

8 "Looking Forward" section, we talk about examining models and talk about looking at fee-for-service, case

9 management programs, the PACE program, special needs plans. I want to make sure we include in there

10 looking at the dual demonstrations that are coming, since they're going to be significant and they're going to

11 start launching before the end of this calendar year.

12 There was one statement about examining high cost of spending and assess opportunities for

13 savings. I just -- I found it sort of entertaining is that it says, the Commission wants to understand the

14 causes of high spending and whether there are opportunities to reduce spending without harming the quality

15 of care or quality of life for dual eligible beneficiaries, and, of course, that's assuming that the status quo

16 today is not harming life or quality of care, because I would challenge that with the lack of integration and

17 coordination of services, probably we're doing as much harm to very high-needs populations going forward.

18 And also, I was glad to see we're continuing the focus on the intersection of behavioral health, since

19 dual eligibles, I think, what is it, 50 percent, somewhere in that range, have mental health diagnoses.

20 I'll tell you a story, is I was talking to a colleague who has a sister who is a dual eligible in California

1 and has a behavioral health condition, also, and in fee-for-service Medicare as a dual eligible, had been
2 admitted to the hospital 60 -- 60, six-oh -- times in 2012 before enrolling in a special needs plan, and in the
3 last six months, has been in the hospital once in six months. So, I mean, it's just an example of, getting
4 back to Patty's comment, is very high cost, high utilizers. I think there's great opportunities where we look
5 at it.

6 Certainly, some, you have chronic conditions that you need hospital stays, extended hospital stays.
7 But there are other conditions that, with appropriate intervention, coordination, community-based services,
8 we have great opportunities, I think, to save money and improve quality of care and quality of life.

9 CHAIR ROWLAND: Andy.

10 COMMISSIONER COHEN: Maybe a little bit far afield, but it strikes me that, as Richard was
11 saying, since so many dual eligible beneficiaries have issues -- either have need for long-term care services
12 and supports or -- and many instances, the highest-cost ones, institutional care -- and many have behavioral
13 health needs, I wonder if this might not be a good place to look for future work at the issue of managed
14 care carve-outs. Those are two areas that are very commonly carved out of managed care or carved into
15 different arrangements and I just wonder, you know -- and in some ways, effectively for this population,
16 many Medicare and Medicaid arrangements are sort of like -- effectively are like carve-outs, and I just
17 wonder what the impact of that sort of carve-out arrangement can be. In other words, you have some
18 entity that is sort of financially at risk for a portion of a person's care, but maybe not in the long-term care
19 side and maybe not in the behavioral health care side, and just are there any observations we can make, any
20 lessons we can draw about that, because it does seem like it's a very relevant point in this population.

1 Whether or not it's really technically a carve-out like it is in straight Medicaid or not, it effectively works
2 where there's management for much of this population on part of what they do but not on other -- and risk
3 -- and not on the other part. And I think that might be a very sort of relevant consideration.
4 CHAIR ROWLAND: Judy.
5 COMMISSIONER MOORE: I'd just like to echo a couple of things that Richard and that Mark
6 said, primarily that I think in the final section on looking forward, we need to at least mention our
7 continuing dialogue with, work with, whatever, MedPAC on this, and also the importance of and our
8 monitoring of the demonstrations that are going on in CMS, because otherwise, it kind of looks like we
9 don't know what we're doing. The rest of the world is paying a lot of attention to that, and, of course, we
10 will be, too, but I think we need to put that in writing.
11 CHAIR ROWLAND: Donna.
12 COMMISSIONER CHECKETT: Well, you know, just great work and very, very interesting for
13 all of us to read.
14 I guess I had more of a question to the group, but it's my understanding the duals demos have an
15 evaluation component to them, so, obviously, I think just getting that reported back to us and then for us to
16 look at and say, what can we learn about recommendations we as a Commission are making about dual
17 eligibles. And, of course, those demos are really just coming up now, too, so we're probably several years
18 out before we'll see anything meaningful. So we don't want to wait for that, because I think we have really
19 important, interesting information here as States look at just the costs of managed care -- I mean, of
20 long-term care. It's really fascinating that it's just once again down to this drill-down to a very small

1 population of extremely high users.

2 I just want to put out there, you know, Ellen and this team, is to think about are there more things

3 we can do with that information? Is that something that we want to really call out to States, to say, boy, if

4 you are just going to -- if you can't do risk-based managed care, just look at this population. I mean, can

5 you put something in place for this population in the short term, in the near term? I just think it's really,

6 really compelling data and we should look at it.

7 And then another thing that strikes me of interest, when you look at the previous work on the

8 partial duals and this, is just all the different ways that people are getting enrolled voluntarily and

9 involuntarily in these programs. And at some point, I think it would be interesting for us to actually have

10 just a section on those eligibility pathways. And I think, again, it could help guide us in some of the

11 recommendations and the debate that is going on about passive versus mandatory enrollment of duals into

12 risk-based managed care.

13 So, thank you. Lots to think about and good work so far.

14 CHAIR ROWLAND: Ellen, could you talk a little about some of the data limitations here? I

15 mean, you keep mentioning that you don't have much on functional impairment.

16 DR. O'BRIEN: Just in terms of what we were able to bring to the Commission on the time frame

17 we were on, we were focused on their Medicare and Medicaid service use and spend. We could link these

18 data, for example, to survey data from the Medicare Current Beneficiary Survey to better understand some

19 of the socio-economic characteristics of this population, the health and functional status, and the like.

20 We also were limited in terms of our ability to get at information on diagnosis and chronic

1 conditions, but in our next round, in the work with MedPAC, we will be able to access these flags in the
2 data that indicate whether a person has a mental health disability or an intellectual disability or various kinds
3 of chronic conditions, and those flags have been substantially improved recently to better reflect the
4 conditions that affect non-elderly persons with disabilities. So we're really excited about adding that work.
5 We'll also potentially add indicators of access to care, like potentially avoidable hospitalizations and
6 other indicators of the clinical quality of care. But we're just starting to look into that. So we have lots of
7 hope for a much richer description using broader kinds of data.
8 CHAIR ROWLAND: In one of our earlier discussions with MedPAC, the question also came up
9 about whether the dual eligible population typically uses the same set of providers as other Medicare
10 beneficiaries or whether their provider choice and use in the fee-for-service area has been different or more
11 reliant on community health centers and outpatient departments. So even looking at the utilization
12 patterns would be interesting, as well.
13 DR. O'BRIEN: I agree. I'm not an expert in what these provider -- the data files that allow you
14 to look at provider characteristics, but we certainly have them on the agenda. And even in that work I was
15 discussing, looking at the impact of State policies with regard to payment of Medicare cross-over claims,
16 Sara has mentioned several times that she's interested in whether those payment policies may help to explain
17 what she sees as large growth in the volume of dual Medicare beneficiaries at FQHCs. So we definitely
18 have that on the agenda, as well.
19 CHAIR ROWLAND: But I think, to go with some of Richard's point, the current use of
20 providers and the patterns helped give you a better understanding of why integrating care is so important,

and the more we can shed light on that, the better, I think, that will be, as well, and understanding what the meaning of moving to integrated systems really is, because not every dual went to Denver Health.

Andy.

COMMISSIONER COHEN: I also just want to put in a plug for your number three "Looking Forward." I do think that looking at State variation and really benefit design, like the benefit package that States have and the impact on Medicare spending or Medicare utilization. I sometimes wonder, it might be really hard to figure out whether or not Medicare spending -- how much of it is a function of utilization versus what States -- I'm sorry, Medicaid, versus what States pay or what Medicare pays in a given State. But I do think this question of when a State Medicaid program has, for example, richer or more available home and community-based services, long-term services and support, what's the impact on Medicare utilization, different kinds of utilization? I think that's a really critical piece for us to look at.

CHAIR ROWLAND: Okay. Other points? Okay. Thank you, Ellen.

Why don't we move on to Chris. Given that we have rapidly gone through these issues, we're going to move before our break to take a look at the proposed Medicaid rule on eligibility and potential comments, and so we're asking Chris to give us a quick overview of that, and then we'll take our break. And you got a new handout that was on your table to go with Tab 5, correct?

SUMMARY OF PROPOSED RULE:

ESSENTIAL HEALTH BENEFITS IN MEDICAID;

ALIGNED ELIGIBILITY AND APPEAL PROCESSES;

MEDICAID PREMIUMS AND COST-SHARING

1 * MR. PETERSON: All right. Thank you, Diane.

2 I want to talk briefly in summarizing the proposed rule enumerated there on the slide. As Diane

3 mentioned, I handed out to Commissioners a summary of other guidance that has recently come out that is

4 relevant to Medicaid for your consideration. But our focus here is on this rule, and I will summarize some

5 of the provisions around eligibility, benefits, and cost sharing. There are many provisions, but we'll hit

6 some highlights, and then get your thoughts and feedback regarding whether to comment, and if so, on

7 what issues to comment.

8 With respect to eligibility, this proposed rule is the latest in a series, so this further aligns processes

9 between Medicaid, CHIP, and exchanges. Now, we're at the level of notices and appeals, but there are

10 many other important issues that have been raised in this one.

11 We have talked about making -- the possibility of doing a recommendation on a statutory option for

12 12-month continuous eligibility for CHIP. It is not explicit in the statute currently. It has not been in the

13 regs. And now, in this latest one, CMS is proposing that this option be available in the regs.

14 Another action that they are proposing that one of the previous panelists talked about is having

15 State plans available electronically. In this proposed rule, they talk about requiring this of States within one

16 year of that system being available.

17 Another issue is to limit CHIP waiting periods to no more than 90 days, and the rationale cited in

18 the proposed rule is that many of the ACA provisions limit waiting periods for private coverage to no more

19 than 90 days, so that the rationale, then, that this should also apply for CHIP, as well. But 19 States

20 currently have longer waiting periods.

1 This proposed rule would also require certain exceptions to CHIP waiting periods. States currently
2 implement their own exceptions to waiting periods and this would be new in terms of a list of Federal
3 exceptions to those waiting periods.
4 And another thing that was described in this proposed rule is the possibility that Medicaid and CHIP
5 programs could use their authority for premium assistance to purchase exchange coverage, and I want to be
6 clear. What that is talking about is that, let's say, for example, parents are covered up to 100-and -- let me
7 think of how best to describe this. So you have parents who might be eligible for coverage through an
8 exchange and the children are eligible through CHIP. In this case, the CHIP program could be used to
9 pay the premiums attributable to those children. So CHIP could pay that part of the premium. To be
10 clear, this is not talking about CHIP enrollees getting exchange credits. That is still prohibited. So I just
11 wanted to clarify that, and I hope that helps.
12 With respect to benefits, this is the first rule that describes how essential health benefits would be
13 implemented in Medicaid. We've seen guidance already on exchanges, but this is the first proposed rule
14 with respect to Medicaid. It provides States with some guidance and options in establishing habilitative
15 benefits and it would add to the list of individuals exempt from enrolling in alternative benefit plans.
16 With respect to cost sharing, it would simplify current cost sharing regulations. It would also
17 permit higher cost sharing in some cases, for example, up to $8 for non-emergency services provided in an
18 emergency department for individuals who are under 150 percent of poverty or otherwise exempt from cost
19 sharing.
20 In addition, this proposed rule would allow States to permit a provider to deny services for

1 non-payment of cost sharing for individuals who are above 100 percent of poverty who are not in an

2 exempt group.

3 So in your materials that were sent to you last week, we provided a draft comment letter. That

4 draft comment letter addressed two issues for your consideration, 12-month continuous eligibility in CHIP

5 and electronic State plans. Notwithstanding that when the proposed rule was first published, it said that

6 the comment period closes February 13, I believe it was. They came out with a later notice saying that it is

7 actually February 21, so I just wanted to make you aware of that. So we look forward to your comments

8 about whether to -- your feedback as to whether to comment, and if so, on what issues. Thank you.

9 CHAIR ROWLAND: Richard.

10 COMMISSIONER CHAMBERS: When I first looked at this and saw what was in the regulation

11 that got put out, it was, like, geez, we really should go on the record commenting on a lot of these things.

12 There's a lot of significant things here. But then I was drawn back to sort of our core principles, is not

13 commenting on things that we have not had the opportunity to really spend a lot of time or take positions

14 on. So I was torn between -- because when I saw the letter, the draft letter, it's, like, geez, it looked kind of

15 insubstantial, you know, just having two comments on this very substantive publication. But I assume

16 that's -- I'll be curious to hear what others say, but I assume that puts us in a really tough position as to can

17 we go out and support things that some of us may think are pretty no-brainers, but at the same time, can we

18 do that or not.

19 CHAIR ROWLAND: I know Sara Rosenbaum, before she left, said that commenting on the cost

20 sharing, she thought was potentially an important area, but it does go with the same caveat as you just made,

1 that we have not actually done an exhaustive review of cost sharing.

2 CHAIR ROWLAND: Other comments? Andy.

3 COMMISSIONER COHEN: I guess I have the same concerns as Richard. I feel like the letter

4 doesn't add a lot to the discussion. It points out that we have supported things like this, so, I mean, I

5 guess it's like -- it's almost like a statement of support for these two things, but it's not very analytical. And

6 note that's no criticism of the letter. It's sort of the topics and what they lend.

7 Personally, I would -- I don't know what our time frame is, but I'd like it if we had some time to

8 think a little bit more about whether there are other areas that might be appropriate for us to say something

9 about, even if it is, you know, not taking a position one way or -- support or not support, observations or

10 other things that we have included in past reports. I'm not entirely comfortable with the letter as it is now.

11 EXECUTIVE DIRECTOR SCHWARTZ: I would just clarify that the time frame is that the

12 comment period closes February 21.

13 COMMISSIONER COHEN: Although I don't think we are bound to a comment period. I

14 thought we had -- don't we have our own sort of time frames for how long after a rule?

15 EXECUTIVE DIRECTOR SCHWARTZ: We could comment any time we want, but that's when

16 their --

17 COMMISSIONER COHEN: Their record closes.

18 COMMISSIONER CHECKETT: Well, I think --

19 CHAIR ROWLAND: Donna, and then Burt.

20 COMMISSIONER CHECKETT: Oh, I'm sorry. I think the comments from my fellow

1 Commissioners are excellent. However, I don't want to miss the chance to do something. I'd like to

2 comment on this opportunity, and so I think the cost sharing recommendation is actually a very big one for

3 those of us who have been in Medicaid for a long time. We've been looking at the same, you know, $3, the

4 famous $3 copay since, I think, like, the early 1980s, maybe longer than that. So the fact that we went to

5 $8 is actually really a big thing.

6 Therefore, I don't think I'm ready to say as a Commissioner -- I mean, we haven't discussed that.

7 So I would not feel comfortable including a comment on that in this letter, but I'm very comfortable,

8 somewhat banal, but the fact that I would like to go on record. I'm comfortable with what's in here. So,

9 my thoughts.

10 CHAIR ROWLAND: Okay. Burt.

11 COMMISSIONER EDELSTEIN: I may be missing something really fundamental here, but as I

12 look at this list on Slides 3 and 4 of the issues to be addressed, I'm wondering which ones require analysis.

13 Which ones are even amenable to analysis and which ones are just conceptual and we could briefly discuss

14 and feel comfortable commenting on?

15 CHAIR ROWLAND: Richard.

16 COMMISSIONER CHAMBERS: I was just going to suggest that if we can't do any more specific

17 comment, at least put a stronger closing in which we say we hope that we can help -- you know, comments

18 in the future to help in the debate of the issue -- these issues that are probably not going to get resolved

19 immediately, but that as we look at these in the future, we hope that we can help in the debate in finalizing

20 these issues, as to be able, as Andy says, is we can comment at any time and make it clear that we will, when

1 the time is appropriate, be able to, unless we can accommodate what Burt says of making some kind of

2 comments in the short term to meet the deadline.

3 CHAIR ROWLAND: Did you want to go through and talk a little bit, Chris, about which areas

4 you think we will be moving forward to have more data and information on in the future that we might

5 comment around later? Can we see that we're going to be looking at how the eligibility system actually

6 works, we're going to be looking at some of the data requirements down the road, and so we should be able

7 to be more informed about these topics, and how does that relate to our agenda?

8 MR. PETERSON: Well, we are definitely going to be looking, going forward, at 12-month

9 continuous eligibility to see whether, you know, what the costs are. And I think that, by and large, we plan

10 to look at eligibility-related issues, the costs of determinations --

11 CHAIR ROWLAND: At our last meeting, I thought we talked about going, just to use that as an

12 example, going back and seeing which States are using it now, what their experience is with using it, how

13 effective it is, to pick up on some concerns about it. Are they finding that people get through the process

14 who are not technically eligible, and if so, are they removed from the process or are they given the 12

15 months of eligibility? I think there's a range of things we could do if we took some of these topics and

16 said, let's figure out if this is an issue, a topic. What should we look at on cost sharing? What should we

17 be looking at around the way the eligibility system works? What data should we be gathering on

18 continuous eligibility so that we can make informed statements about this, even when it becomes a final reg.

19 MR. PETERSON: Well, let's take, for another example, the CHIP waiting periods, that they are

20 proposing to limit to 90 days. So 19 States, I think the slide said, have it above -- beyond that. So the

1 type of analysis -- it was in your materials who those States are, the lengths of those waiting periods. So in
2 this case, one might say, well, we would like to know, given who those States are, what would be the impact
3 of pulling it back to 90 days? Why did they go with 12 months or nine months? Now, the original intent,
4 of course, was to prevent crowd-out. Those policies are there so that people do not drop
5 employer-sponsored coverage in favor of CHIP. So, then, would we be recommending, essentially, some
6 encouragement of crowd-out? I mean, I think these are the kinds of complicated issues that are raised by
7 any one of these that we take on.

8 CHAIR ROWLAND: Okay. Richard.

9 COMMISSIONER CHAMBERS: Yeah, I think you're right, and maybe, at the least, we could put
10 those kinds of comments, is these are very difficult issues and we're not prepared to, but they're critical
11 issues and, you know, as -- you know, CMS may come out with final rules and they're going to move
12 forward with whatever they decide. It's like on the cost sharing. California had a proposal in last year on
13 copays as to deny care if the copay is not paid, and that's one of the provisions. It's a pretty fundamental
14 issue and it's just -- you know, they may go forward and approve it, but that doesn't mean we can't look at it
15 and say, that wasn't a very smart move. And we could at a later time point out that we disagree with that
16 policy and propose that it be changed.

17 That's the best we can do, because they will move forward as they choose on their time frames and
18 all we can do is just talk about that these are important issues and we are going to look at them, and we
19 hopefully will weigh in at the appropriate time if we come to a conclusion on what we think is right. Just
20 stronger, I think, in that even though we're not commenting, that these are really difficult issues that should

1 be debated seriously.

2 CHAIR ROWLAND: But we're agreeing to submit a letter or not? And if we submit a letter,

3 then what should that letter say, I guess are the two things. So how many would say we should go forward

4 with submitting a letter at all?

5 COMMISSIONER MARTINEZ ROGERS: I think that we should submit a letter, but it needs to

6 be edited somewhat, tweaked.

7 CHAIR ROWLAND: But with the two points that are currently in the letter and then an

8 acknowledgement of the complexity of the other issues and the need to do further study on them and move

9 forward?

10 COMMISSIONER MARTINEZ ROGERS: Right. That's what I say.

11 CHAIR ROWLAND: Some of which we will be doing, and some of which we would hope that

12 the Department would engage in, as well, in terms of evaluating the impact of any of these proposals. Is

13 that the -- Norma.

14 COMMISSIONER MARTINEZ ROGERS: I would like to suggest that, if possible, that when

15 the letter is tweaked, could they send it to the Commissioners so we could see it one more time?

16 CHAIR ROWLAND: Sure.

17 COMMISSIONER MARTINEZ ROGERS: Thank you.

18 CHAIR ROWLAND: Have you gotten a sense, Chris, of how to move forward? You look

19 dazed.

20 MR. PETERSON: No, I think that's fine. If I understand correctly, you want another draft of

1 the letter. We're going to stick with the two points that are there, but emphasize the fact that there are

2 many, many issues that are raised in this. They are complicated. We plan to look at them and, you know,

3 we could put in a couple just as examples to highlight the issues, and we do want to follow these things

4 moving forward.

5 CHAIR ROWLAND: Donna.

6 COMMISSIONER CHECKETT: Could I just -- a couple questions for Chris, and I did actually

7 read a lot of the summaries of the proposed rule when it came out. But what providers are allowed to

8 require cost sharing as a condition of receiving -- of providing the service? Your notes here say pharmacy

9 or hospital, but is it literally any provider, because that is -- there are two things that are so big in this, and

10 one is just the increase -- well, three things, the increase to $8, the fact that they've finally developed a way

11 to have a penalty for seeking non-emergent care in an emergency room even though there's a lot of steps to

12 go through, and then this last one, where you can actually refuse a service if someone doesn't pay the cost

13 sharing. Who are the providers and who is not in the exempt group?

14 MR. PETERSON: Well, so what the proposed rule says is “the agency may permit a provider,

15 including a pharmacy or hospital, to require an individual to pay cost sharing.” So my interpretation is

16 that's any provider is able to do that if the State chooses to have that policy. If the State chooses to have

17 that policy, the provider may still waive that.

18 COMMISSIONER CHECKETT: Sure.

19 MR. PETERSON: Now, for whatever reason, CMS chose to highlight pharmacy and hospital, but

20 there's nothing here that seems to indicate to me any limitation on the providers.

1 COMMISSIONER CHECKETT: And for the record and the Commission, would you repeat

2 again who is in the -- to whom this would apply, in other words, who is not exempt. Can you do that off

3 the top of your head? I think it's children and pregnant women --

4 MR. PETERSON: Right, children and pregnant women --

5 COMMISSIONER CHECKETT: -- seniors, and --

6 MR. PETERSON: -- is primarily the biggest group. I think the disabled --

7 COMMISSIONER CHECKETT: -- and maybe people over 65 --

8 MR. PETERSON: -- medically needy, let's see here -- hospice, an Indian who is eligible to receive

9 an item, service by an Indian Health provider, but those are the --

10 COMMISSIONER CHECKETT: Right, the big ones.

11 MR. PETERSON: We named the big ones.

12 COMMISSIONER CHECKETT: Okay. Thank you.

13 CHAIR ROWLAND: Patty.

14 COMMISSIONER GABOW: Yeah. I was just going to ask the same question about children

15 being exempt. But what about mentally ill?

16 MR. PETERSON: Is your microphone on? I can't hear.

17 COMMISSIONER GABOW: Yeah. What about people who are mentally ill or seeking

18 psychiatric care? That seems like a group that might be relevant, along with children and pregnant women.

19 So I think this is a very important area and I agree that we should say, this denial of service needs a lot of

20 thought about the implications of it.

1 And I don't like stories, generally speaking, but I will tell you one that gets to this denial of care,
2 although pregnant women are excluded. But when I had my child, my second child, and I was in labor,
3 there was a woman in labor in the next room and her doctor was the same as mine, and I was a nephrologist
4 and he kept coming and asking me advice. This was before HIPAA and, I'm sure, many things. But it
5 was a pregnant woman who had been seen somewhere earlier, a week earlier, with bad hypertension,
6 couldn't afford payment, was denied care. Now, of course, you can't do that, but she ended up in very
7 severe preeclampsia and died.
8 So I just think I'm glad there are groups that are excluded, but I think we need to think about the
9 implications of denying services to a broader group than children and pregnant and women without copay.
10 So I think just commenting that we understand why this is there, but this, if it's done, should be looked --
11 the consequences should be looked at carefully to understand impact on quality and cost downstream.
12 CHAIR ROWLAND: Burt.
13 COMMISSIONER EDELSTEIN: Chris, to what extent are each of these in the proposed rule
14 offered as options for the States? Are each of them --
15 MR. PETERSON: These are actually all statutory in the first place. That's probably a point
16 worth making. These exempted individuals are groups that are specified in the statute.
17 COMMISSIONER EDELSTEIN: Oh, I'm sorry. I'm not talking about exempted individuals.
18 MR. PETERSON: Oh.
19 COMMISSIONER EDELSTEIN: I'm talking about the entire laundry list of issues that are raised
20 in this proposed rule that you have on Slides 3 and 4.

CHAIR ROWLAND: He wants to know, which ones are at the option of the State to implement and which ones would be required as part of the implementation.

COMMISSIONER EDELSTEIN: Is each suggested as a State authority, a State option, or are the majority of them, at least, offered as State options by CMS?

MR. PETERSON: Okay, well, if we go through, you would have to align your notices and appeals, continuous eligibility is an option, state plan is a requirement to do that electronically, 90-day waiting periods would be a requirement. The exceptions for the CHIP waiting period would now be a Federal requirement and premium assistance is an option to states.

The essential health benefits, that is a requirement on those plans, but with state options about how to do that. To say that the proposed rule provided guidance and options may be a little generous because they are really seeking comment on that, but I think the intent is to provide state flexibility.

The list of individuals who would be exempt from ABPs would be in a Federal reg, so that would be a new requirement. It's a fairly long list so states could contend this is too long a list, given you would have to figure out some of these individuals who have certain conditions, et cetera.

Cost-sharing, one could -- I think the administration would contend a lot of this is just housekeeping, that they have a lot of flexibility to set the cost-sharing levels and it's been tweaked a little bit. There's one section in the statute, 1916, there's another section 1916A. They are confusing. Sometimes they interact, sometimes they don't. And the way the preamble says it, this is just to make things a lot simpler for states, but it's their option how much cost-sharing they want to do up to those maximums.

And then again, this last one would permit states to have providers to be able to deny services.

1 So it's a mix.

2 COMMISSIONER EDELSTEIN: So given that mix, might we want to say in our letter

3 something about the fact that we generally are in favor or are consistently in favor of simplification, using

4 that one as an example, that we recognize that granting states options allows experimentation that we can

5 then analyze to determine what works and what doesn't work.

6 In other words, add some comment about the value of some of these to our work at MACPAC.

7 Those would be two examples. In this letter add something about the fact that the Commission is

8 consistently supportive of simplification and add that we recognize that allowing states new opportunities

9 provides the ability for us to then analyze what works and what doesn't work.

10 CHAIR ROWLAND: I think it would also be fair to say that the Commission is also concerned

11 with access to care for the beneficiaries that are served by the program and that any of these changes ought

12 to be evaluated with regard to their impact on access to care.

13 COMMISSIONER MARTINEZ ROGERS: I agree with what you say, Diane, about access to

14 care. And I know that the higher cost-sharing permitted, I gathered what you said was it's not going to be

15 mandatory, it's going to be up to the state?

16 Because I know that -- I know we frown on people going to the ED, but if you live in an area that

17 doesn't have transportation and the only time you can get transportation is if somebody pops to visit you

18 that has a vehicle that can get you someplace, that's when you're going to go. And that happens all the

19 time, I know, in Texas because of our rural community, I'm sure the same thing for Florida.

20 And they would not have $8. I can promise you that. That would be like taking food off the

1 table. And that has to do with access to care.

2 CHAIR ROWLAND: Judy, did you have a comment?

3 COMMISSIONER MOORE: It just feels like it's a little late and a little under the gun to be --

4 CHAIR ROWLAND: Commenting.

5 COMMISSIONER MOORE: -- commenting -- well, I don't know about commenting, but

6 certainly having this conversation.

7 CHAIR ROWLAND: Okay. Well, I think that where we will go is to have Chris redraft the

8 current letter, and add in some of the more general comments. And obviously, it is not an area where we

9 have yet done the evidence-based groundwork to really go forward and comment specifically on a provision

10 such as the cost-sharing provision.

11 But it is one that I think is an important issue of what level of cost-sharing, what level of skin in the

12 game can low-income patients who are below the poverty level for the most part really have to put in?

13 That that's probably an area where we really need to focus more of our research and more of our effort on

14 looking at those issues so that in the future we can make a comment that isn't based on our anecdotal

15 evidence but is based on what the research shows or what some of the states that have actually

16 implemented. I know Washington state looked at implementing a non-urgent cost-sharing requirement and

17 we had Anna present to us at one of our earlier meetings on the use of the ED by people with non-urgent

18 conditions and the fact that it's pretty similar across the Medicaid population compared to the privately

19 insured.

20 So I just think this is an area where we need more focus and more work before we can say that our

comments are based on evidence instead of on personal observation and emotion.

So more work to be done, but we will proceed with circulating to the Commission members a revised draft based on your comments today.

We’re going to take a 10-minute break and then come back to talk about MACStats and data.

[Recess.]

CHAIR ROWLAND: Okay, if we could reconvene for our last issue area of the day, which is to really review the March chapter on MACStats and to talk about how we're going to be moving forward with explaining these statistics and putting our chapters together. So I'm pleased that Mary Ellen Stahlman and April Grady are going to walk us through MACStats.

MARCH CHAPTER REVIEW:

MACSTATS AND INTRODUCTORY CONTEXT SECTION

* MS. STAHLMAN: Thanks, Diane.

We're also going to talk about the short piece for the front of the book that we all talked about in January that provides a policy context.

And I want to start by saying that April and I; we drew the short straw, and we've got the last session of the day. So we're going to try very hard to keep you entertained and informed and awake. So wish us luck.

You'll find the material for this --

CHAIR ROWLAND: There's been an infusion of sugar on the side.

MS. STAHLMAN: Oh, that's good.

1 UNIDENTIFIED SPEAKER: We're very excited.

2 MS. STAHLMAN: You are? Oh, good. You won't believe how excited you'll be about this

3 context.

4 [Laughter.]

5 MS. STAHLMAN: Actually, I guess we should be channeling Jim right now. He always gets this

6 session.

7 Anyway, your material for this session is in tab 7 in your briefing book, and it includes a draft of the

8 chapter that I'll spend a few minutes summarizing. As MACPAC presents its March report to the

9 Congress, this chapter serves as an introductory piece, or perhaps a forward if you prefer that, that

10 highlights the overall policy context in which Medicaid and CHIP operate today, and it also relates the

11 chapters that you've chosen for the March report to that policy context.

12 The idea for this type of introduction was yours at the January meeting. We hope it reflects your

13 thinking on this, but we certainly look forward to your comments, so just a very quick review of the chapter

14 that you have there in tab 7.

15 As previous Commission reports and many of the Commission's discussions here before have

16 highlighted, Medicaid and CHIP play significant roles in American health care. The two programs cover

17 nearly half the nation's children, over 9 million low income persons with Medicare coverage and low income

18 persons with disabilities.

19 The programs account for 15.5 percent of national health care spending in 2011 and provide

20 benefits not typically covered by other insurers given the diversity of the population they cover.

1 Medicaid and CHIP also help finance the nation's safety net and reduce the burden of

2 uncompensated care for providers.

3 Over the years, since its enactment in 1965, Medicaid and, more recently, CHIP have evolved,

4 adding new populations, experimenting with new payment and financing mechanisms, increasing the use of

5 managed care arrangements, particularly and more lately for high cost, high need persons, dual eligible

6 enrollees and persons with disabilities.

7 Today, Medicaid and CHIP are at a critical juncture in their evolution. While not fully

8 implemented, the Affordable Care Act is changing the fundamental aspects of Medicaid and CHIP and

9 reinventing how they relate to other public and private coverage.

10 The Medicaid eligibility expansion is perhaps the most fundamental change to the program since its

11 enactment. The expansion heightens Medicaid's role as a major purchaser, adding millions of new

12 individuals to Medicaid and CHIP, most of them adults.

13 Over the next several years, policymakers will weigh the future of CHIP in the context of the

14 Medicaid expansion and new federally subsidized coverage through health insurance exchanges.

15 In 2013, federal and state policymakers have a full plate of issues before them, and we highlight

16 several of them in the draft chapter before you. Probably the most -- the highest priority for policymakers

17 right now is the implementation of the Affordable Care Act. In addition to preparing to enroll millions of

18 people in new coverage, states are standing up health insurance exchanges. They are redesigning and

19 upgrading their information technology systems to share information with exchanges. They're developing

20 underlying policies and procedures having to do with eligibility. And they're planning for the longer-term

1 funding of this new expansion.

2 Like all payers, Medicaid and CHIP face spending pressures. As you recall from our January

3 meeting, the CMS Office of the Actuary discussed the outlook for Medicaid and CHIP in terms of spending

4 and discussed the fact that spending growth has actually moderated in Medicaid in recent years but that total

5 spending would grow, clearly, in response to this expansion.

6 And, as you well know from so many of the sessions you've listened to over the course of this last

7 report cycle, Congress places a very high priority on budget discussions right now as do the states who are

8 required to balance their budgets every year.

9 In response to spending pressure, and also a desire to improve quality and outcomes of care, both

10 the federal government and the states are actively pursuing payment and delivery system innovations.

11 Many of these innovations are aimed at reducing costs and improving quality of care for high cost, high

12 need enrollees, including dual eligibles.

13 So, with that as a backdrop, the Commission's 2013 report to the Congress builds on foundational

14 work undertaken during the Commission's startup. This report takes a more in-depth look at two issues

15 that are very relevant to the Congress and important to policymakers right now -- implementation of the

16 Affordable Care Act and payment and delivery system improvements, particularly for dual eligibles.

17 Tomorrow, the Commission is going to finish the discussion that we've been having and

18 considering, perhaps, recommendations regarding Medicaid and CHIP interactions with exchange coverage

19 in terms of eligibility. And, clearly, the March report has a major focus on persons dually eligible for

20 Medicare and Medicaid, with chapters exploring service use and spending, Medicaid payment of Medicare

1 cost-sharing, rate setting for dual eligibles enrolled in integrated managed care plans and, of course,

2 MACStats which is always a great seller.

3 So, with that, I'll stop.

4 What we tried to do in this chapter is -- or forward if you prefer -- you know, provide a backdrop, a

5 policy context, for the March report. So, as it's delivered to Congress, what are the major issues that

6 policymakers are discussing?

7 So we'd love to have your comments and feedback about this section. Happy to have them.

8 COMMISSIONER HOYT: I like the overview of all the chapters. I thought that was well done.

9 That was a good addition.

10 And I just wanted to identify myself as being just like Donna Checkett. If I can't find a Starbucks,

11 then I just pull out MACStats and get a powerful buzz from that.

12 When I was consulting -- this term is overused, but -- we did kind of practice this. You always

13 needed some kind of elevator speech, something really short and to the point. And I was thinking that for

14 some reason not all my clients were as addicted to numbers and tables as I was.

15 And so, if you're presenting to somebody from the governor's office, or treasurer or somebody else,

16 it would be like, okay, just like give me the trends or like four or five key things I really need to notice here.

17 I was wondering if we could come up with a facing page on the stats themselves and give it some

18 cute name of Special Notice or I Want To Draw Your Attention To or something, where you just hit like

19 four or five key things in there that would be of special notice -- trends or something that's especially

20 noticeable -- between the last time we did the charts and this time.

1 Like you noticed -- you mentioned in there already -- I don't remember the table number, but it was

2 like, you can see here the effect of the federal -- the FMAP declining, and so the state share increased. I

3 know that's noticeable in this table. That type of thing, I think is really helpful.

4 CHAIR ROWLAND: I think maybe we should have April do her presentation and then we can

5 talk about both together because I think that's on our mind as well.

6 * MS. GRADY: Can you get us to the presentation, Matt? Can you get his attention?

7 MS. CHECKETT: Well, this is exciting.

8 MS. GRADY: It is.

9 MS. CHECKETT: I told you this was going to be a great session.

10 MS. GRADY: Here we go. All right. So all of you are very familiar with the MACStats at this

11 point.

12 In our March 2013 report -- the MACStats -- we plan to follow the order and the content of last

13 year's report, and you have last year's table of contents in your meeting materials if you want to have a look

14 at that detailed list.

15 Of course, all of our data are going to be updated to reflect the most recent year available. And, as

16 you heard from Julie Boughn, sometimes that year is fiscal 2010 if we're talking about enrollment; with

17 spending, we're lucky to have fiscal 2012. So it depends, based on the table that we're talking about.

18 And, as in the previous reports, the March MACStats cover a variety of issues related to enrollment

19 spending, eligibility, cost-sharing, FMAP, and we also try to provide some contextual information to help

20 you interpret Medicaid and CHIP in the context of state budgets as well as national health expenditures.

1 And I'm not going to go through the tables one by one here. I won't torture you with that. But
2 instead, I'm going to highlight some key points and changes and interesting things to note since last March.
3 And I'll caution that not all of our numbers are final. We work right up until the last minute with
4 MACStats to get the most recent information available, but I don't expect that anything we discuss today is
5 going to change radically before the March report is published.
6 So the first thing I want to talk about is Medicaid and CHIP spending. I think that Chris Truffer
7 from OACT stole a little bit of our thunder last session, but I'll review with you some of the numbers that
8 he also talked about in his session.
9 Of course, overall Medicaid and CHIP spending, a big thing this year is that total Medicaid spending
10 only grew by about 1 percent or at an estimated 435 billion in fiscal 2012. And although overall Medicaid
11 spending grew by only about 1 percent, there was a difference in the federal spending; that share actually
12 decreased while state spending increased. And I'll talk a little bit more about the reasons for this on the
13 next slide, so we'll come back to that point.
14 Total CHIP spending also had a very low growth rate, about less than 2 percent. So we're at about
15 12 billion in CHIP spending in fiscal 2012.
16 Medicare as a share of state budgets is something we have talked a lot about in the Commission over
17 the years, and, as you very well know, it depends on how you measure the share of state budgets.
18 If you're looking only at the state-funded portion of the state budget, the states that -- the portion
19 that states have to pay from their own revenues, Medicaid is only about 13 percent of the budget, and that is
20 second to elementary and secondary education which is about 24 percent. So if you're looking at the

1 state-funded portion, about 13 percent.

2 If you are looking at the state's total budget, including revenues from all sources, including federal

3 dollars, Medicaid spending is higher. It's about 24 percent of the total.

4 So, again, it depends on what you're looking at.

5 The next point that we have here is Medicaid and CHIP as a share of national health expenditures.

6 As Mary Ellen mentioned in her presentation, we're at about 15.5 percent of national health expenditures in

7 2011, and that's projected to reach about 20 percent by calendar 2021. So there is some growth there.

8 And, just as a point of reference, Medicare as a share of national health expenditures over this

9 period is projected to remain steady at about 21 percent and private insurance is expected to decline slightly

10 over this period, from about 33 percent to 31 percent in calendar year 2021.

11 CHAIR ROWLAND: April, just as an aside, in the share of state budgets numbers, those will be

12 interesting to track as the share of state-funded budgets should remain relatively the same, or one can look

13 at that. But, obviously, as more federal funds are infused with the ACA, the share of the total budget that

14 Medicaid accounts for will go up.

15 MS. GRADY: That's true.

16 CHAIR ROWLAND: So keeping those two numbers in parallel I think is an important

17 contribution.

18 MS. GRADY: And that's something -- I mean, so this is our third iteration of the March

19 MACStats, and we can start to talk about trends now that we have those numbers from previous years.

20 That's a good point.

1 CHAIR ROWLAND: Andy, did you have a question on this?

2 COMMISSIONER COHEN: Is now an appropriate time to ask a question?

3 I'm just curious. Why is there -- and you can defer me to the end. Why is there such a big jump

4 in -- between calendar year '11 and '12 in the share of national health expenditures?

5 MS. GRADY: That's a good question. I'll have to go back and look into that because, you know,

6 we're not in expansion of Medicaid at that point yet. So it may be -- it may have something to do with the

7 other, you know, programs or projections that are going on, but I'll -- that's something we can get back to

8 you on.

9 CHAIR ROWLAND: Or other cuts. Cuts in other health care spending, like NIH and whatever.

10 COMMISSIONER CHAMBERS: Can I just clarify to understand about the state -- share of state

11 budgets?

12 So let's just -- let's use a hypothetical. California; they call it the general fund budget. Okay.

13 So say the general fund budget of the state is 100 billion, just for rounding. So, if it's 13 percent

14 average, it would be that the state is spending $13 billion of its general fund budget on the state's Medicaid

15 program, correct, but there's federal dollars that aren't in that equation?

16 MS. GRADY: That's correct. And the only clarifying point I would make is that when we do this

17 calculation we're not limiting ourselves to the general fund. There are other sources of state revenue like

18 bond funds and, in some cases, local funds that flow through the state government. So we're not limiting

19 ourselves to the general fund.

20 COMMISSIONER CHAMBERS: Okay. So then when it says the Medicaid spending is a share

1 of total budgets, it was 24. So total budget is total Medicaid budget?

2 MS. GRADY: So the entirety of the state budget including federal and state funds.

3 COMMISSIONER CHAMBERS: It's for all programs.

4 MS. GRADY: I know the terminology gets tricky to shorthand on the slide.

5 COMMISSIONER CHAMBERS: All right, that's what I wasn't quite clear on.

6 MS. GRADY: But we have many clarifying notes to explain what we mean.

7 COMMISSIONER CHAMBERS: Okay. Thank you.

8 COMMISSIONER HOYT: Can I ask just a short follow-up question?

9 So I think New York still does this; the counties pay half the state share. What did you do in New

10 York specifically then?

11 MS. GRADY: It depends on how the state reports that data to NASBO -- the National

12 Association of State Budget Officers -- that publishes this information. I could go back and check to see

13 how New York reports that information. But in states that do have a large county funding component it

14 will sometimes fall into an other/non-general fund category in the NASBO report, and so it's really -- it

15 depends on how the state chooses to report that to NASBO, whether they count it as general fund versus

16 an Other state fund.

17 Okay, the next thing I want to talk about is Medicaid FMAPs and enrollment. And, as I alluded to

18 on the previous slide, this is part of the explanation for some of the spending numbers that we saw.

19 As you know, there was a temporary Medicaid FMAP increase that was in place for, I believe, nine

20 quarters, and it ended in June 2011, and it had a pretty big effect on states. FMAPs dropped by 10 or more

1 percentage points in most cases. And so what we see in fiscal 2012, as I mentioned, is this decline in the

2 federal spending and an increase in state spending, and that's because of this temporary FMAP expiration.

3 And in the MACStats we have FMAPs for several years. The most recent published information is

4 for fiscal 2014. And those are the regular formula level FMAPs, but I just want to point out that states will

5 be receiving 100 percent FMAP for the newly eligible population in Medicaid, and we'll have a note about

6 that in the table itself.

7 The other thing I want to talk about is Medicaid enrollment and with regard to the slow growth in

8 total Medicaid spending that we talked about -- that part of that reason for that slow growth in spending is

9 because of the slow growth in enrollment. In fiscal year 2012, estimated growth in enrollment was only

10 about 2 percent. So that was a contributing factor to the spending slowdown.

11 Just as a point of reference, during the height of the recession, annual growth in Medicaid

12 enrollment was closer to 6 or 7 percent. So this is a pretty dramatic slowdown here.

13 And I do want to point out that I just cited fiscal 2012 enrollment, which is an estimated number --

14 estimated national number -- from OACT. As you heard from Julie Boughn, the actual state-level data

15 that we have right now is only current through fiscal 2010 for most states, and even then we're waiting for

16 those last 5 states to come in -- fingers crossed -- before we publish the MACStats. And for fiscal 2011,

17 we have about half the states right now. So it's just something to be aware of.

18 And this is something I know we've also discussed a number of times, but in general in the

19 MACStats we're presenting estimate of the number of people who are ever enrolled in the program during

20 the year. And those are going to be higher than some of the other numbers you might hear OACT or

1 other people citing, which are reflective of a point in time during the year. So it's just something to keep in
2 mind; if you're seeing a number that looks high or low, you want to know at what point in time that's being
3 measured.
4 And I don't have final CHIP enrollment data yet for fiscal 2012. We're still working on that. We
5 had about 8.2 million enrollees in fiscal 2011. The vast majority of those are children. And we don't
6 expect the trend in enrollment growth to differ much for CHIP, but we're still waiting to see what that's
7 going to be like.
8 The next thing I want to talk about is Medicaid and CHIP eligibility levels that we discuss in
9 MACStats, and as you heard in previous presentations, right now there is a Maintenance of Effort provision
10 in place that prevents states from restricting eligibility in most cases. As noted here, there is an exception
11 for adults right now. If a state has a budget deficit, they can roll back eligibility for those non-disabled,
12 non-pregnant adults above 133 percent of the poverty level.
13 And looking at eligibility policies in 2012, what we see is that 3 states reduced their income eligibility
14 levels for adults under the Maintenance of Effort exception. Again, because these states were covering
15 adults in excess of 133 percent of poverty and had a budget deficit, they were allowed to do this. And
16 there were two states that increased levels slightly for adults.
17 With children and pregnant women, most of the changes that we see -- expanded coverage to
18 additional groups of children rather than covering children at higher, and pregnant women at higher, income
19 eligibility levels.
20 Not noted in the slide here are eligibility levels for seniors and persons with disabilities. We're still

1 working on that. But there appear to be few changes since we last updated that MACStats table.

2 And something I want to point out here -- it's not an issue we address specifically in the MACStats,

3 but we wanted to mention it because it's likely something that we'll talk more about in future Commission

4 meetings. And that's the fact that regardless of where the income eligibility levels are for seniors and

5 persons with disabilities, it's often the case that the calculation of the income and the assets that are used in

6 those eligibility determinations can be pretty complex, especially for people who have long-term care needs.

7 So that's something that you might hear more about in the future.

8 And I raise that because this is sort of in contrast to what's going to happen as of 2014 for children

9 and non-disabled adults, where MAGI is going to standardize the income calculations and there's actually

10 going to be no more asset test for those groups. So there's a streamlined process for several groups, or

11 many of the Medicaid enrollees, whereas seniors and persons with disabilities continue on under the old

12 rules that are pretty complex and can vary by eligibility pathway.

13 All right, and that concludes what I wanted to raise, or highlight, with you, but you can rest assured

14 that in the March report we'll have 22 tables worth of the gory detail that you all know and love.

15 Thank you.

16 CHAIR ROWLAND: Okay, I want to turn back to Mark's earlier comment, which I take it is to

17 take things like these slides and put them into a one-page header that says, Dig Into These Statistics, But

18 Here's the Highlights.

19 COMMISSIONER COHEN: I guess, you know, sort of reading a lot about it in the press and a

20 lot of theorizing, it just seems like we should perhaps say a little bit more about -- I mean, it's a pretty

1 dramatic slowdown in Medicaid growth.

2 I mean, you said enrollment -- there was a significant enrollment slowdown too. But in what year

3 have we had higher enrollment than total program growth? Not in a long time. Two percent enrollment

4 growth. One percent total growth.

5 So I mean, looking over the last few years, it's been kind of sustained. I think it's worth making

6 that kind of a headline.

7 Again, you know, I don't know how much we can say about the causes. I think everybody in the

8 entire health care world is, you know, a little bit mystified, a little bit thinking it's more than just the

9 recession. But, you know, at the very least, we should make it clear that Medicaid is right in there with

10 other programs and the spending is slowing.

11 CHAIR ROWLAND: And perhaps even highlight that in our transmittal letter.

12 COMMISSIONER CHAMBERS: April, in the eligibility, does it pick up -- I don't know if any

13 other state other than California did the early adoption, you know, of the Medicaid expansion.

14 So those individuals--did they get picked up?

15 And is that -- was that considered an expansion or was it just -- they didn't really change any levels.

16 They just -- you know. They allowed the, you know, the childless adults, you know, to come in, so just

17 curious where that gets picked up.

18 MS. GRADY: I'll have to double-check that, but looking specifically at 2012 I'm not sure that

19 there were any states that picked up the option this year, this past year. It might have been the year prior.

20 COMMISSIONER CHAMBERS: 2011.

1 MS. GRADY: But that's something we can double-check for you.

2 COMMISSIONER CHAMBERS: Okay. Another question is when we talk about total spending
3 do we break it down also in like per member per month just to -- because it's always curious to see where
4 the costs of the program. And you get that more in a PMPM versus if it's just volume. You might have
5 additional expenses or, you know, with a growing population.

6 But it's like -- I'm always curious as to how is the Medicaid cost inflation going, and you get a better
7 sense on a PMPM year-over-year.

8 MS. GRADY: That's not something we address specifically in March because we're working with
9 the aggregate numbers. And, as you know, the PMPMs require good enrollment data to reliably calculate.

10 But what we do know about decomposing the aggregate spending growth we're seeing now is that
11 of that 1 percent increase in the total Medicaid spending, if you break total Medicaid into benefits and
12 administration -- and this is a break that Chris Truffer made in his presentation last time around -- the
13 growth in the benefits portion, which is 95 percent of the total, was very small. I think it was only about
14 0.2 percentage points.

15 But where you look at the administrative cost, that's where you saw, I think, higher growth, and I
16 believe he attributed most of that to the new incentive payments for adoption of electronic medical records.
17 That's being counted as a Medicaid administrative cost, but it really is just sort of a pass-through payment.
18 So it's -- in one way, it's not really -- it's not administering the program, but it's counted as a Medicaid
19 administrative cost at this point.

20 COMMISSIONER CHAMBERS: The same thing -- Mark, maybe you know this, but I see this

1 occasionally in stories is what -- like for 2012, what was the overall inflation in health care, and I think it was

2 somewhere still growing at 5 to 7 percent, something like that.

3 I just think this is a fact; Medicaid spending only increased a percentage point, and I think it was a

4 growth in membership of about a percentage point. So my simple math is it means the unit costs aren't

5 increasing that much, and that's good. States seem to be keeping a pretty good handle on inflationary costs

6 in health care spending, for me.

7 That math could be wrong, but that's the way I saw it.

8 CHAIR ROWLAND: Okay. Other comments?

9 Mark. I've got Mark and Richard. Mark and Richard, okay.

10 COMMISSIONER HOYT: I don't know whether there's any reasonable way to get at this

11 number or not, but I'm thinking of something that's more like an effective FMAP.

12 So you said --

13 [Laughter.]

14 COMMISSIONER HOYT: -- I think, in giving the percentage of state budgets, that the state

15 share is and then the total cost is. Do you have the total, say if it was $400 billion, allocated to all -- is it 56

16 programs?

17 Or, is the total cost kind of imputed value by dividing back by an FMAP type of thing?

18 What I'd like to see -- because having done this well before, you know, the stated FMAPs are

19 sometimes a little bit far from how it really plays out. And then you're going to have the complicating

20 factor going forward of these various FMAPs in effect for the expansion populations.

1 Can you get a general fund number, a state share, and then divide it by the total program costs, state

2 by state, or is that like totally ridiculous?

3 MS. GRADY: You -- so what you're pointing out is sort of the federal data have the straight sort

4 of FMAP calculation, and you know, what we see there is reflective of the states' FMAP.

5 I think in theory you could what you're suggesting. The concern I have, I guess, is the state

6 reporting of the data varies, and so I'd be concerned about calculating that number in a comparable fashion

7 across states.

8 So it might be possible if you knew that all the money was reported in the general fund for a given

9 state, but as I mentioned, sometimes there is local funding that may or not be flowing through the state

10 budget, depending on the state practices. And so it's not as straightforward as you might want it to be.

11 CHAIR ROWLAND: Okay. Other comments?

12 Okay. And any comments -- we went from Mary Ellen to MACStats. So going back to the

13 context setting chapter, which is going to be the lead chapter in our report, are there any additional

14 comments there. Or, if not for today, can you please review that chapter this evening and come in

15 tomorrow with any comments or refinements since we obviously are very close to needing to go to press?

16 COMMISSIONER GABOW: I just wondered if you could clarify the looking-forward? Over

17 what period of time are you looking forward -- because certainly this isn't just for the June report that you're

18 going to achieve all of this. So I -- it may just be useful to have a context of, we're thinking of doing this

19 over the next year or the next five years, whatever.

20 MS. STAHLMAN: So what -- we can clarify that, and I would love any comments you have on

1 what your preference would be.

2 CHAIR ROWLAND: Tomorrow morning would be fine.

3 Okay, so this is the time in our meeting where we would welcome comments from the public, and if

4 anyone has a comment to please come to the mic and if you could identify yourself.

5 **#### PUBLIC COMMENT**

6 * MS. HUANG: Sure. Good afternoon. My name is Xiaoyi Huang. I'm with the National

7 Association of Public Hospitals and Health Systems.

8 NAPH members are major providers of care to Medicaid, Medicare and uninsured patients. We're

9 about 2 percent of the hospitals in the U.S., and we do 20 percent of the hospital uncompensated care.

10 My comments today will be focused on discussion of the proposed Medicaid rule. We would urge

11 the Commission to weigh in on the proposed changes to the cost-sharing responsibilities of Medicaid

12 beneficiaries and to examine any impact on beneficiary access to care should this proposal become final.

13 We would also urge you to weigh in on the best way to inform beneficiaries of the availability of

14 alternative providers should a beneficiary come into the emergency department for non-emergency services.

15 We believe that the proposed rule actually goes beyond incorporating existing hospital obligations in such

16 situations and actually adds additional administrative burden on hospital ED staff.

17 Thank you for the opportunity to comment.

18 CHAIR ROWLAND: Thank you.

19 MR. MASON: Thank you. I'm Dave Mason, and I represent four nurse practitioner

20 organizations -- the American Association of Nurse Practitioners, the National Association of Nurse

1 Practitioners in Women's Health, the National Association of Pediatric Nurse Practitioners and the National
2 Organization of Nurse Practitioner Faculties. And from that list, you may guess that I want to take you
3 back to this morning's discussion.

4 Thank you for the discussion about the Medicaid primary care payment increase. I thank both the
5 staff and the commissioners for comments and work with us on this. It will come as no surprise to anyone
6 that nurse practitioners are frustrated, as you are, about the limitations of the increase and the policy the way
7 that it was put forward.

8 I think we very much appreciate some of the discussions -- not only in the meeting today but in your
9 initial comments when the rule came out in November -- about better ways to spend the money and other
10 incentives that might be put into place to promote primary care and the access to primary care services for
11 Medicaid enrollees. We would hope, obviously, that those kind of incentives could include policies at the
12 federal and state level that would eliminate barriers to nurse practitioners being able to provide primary care
13 services at the full extent of their education and training, and we think there are opportunities to provide
14 constructive incentives to be able to go in that direction.

15 We would recommend, or urge you to make recommendations, to Congress along the lines of what
16 kind of incentives might be more effective in promoting the delivery of primary care services, and we would
17 greatly look forward to working with you as you work on those kinds of recommendations, to contribute to
18 expanding access to primary care.

19 Thanks.

20 CHAIR ROWLAND: Thank you very much.

1 We have one additional comment that we wanted -- did you have a comment, sir?

2 MR. GORDON: That's okay. Thanks.

3 CHAIR ROWLAND: No, come to the mic.

4 MR. GORDON: Stuart Gordon with Amerigroup-WellPoint, and I -- as you look at the

5 cost-sharing regs, I guess I'd urge you to compare them closely to the existing cost-sharing regs. At least

6 one of the elements that was discussed as a change to existing cost-sharing has actually been in place since

7 2005 and has been in the regulations since 2008. It became part of the law under the Deficit Reduction

8 Act.

9 So, as you look at those things, I think you need to compare them fairly closely.

10 CHAIR ROWLAND: Thank you for your comment, and we will do so.

11 We have one additional comment that came in from someone who could not be with us at this

12 point, but Rodney Whitlock, the Health Policy Director in the Office of Senator Grassley, has asked us to

13 enter his comment into the public record, and I will so read it. It's a little lengthy, but I hope you'll bear

14 with me.

15 He notes that, people who are focused on Medicare and Medicaid devote a lot of time and energy to

16 the dually eligible. Your efforts with the research presented today will help contribute to the conversation.

17 Our office has been looking at duals as well with a particular focus on the differences between those

18 younger and older than age 65. The statistic commonly cited is 38 percent of duals are under 65 years of

19 age.

20 The pathway to becoming an under-65 dually eligible individual can basically be reduced to OASDI

1 and SSDI pathways. As we have studied this issue, we have come to realize that many of the under-65

2 duals were eligible for Medicaid before becoming Medicare-eligible. We have been working with you all

3 and MedPAC and have high hopes of learning how many of the 3.5 million duals under age 65 were

4 Medicaid-eligible first.

5 Essentially, disabled young people, people who qualified for Medicaid as a disabled child, become

6 eligible for Medicare either through a parent becoming eligible for Medicare or by achieving the requisite

7 number of work quarters. So there are a number of individuals -- we believe from Social Security; there are

8 just under 1 million eligible through the OASDI pathway; the SSDI pathway number is still being

9 researched -- who had an acute and long-term care benefit provided by the same source, a state Medicaid

10 program, in what is a theoretically coordinated manner and then left Medicaid to receive an acute benefit

11 provided by Medicare while still relying on Medicaid to serve as the supplemental payer for the Medicare

12 acute benefit and still providing long-term services and support benefit through Medicaid. We believe

13 there is a public policy question here worthy of exploration by MACPAC.

14 Simply put, some number of duals had a coordinated, comprehensive benefit under Medicaid but

15 now receive an uncoordinated benefit as a dual that we all talk about fixing through improved dual

16 coordination. We think it is an appropriate research area for this body to examine this subject.

17 What are people who transition from Medicaid-only to dual status getting in terms of a benefit and

18 access?

19 I realize it is uncomfortable for you to consider value-laden words like this, but is it better?

20 The policy implications are very important. Individuals may be transitioning between programs

1 without any advantage from making that transition. Individuals may be receiving a better benefit from
2 Medicare while similarly situated individuals remain in Medicaid solely because they aren't fortunate enough
3 to have a Medicare-eligible patient.
4 Duals include an extremely expensive 85-year-old with multiple chronic conditions and functional
5 impairment, a 67-year-old that is relatively healthy and inexpensive, a 47-year-old who fell off a ladder at
6 work and disabled young people who transition from Medicaid-only to dual status through a parent or work.
7 We continue to believe there is no one-size-fits-all solution to the duals and that we need to focus
8 on subpopulations and not be afraid to ask tough questions about the way our system does things today.
9 We hope you can be of assistance to policymakers in our process.
10 So entered. And we can get you the actual text for your transcription.
11 Any other closing comments?
12 All right, with that, we will adjourn today and resume tomorrow morning at -- 10:00 a.m.? At
13 10:00 a.m.
14 Thank you very much.
15 [Whereupon, at 4:37 p.m., the meeting was recessed, to reconvene at 10:00 a.m. on Wednesday,
16 February 13, 2013.]

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

Horizon Ballroom
Ronald Reagan Building and International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

Wednesday, February 13, 2013
10:20 a.m.

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

ANNE SCHWARTZ, PhD, Executive Director

AGENDA PAGE

Session 8: Review of recommendations for March report for eligibility issues in Medicaid and CHIP: Interactions with the ACA
Chris Peterson, Director of Eligibility, Enrollment, and Benefits 140

Session 9: State Medicaid managed care enrollment policies
Molly McGinn-Shapiro, Senior Analyst 164

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Adjourn 190

1 P R O C E E D I N G S [10:20 a.m.]

2 CHAIR ROWLAND: Okay, we are reconvening the meeting of the Medicaid and CHIP Payment
3 and Access Commission this morning to take up the topic of Medicaid -- of our March report and our
4 recommendations on eligibility as part of the March report.

5 However, one of the things that we wanted to make everyone aware of is that we have also just
6 issued an overview of Medicaid and CHIP, a primer on the programs that also includes a substantial update
7 of all of our MACStats, and that is available on our web site, and I think it's going to be a tremendous help
8 to those who want a real orientation to the program. And I want to congratulate the staff on such an
9 excellent report and please note its availability in the public record.

10 But, for this session, we want to resume our discussion of recommendations for the March report
11 on eligibility issues in Medicaid and CHIP and especially to look at some of the interactions from current
12 policy with the Affordable Care Act, and so we've asked Chris to lead us through a discussion of the
13 revisions to the chapter that we discussed at the January meeting and to lay out some of the
14 recommendations that we plan to discuss and vote on.

15 #### **REVIEW OF RECOMMENDATIONS FOR MARCH REPORT**
16 **FOR ELIGIBILITY ISSUES IN MEDICAID AND CHIP:**
17 **INTERACTIONS WITH THE ACA**

18 * MR. PETERSON: Thank you, Diane.

19 So I want to walk through briefly some of the modifications that we've made to the chapter and
20 then turn to your consideration of the recommendation to the Congress on 12-month continuous eligibility

1 and then consideration of the recommendation to the Congress on transitional medical assistance, TMA.

2 So thank you so much for your comments that we have received from you. We've also received

3 great insights from external reviewers as well. So we've made changes to incorporate your

4 recommendations.

5 In addition, we reflect the new proposed rule where they -- CMS proposes to have CHIP

6 continuous eligibility as an option in the regulations.

7 Let me take a pause actually at this point to give a little more background on 12-month continuous

8 eligibility just as a way of a refresher.

9 Remember that it is a requirement in federal regulations that individuals report changes in their

10 income that could affect eligibility. So, when the first ACA rule came out on Medicaid eligibility, some

11 folks wondered whether this requirement would be struck because essentially the folks who are affected by

12 this requirement are those Medicaid enrollees who report their income changes. CMS, nevertheless, left

13 that in there.

14 What 12-month continuous eligibility does is say, okay, those of you who are going to report your

15 income changes, don't bother with that because there's going to be a redetermination likely coming up soon.

16 The magnitude of your income change is likely not large enough to merit a big change at this point.

17 But individuals would always have the option to dis-enroll. So if they said, look, I now have access

18 to employer-sponsored coverage — I want to dis-enroll — then they always have the ability to do that.

19 So the implementation of 12-month continuous eligibility is fairly straightforward for states. It

20 merely is not to require individuals to report income changes within that 12-month period.

1 Plans have been generally supportive of 12-month continuous eligibility. ACAP has gone on the
2 record. They have said that they would like mandatory 12-month continuous eligibility for all Medicaid
3 populations, the rationale being primarily the one that's addressed that we have as part of our rationale --
4 similar, that we want to reduce churning.
5 In addition, from the plan perspective, they can only make measurements of the impact of quality if
6 individuals are enrolled for 12 months. So that is another consideration as well as we look to trying to
7 improve the quality of health care in Medicaid.
8 So that's a little bit more background I wanted to provide before moving forward.
9 You had requested some additional information, and I want to highlight some of the additional
10 findings that we've added.
11 We did an analysis that compared children's average months of enrollment in Medicaid compared to
12 states with continuous eligibility and those without. Those with continuous eligibility had lengths of
13 enrollment for children that were 4 percent higher than those without.
14 Also -- this triggered my memory. I also want to mention as way of background that there is a
15 statutory option currently for 12-month continuous eligibility for children in Medicaid. There isn't an
16 explicit option like that for adults in Medicaid or for CHIP, notwithstanding, as I mentioned -- and perhaps
17 because of the attention we've given to this issue -- CMS is proposing 12-month continuous eligibility in
18 CHIP in their latest proposed rule.
19 Yes?
20 COMMISSIONER ROSENBAUM: I'm sorry, one question. Can you tell me in the estimates

1 that were done whether those estimates include also factoring in passive reenrollment or it's just looking at

2 the length of time?

3 MR. PETERSON: Just looking at the length of time.

4 COMMISSIONER ROSENBAUM: Okay.

5 MR. PETERSON: So we did exclude from the analysis states that had a redetermination period of

6 6 months rather than 12 months, but besides that, it's just yes or no.

7 So these differences are affected by multiple state-level factors that we just don't account for.

8 We got one estimate from Colorado, and they estimated that implementing 12-month continuous

9 eligibility would increase children's average months of enrollment by 25 percent. So this illustrates the

10 magnitude, how that can differ based on the state.

11 One reason, potentially, for Colorado is their starting place -- is that they have among the lowest

12 length of enrollment for children in Medicaid. So that could affect, you know, the impact of 12-month

13 continuous eligibility. It could be larger, but there are many other state-level factors that could be at play

14 here.

15 So, while these two estimates provide useful information, we want to acknowledge it does not

16 provide all of the data points on 12-month continuous eligibility that you mentioned at that last meeting.

17 Part of this has to do with the fact that 12-month continuous eligibility deals with a very narrow issue --

18 enrollees who report income changes during the year that would make them ineligible, and that's who is

19 targeted by 12-month continuous eligibility.

20 As we reached out to states and experts, the Colorado example is the only one that we could find on

1 the record that gave estimates of the projected impact of 12-month continuous eligibility.

2 While there is a sizeable literature on churning - - and Lindsay did a great job of scanning all that and

3 getting all that together -- much of it, frankly, is not relevant to this narrow question, or even to other

4 questions, considering the recent changes in federal law and regulations. For example, most of the existing

5 literature on churning focuses on eligible individuals churning off of Medicaid or CHIP at their regular

6 redetermination because of administrative requirements, like having to do face-to-face interviews. For

7 MAGI-based populations, many of these policies go away in 2014.

8 So, in the latest draft, we acknowledge there is a literature out there on churning, but unfortunately,

9 it doesn't provide us with much help on this particular issue.

10 This penultimate bullet on estimated size of income change -- I want to walk you through that.

11 You remember we used the widely cited numbers by Ben Sommers and Sara Rosenbaum that within

12 a year 50 percent of low income adults would have income changes requiring a program change. Now the

13 authors acknowledge this estimate does not account for how many people would actually report such a

14 change. But based on your questions in our last meeting we asked Ben Sommers to follow up his analysis,

15 to look at adults who began the year with income below 138 percent of poverty, who then went above 138

16 percent of poverty during the year. How high did their income go?

17 And, as you see in the draft chapter, according to his estimates 43 percent would still have income

18 below 200 percent of poverty, 39 percent would have income between 200 and 400 percent of poverty, and

19 18 percent would have income above 400 percent of poverty.

20 And I want to emphasize that these numbers say nothing about people's coverage, either what they

1 began the year with or in 2014 where they would end up after the income change with respect to their
2 coverage. For example, you might expect some individuals who went to 400 percent of poverty or above
3 could dis-enroll from Medicaid and enroll in employer-sponsored coverage.
4 In his analysis, he did not make those kinds of projections. He's merely showing the size of
5 income changes for this particular group of individuals.
6 And then the final bullet here speaks to the updated numbers we provided based on the recent
7 GAO analysis of TMA enrollment of 3.5 million in 41 states, with 4.1 billion in spending in 36 states, based
8 on 2011 data.
9 So just to talk about what we've included in the draft chapter with respect to the recommendation,
10 the draft wording at this point is: In order to ensure current options remain available to states in 2014, the
11 Congress should provide explicit statutory authority for 12-month continuous eligibility to children enrolled
12 in CHIP and to adults enrolled in Medicaid.
13 The rationale points out -- the rationale section of the chapter points out this would not create new
14 options or expansions but would ensure continued flexibility for states — rationale also being that
15 12-month continuous eligibility reduces churning.
16 I didn't have room on the slide, but I want -- I think it's important to highlight for you a couple
17 other points we added to this draft and would like your feedback.
18 In the rationale section of this draft, we added that: In making this recommendation, the
19 Commission also wants to emphasize the importance of accurate eligibility determinations and meaningful
20 verification of applicants' self-reported information. If, under 12-month continuous eligibility, states will

1 have the option to keep individuals in Medicaid and CHIP regardless of what are typically modest income

2 changes, then it is critical for applicants' initial determinations and enrollees' regular redeterminations to

3 reflect the most accurate information available.

4 To accomplish this, it is critical that the executive branch successfully establish the proposed Federal

5 Data Services Hub, an electronic service by which states will have information verified by various federal

6 agencies -- citizenship by the Social Security Administration, immigration status by the Department of

7 Homeland Security and income data from the Internal Revenue Service.

8 While pursuing streamlined, simplified application processes, newly promulgated federal regulations

9 make it appropriately clear that, quote, nothing in the regulations in this subpart should be construed as

10 limiting the states' program integrity measures or affecting the states' obligation to ensure that only eligible

11 individuals receive benefits.

12 So that's an addition that we've made to the rationale section.

13 And then with respect to TMA, the Congress should permanently fund current TMA required for 6

14 months with state option for 12 months while allowing states that implement the adult group expansion to

15 opt out of TMA, and the rationale being that permanent funding for TMA would end the perennial

16 uncertainty for states about continuation of 6-month plus TMA and that TMA is not as necessary to

17 prevent uninsurance in states that expand to the new adult group and opting out of TMA in those states

18 could reduce confusion and administrative burden.

19 For this recommendation, the federal spending increase for a single year is the smallest non-zero

20 bucket that CBO has and actually shows some very small decrease in federal spending.

1 So we look forward to your thoughts on the draft chapter and how you want the wording of the
2 recommendation to look.
3 CHAIR ROWLAND: Comments?
4 Trish.
5 COMMISSIONER RILEY: I think the rewording is really good. I think to note that it's just the
6 current option that we want to continue is important.
7 Where my worry comes in -- and I know it's beyond the scope of our task. The notion that the
8 subsidies are supposed to be seamless between the tax credits and Medicaid -- a recommendation that
9 doesn't talk to the tax credits, it seems to me, belies all that we're trying to do.
10 So I recognize that's not our scope, but I would love to see in the narrative some recognition that --
11 particularly since it will cost states and the federal government to do continuous eligibility, a cost that could
12 otherwise have been borne by the tax credits. It seems to me that at the very least the narrative, if not the
13 recommendation -- the narrative needs to say, in order to ensure equity across the subsidy structures, that
14 continuous eligibility has to be applied to the tax subsidies as well, or Congress should consider --
15 something that we can do within our scope and at least write in the narrative because it makes me -- I'm
16 disquieted by a recommendation that speaks only to Medicaid, recognizing that that's our charge, but I think
17 there's a bigger issue there.
18 CHAIR ROWLAND: Sara, then Andy.
19 COMMISSIONER ROSENBAUM: I think your point is really well taken. I would note that it is
20 a slightly different issue on the subsidy side, and maybe we could say it -- make the observation in a way that

1 sort of gets at the point you're trying to make, I think.

2 On the premium side -- and to me, that's one of the drivers, one of the justifications for our doing

3 12 months on the Medicaid side.

4 On the premium assistance side, the whole structure is around an annual enrollment period. And

5 what can happen to you during your enrollment period is that your income changes and it may go down

6 some, in which case you qualify for more assistance; it would go up, in which case you might be liable for

7 some recovery. But the whole logic of the model is an annual enrollment period.

8 And to the extent that Medicaid -- as we think more and more about how Medicaid is obviously

9 going to change fundamentally as part of a bigger insurance system, to the extent that Medicaid has to work

10 in alignment with this new subsidized market, I think that becomes a justification for making this

11 recommendation on a restoration -- that more and more the way the world will function and the way plans

12 will function and the way markets will function is around annual enrollment periods, just as it does in the

13 employer-sponsored world. And so, if we flesh that a little bit, then we would also draw Congress's

14 attention back to the fact that this restoration just makes things comport better with the new market. So.

15 CHAIR ROWLAND: So I think that I'm hearing that that should be both added to the narrative,

16 but also it is a part of the rationale as well, to begin to align the annualness of the two.

17 And, Andy, you are next.

18 COMMISSIONER COHEN: I just want to make sort of a general point about this. I think that

19 churn is a huge problem in this program, and I recognize that the literature obviously has not yet -- you

20 know, there has not yet been analysis of churn in a new environment where there may be -- where there are,

1 we hope, alternative coverage sources for people whose income rises or for other reasons are no longer

2 eligible for Medicaid.

3 That said, there are decades of evidence about the impacts of, you know, discontinuity of care and

4 people rolling off of coverage for periods of time.

5 The idea that -- I support this recommendation. I am -- I believe -- and there are experts who may

6 have more of a basis for this, that it will -- that probably not a lot of states will pick it up. They haven't at

7 this time. So we are maintaining an option, but I don't think we're really moving the ball forward in terms

8 of preventing churn.

9 And I think in this environment where we now have multiple -- there's coverage availability at

10 different income levels and yet just different payers. We are sort of like -- as sort of government entities,

11 we're falling into the -- this is the ultimate non-patient-centered kind of way of looking at things. And we

12 are expecting a lot of our delivery system in terms of requiring cooperation in handoffs and trying to have,

13 you know, a patient-centered kind of environment.

14 And here we are. We have two subsidized public programs, and yet we are going to sort of

15 potentially kick people around between them rather than being able to work out the financing on the back

16 end between government.

17 So I just -- I hope this is something that MACPAC will continue to look at and think about larger

18 solutions for, and I happily support this sort of first step.

19 CHAIR ROWLAND: Chris, can you put the recommendation back up on the -- slide 3, right?

20 MR. PETERSON: And while we're turning to that, I just wanted to note with respect to that

1 literature that talks about the impact of the discontinuity, you know, that's -- we've included those aspects in

2 the chapter, and I should have mentioned that again. So what is relevant from the literature -- we pull that

3 in.

4 In addition, 33 states currently use 12-month continuous eligibility for CHIP. No state has

5 implemented it for adults at this point. As you know, New York has approval through their waiver to do it

6 for low income parents but as of yet has not implemented it.

7 I think that CBO, in doing their cost estimate, did consider there would be some uptake for adults

8 because of the enhanced federal matching.

9 COMMISSIONED COHEN: For a child. For new adults.

10 MR. PETERSON: For new adults, that's right.

11 But I would assume that you wouldn't do that for, you know, just childless adults. You're going to

12 do parents and new adult group individuals simultaneously, so point being you would have a mixture of

13 people who were at the -- newly eligible FMAP and those who were at the regular match if you went down

14 that path.

15 CHAIR ROWLAND: Burt.

16 COMMISSIONER EDELSTEIN: Chris, in your introduction, you mentioned that one of the

17 rationales for maintaining continuous eligibility is being able to track patients long enough to do quality

18 assessment. Is that a rationale that has been included in the chapter as a rationale?

19 MR. PETERSON: I know we talked about it up at the front part as a reason plans want to do it.

20 I can't remember specifically if it's in the rationale. Probably we can put that in there so that if folks kind

1 of skip over the upfront part and just read that we'll make sure that's in there.

2 CHAIR ROWLAND: I think as much as the rationale can be strengthened we want to do that.

3 Mark had a comment.

4 COMMISSIONER HOYT: I think I understood what you said about Medicaid children earlier.

5 If the effect of the recommendation is to standardize this as policy for everybody, then I'd be in favor of

6 just word-smithing it slightly to --

7 COMMISSIONER ROSENBAUM: Yeah, I'm the same.

8 COMMISSIONER HOYT: Yeah, to, you know, continuous eligibility be optional for all Medicaid

9 and CHIP beneficiaries, something like that.

10 COMMISSIONER ROSENBAUM: Otherwise, I think it reads strangely. I think what we want

11 to do is make clear that this would be a uniform policy for children across the two programs and then adults

12 in Medicaid.

13 CHAIR ROWLAND: Okay, Richard.

14 COMMISSIONER CHAMBERS: Yeah, first a question, Chris. On an earlier slide, you talked

15 about that states that adopted continuous eligibility only saw a 4 percent rise in length of -- is there some

16 reason for that?

17 It seems the number would be higher. Is it that there's really not that much change even when you

18 don't have continuous eligibility?

19 MR. PETERSON: Well, that was kind of the point we were talking about before. There are so

20 many different things going on in these states that we can't separate out.

1 I mean, this was not a sophisticated analysis. This was just running -- you know, comparing the

2 average length of this group of states to that and done.

3 So I think that's why we -- I'm very glad we had the Colorado example so we could at least say,

4 when you look at a particular state who's done an analysis, they showed a very large impact.

5 So, you know, the truth is somewhere in between, perhaps. I'm not sure.

6 COMMISSIONER CHAMBERS: And then, just a general comment. I'm supportive of the

7 recommendations. Certainly, continuous eligibility is one way of trying to get at the churn issue. The

8 draft chapter goes in to all of the other opportunities of trying to provide continuity of care, which is really

9 what we're all trying to ultimately get at. It's financing of programs, but it's continuity of health care for

10 folks that are going to go through transitions across different programs.

11 And I think as over the next, you know, six months evolves, as -- particularly with states with the

12 churn issue of transitioning from Medicaid to exchange programs, exploration of options such as the bridge

13 plans that Tennessee has proposed and other states are exploring are ways of making sure we have that

14 continuity of care.

15 But I think the continuous eligibility is one way of trying to limit those transitions -- is to keep folks

16 into systems of care.

17 So, just my general comments.

18 CHAIR ROWLAND: Okay, Sara.

19 COMMISSIONER ROSENBAUM: I was going to make the same point.

20 CHAIR ROWLAND: Oh, you already made -- okay.

1 Any other discussion before we take a vote?

2 Patty?

3 COMMISSIONER GABOW: [Off microphone.] Are we going to change the language to

4 [inaudible].

5 CHAIR ROWLAND: Yeah. Can we do that on the computer?

6 MR. PETERSON: So what is it, just to be clear?

7 COMMISSIONER ROSENBAUM: Here's how I revised it: In order to ensure -- I think there's

8 a "that" that may be missing between ensure and current.

9 Ensure that current options remain available to states in 2014, Congress should provide -- so get rid

10 of the "the" unless that's our writing style.

11 MR. PETERSON: That's been our style.

12 COMMISSIONER ROSENBAUM: That's our style, okay.

13 Congress should provide explicit statutory authority for 12-month continuous eligibility for children

14 enrolled in CHIP and Medicaid as well as adults enrolled in Medicaid.

15 Now what you're saying, as I understand it, is that in Medicaid it already is explicit.

16 MR. PETERSON: Yes.

17 COMMISSIONER ROSENBAUM: So why don't we then say: Congress should, parallel to the

18 current Medicaid -- expressed Medicaid option, create a similar option for children enrolled in CHIP so that

19 we are reaffirming the existence of the Medicaid option as it now stands, or say, should align CHIP policy

20 with Medicaid policy and provide continuous enrollment for children.

1 I think what Mark is raising and what I raised and what I see Trish nodding her head over is that
2 even though it's in our text we want to, I think, have the recommendation itself just tip the hat toward the
3 existing clear Medicaid language and say that what we're trying to do here in our recommendation is align
4 with that clear language.
5 So it could be: Congress should, in a manner parallel to the existing Medicaid option, provide
6 explicit statutory authority for 12-month continuous eligibility for children enrolled in CHIP and should
7 extend the same option to adults enrolled in Medicaid.
8 CHAIR ROWLAND: The introductory phrase, though, might need to be subject to better
9 clarification because it says, in order to ensure current options, but we're really only talking about one option
10 here.
11 So isn't it in order to ensure the current --
12 EXECUTIVE DIRECTOR SCHWARTZ: [Off microphone.] It's all the options [inaudible].
13 CHAIR ROWLAND: Right.
14 EXECUTIVE DIRECTOR SCHWARTZ: [Off microphone.] [Inaudible].
15 CHAIR ROWLAND: Right. But do we want to clarify what options we're talking about is what
16 I meant.
17 COMMISIONER MOORE: There are so many that get you there.
18 EXECUTIVE DIRECTOR SCHWARTZ: [Off microphone.] Yeah, yeah.
19 COMMISIONER MOORE: And then it gets really complex, I think.
20 COMMISSIONER EDELSTEIN: Are those current options all regulatory?

1 CHAIR ROWLAND: No.

2 COMMISSIONER ROSENBAUM: No.

3 CHAIR ROWLAND: They're statutory.

4 COMMISSIONER ROSENBAUM: Well, it's a little bit more complicated. The children's
5 option in Medicaid is there -- is statutory. In the case of adults, the option derives from how the federal
6 government has, for almost 50 years really, interpreted state flexibility over valuing income and assets.
7 That flexibility goes away when MAGI kicks in.

8 So now, if we want to --

9 CHAIR ROWLAND: But do we -- well, maybe what we want to say is current eligibility options.

10 COMMISSIONER ROSENBAUM: Yeah, maybe that would be better.

11 CHAIR ROWLAND: It's just we're not talking about all current options to states.

12 COMMISSIONER ROSENBAUM: No. Yeah, current eligibility options.

13 EXECUTIVE DIRECTOR SCHWARTZ: Does it say 12-month --

14 COMMISSIONER ROSENBAUM: [Off microphone.] I think you need "eligibility" between
15 "current" and "options" in the first row.

16 EXECUTIVE DIRECTOR SCHWARTZ: And also, it doesn't say 12 months continuous
17 eligibility anymore.

18 It needs -- it needs to say --

19 COMMISSIONER ROSENBAUM: [Off microphone.] Options for the --

20 EXECUTIVE DIRECTOR SCHWARTZ: Say 12-month continuous eligibility.

1 CHAIR ROWLAND: And we were adding the word "eligibility" to the first option.

2 MR. PETERSON: Say that again, Anne. I'm sorry.

3 CHAIR ROWLAND: We were saying, in order to ensure current eligibility options.

4 EXECUTIVE DIRECTOR SCHWARTZ: But the phrase, 12-month continuous eligibility,

5 disappeared in the editing.

6 COMMISSIONER HOYT: Can I be a pain and suggest that that's not really the reason, is it?

7 Just to ensure the current policy remain an option. We want to expand it.

8 COMMISSIONER ROSENBAUM: No, no, no. No, in adult land you could do this by --

9 through income disregards, and that's what goes away under MAGI.

10 COMMISSIONER HOYT: Okay.

11 COMMISSIONER ROSENBAUM: Yeah, it is a current option.

12 Now very few states do it, but it's there. And there may be more who want to do it in -- as we

13 move to -- that's why I think it's important in our text at least to say that moving to annual enrollment

14 periods is a big theme now in health reform. And so the option, which was modestly taken before, might

15 have some more legs to it.

16 EXECUTIVE DIRECTOR SCHWARTZ: Going once?

17 CHAIR ROWLAND: Comments on the text, the language?

18 [Pause.]

19 CHAIR ROWLAND: Okay.

20 EXECUTIVE DIRECTOR SCHWARTZ: Want to take a vote?

1 CHAIR ROWLAND: Shall we take -- we will now take a vote. Please vote yea or nay or abstain
2 to recommendation 1: In order to ensure that current eligibility options remain available to states in 2014,
3 the Congress should, parallel to the existing Medicaid 12-month continuous eligibility option for children,
4 create a similar statutory option for children enrolled in CHIP and adults enrolled in Medicaid.
5 Okay, Anne will call the vote.
6 EXECUTIVE DIRECTOR SCHWARTZ: Diane Rowland?
7 CHAIR ROWLAND: Yes.
8 EXECUTIVE DIRECTOR SCHWARTZ: Sharon Carte?
9 COMMISSIONER CARTE: Aye.
10 EXECUTIVE DIRECTOR SCHWARTZ: Richard Chambers?
11 COMMISSIONER CHAMBERS: Yes.
12 EXECUTIVE DIRECTOR SCHWARTZ: Andrea Cohen?
13 COMMISSIONER COHEN: Yes.
14 EXECUTIVE DIRECTOR SCHWARTZ: Burton Edelstein?
15 COMMISSIONER EDELSTEIN: Yes.
16 EXECUTIVE DIRECTOR SCHWARTZ: Patricia Gabow?
17 COMMISSIONER GABOW: Yes.
18 EXECUTIVE DIRECTOR SCHWARTZ: Denise Henning?
19 COMMISSIONER HENNING: Yes.
20 EXECUTIVE DIRECTOR SCHWARTZ: Mark Hoyt?

1 COMMISSIONER HOYT: Yes.

2 EXECUTIVE DIRECTOR SCHWARTZ: Norma Martinez Rogers?

3 COMMISSIONER MARTINEZ ROGERS: Yes.

4 EXECUTIVE DIRECTOR SCHWARTZ: Judith Moore?

5 COMMISSIONER MOORE: Yes.

6 EXECUTIVE DIRECTOR SCHWARTZ: Trish Riley?

7 COMMISSIONER RILEY: Yes.

8 EXECUTIVE DIRECTOR SCHWARTZ: Sara Rosenbaum?

9 COMMISSIONER ROSENBAUM: Yes.

10 EXECUTIVE DIRECTOR SCHWARTZ: Robin Smith?

11 COMMISSIONER SMITH: Yes.

12 EXECUTIVE DIRECTOR SCHWARTZ: Steven Waldren?

13 COMMISSIONER WALDREN: Yes.

14 EXECUTIVE DIRECTOR SCHWARTZ: That's a total of 14 yeses and 3 commissioners not

15 present.

16 CHAIR ROWLAND: Thank you.

17 Okay, moving on to recommendation 2.

18 COMMISSIONER MARTINEZ ROGERS: Every time I see TMA I think of Texas Medical

19 Association. [Inaudible.]

20 CHAIR ROWLAND: I actually think we should spell out the words for TMA in the

1 recommendation.

2 Lindsay, I didn't mean you needed to do it right this instant. Just so that Norma doesn't think it's

3 the Texas Medical Association.

4 [Laughter.]

5 CHAIR ROWLAND: Chris, can you briefly, while we're doing that, restate the rationale for this

6 particular recommendation.

7 MR. PETERSON: Right. One of the issues states have under current TMA is uncertainty as to

8 whether its funding will be continued. It was -- its funding was continued in the latest fiscal cliff

9 legislation. Sometimes the extensions are as much as a year. Sometimes they're only a few months when

10 we're doing continuing resolutions, et cetera.

11 So states have often complained about this uncertainty, also uncertainty about what happens if the

12 funding were to expire because TMA would not go away altogether; it would just revert back to the

13 permanently funded four-month TMA.

14 So that -- this creates a challenge for states and the federal government.

15 The latest regulations on TMA only address the four-month TMA because, you know, from the

16 administration's perspective they're not sure what's going to happen with six-month TMA, notwithstanding

17 the fact that it's been in place for decades now.

18 So that is part one -- to ensure that it remains available and that it's clear to states.

19 And then part two has to do with expansion states -- states that implement coverage through the

20 new adult group up to 138 percent of poverty, where now there will be some sort of subsidized coverage up

1 to 400 percent of poverty. And TMA's original goal of preventing uninsurance as individuals' income rises

2 from 20 percent of poverty to 22 percent of poverty, for example, in some states, is not an issue in those

3 states that do an expansion.

4 CHAIR ROWLAND: Mark.

5 COMMISSIONER HOYT: I'm just not sure, so I'm going to ask. Is there any ambiguity at all

6 around the phrase, the adult group expansion?

7 Shall we say 138 percent?

8 COMMISSIONER ROSENBAUM: [Off microphone.] I think it is adult [inaudible].

9 COMMISSIONER HOYT: Or, I don't know if that needs to be modified or if that's just crystal

10 clear the way it stands.

11 COMMISSIONER ROSENBAUM: The adult expansion group, I think -- I think the words are --

12 I think it's just a matter of flipping "group" and "expansion." I think if it's adult expansion group that has

13 enough meaning in today's world to make sense.

14 But we could say, the adult expansion group added under the ACA --

15 COMMISSIONER ROSENBAUM: -- and effective in 2014.

16 MR. PETERSON: In the regulations, they call it the new adult group.

17 COMMISSIONER ROSENBAUM: They call it, literally, the adult --

18 MR. PETERSON: Yeah. Well, let me look before --

19 COMMISSIONER ROSENBAUM: Yeah.

20 CHAIR ROWLAND: And, Lindsay, you can actually put TMA in parentheses after that so that

1 those who only know by its acronym will recognize it as well.

2 MS. HEBERT: [Off microphone.] [Inaudible.]

3 MR. PETERSON: Yeah, the regs refer to it as the new adult group or the adult group.

4 COMMISSIONER ROSENBAUM: So, in this context, we could say, states that opt to expand

5 Medicaid to the new adult group added under the Affordable Care Act, or whatever, just to be a little

6 clearer.

7 MR. PETERSON: Would it be helpful in the second part to say -- to switch the order a bit and

8 say, while allowing states to opt out of TMA if they expand to the new adult group?

9 CHAIR ROWLAND: Yeah, repeat that.

10 MR. PETERSON: While allowing states to opt out of TMA if they expand to the new adult

11 group. Add it under --

12 COMMISSIONER ROSENBAUM: Yeah, yeah, that makes it much clearer, I think.

13 CHAIR ROWLAND: And our rationale for allowing them to opt out if they expand is that it's not

14 needed because the coverage is there and it would reduce administrative, as you put it, confusion and

15 burden to be trying to operate both programs simultaneously.

16 It's all for simplification.

17 Okay, any discussion?

18 Burt.

19 COMMISSIONER EDELSTEIN: Since simplification is one of those things that we continuously

20 strive for, would it be worth adding a phrase at the beginning saying, in the interest of simplification or just

1 feature that in the rationale?

2 COMMISSIONER GABOW: I think that should be in the rationale. Let's keep the

3 recommendation, Chris.

4 CHAIR ROWLAND: Also, that the TMA part doesn't actually simplify anything. It's the letting

5 the states opt out that does the simplification. So I think that's the rationale for the opt-out.

6 Other discussion?

7 [Pause.]

8 CHAIR ROWLAND: Okay. So we will call for a vote on recommendation 2: The Congress

9 should permanently fund current transitional medical assistance (TMA), required for 6 months with state

10 option for 12 months, while allowing states to opt out of TMA if they expand to the new adult group added

11 under the Affordable Care Act.

12 EXECUTIVE DIRECTOR SCHWARTZ: Okay.

13 CHAIR ROWLAND: All right, Anne, please call the vote.

14 EXECUTIVE DIRECTOR SCHWARTZ: Sharon Carte?

15 COMMISSIONER CARTE: Yes.

16 EXECUTIVE DIRECTOR SCHWARTZ: Richard Chambers?

17 COMMISSIONER CHAMBERS: Yes.

18 EXECUTIVE DIRECTOR SCHWARTZ: Andrea Cohen?

19 COMMISSIONER COHEN: Yes.

20 EXECUTIVE DIRECTOR SCHWARTZ: Burton Edelstein?

1 COMMISSIONER EDELSTEIN: Yes.

2 EXECUTIVE DIRECTOR SCHWARTZ: Patricia Gabow?

3 COMMISSIONER GABOW: Yes.

4 EXECUTIVE DIRECTOR SCHWARTZ: Denise Henning?

5 COMMISSIONER HENNING: Yes.

6 EXECUTIVE DIRECTOR SCHWARTZ: Mark Hoyt?

7 COMMISSIONER HOYT: Yes.

8 EXECUTIVE DIRECTOR SCHWARTZ: Norma Martinez Rogers?

9 COMMISSIONER MARTINEZ ROGERS: Yes.

10 EXECUTIVE DIRECTOR SCHWARTZ: Judith Moore?

11 COMMISSIONER MOORE: Yes.

12 EXECUTIVE DIRECTOR SCHWARTZ: Trish Riley?

13 COMMISSIONER RILEY: Yes.

14 EXECUTIVE DIRECTOR SCHWARTZ: Sara Rosenbaum?

15 COMMISSIONER ROSENBAUM: Yes.

16 EXECUTIVE DIRECTOR SCHWARTZ: Robin Smith?

17 COMMISSIONER SMITH: Yes.

18 EXECUTIVE DIRECTOR SCHWARTZ: Steven Waldren?

19 COMMISSIONER WALDREN: Yes.

20 EXECUTIVE DIRECTOR SCHWARTZ: Diane Rowland.

1 CHAIR ROWLAND: Yes.

2 EXECUTIVE DIRECTOR SCHWARTZ: Fourteen commissioners voting yes, three

3 commissioners not present.

4 CHAIR ROWLAND: And one commissioner who forgot to turn her phone off.

5 Okay, thank you very much.

6 And so we will look forward to the strengthening of the chapter in the areas that we talked about,

7 strengthening the rationale and the inclusion of these recommendations with the votes recorded in our

8 March report to the Congress.

9 Thank you, Chris and Lindsay.

10 And now we're going to move on to look at an issue that we've raised in some of our prior

11 discussions: How do states manage the enrollment process for their Medicaid managed care programs?

12 We've heard a lot of discussion around the demonstration for the dual eligible population, about

13 passive enrollment versus auto enrollment, and so Molly McGinn-Shapiro is going to update us on a study

14 underway to help inform the Commission's deliberations on this issue.

15 **#### STATE MEDICAID MANAGED CARE ENROLLMENT PRACTICES**

16 * MS. MCGINN-SHAPIRO: Thanks, Diane.

17 As you all are aware, a priority among the Commission has been a focus on populations with high

18 needs and high costs, in the way in which they access and receive their care, including the increasing role

19 that risk-based management care arrangements play for these populations.

20 Just to remind you, the Commission’s work to date on this began with its June 2011 report that

1 included a preliminary review of issues that individuals with disabilities and dual eligibles face when enrolling

2 in risk-based managed care plans.

3 Also, our March 2012 and forthcoming March 2013 reports profile both individuals with disabilities

4 and dual eligibles, service use and spending, providing insight into the wide variation across these

5 populations in their health care and supportive service needs.

6 So we have continued this focus by commissioning a study on current state practices for enrolling

7 beneficiaries into managed care, which will provide the Commission a better understanding of the lessons

8 learned and challenges states may face as they expand their programs to high need, high cost enrollees.

9 This session provides an overview of state enrollment policies for Medicaid managed care programs,

10 including the current landscape of Medicaid enrollment of beneficiaries into risk-based managed care

11 programs, key design issues that states consider when enrolling high need, high cost populations,

12 preliminary findings from a case study of several states' enrollment policies and practices for their Medicaid

13 managed care programs.

14 So while a number of states have extensive experience enrolling non-disabled children and adults

15 into risk-based managed care programs, they have less experience enrolling persons with disabilities and dual

16 eligibles. In 2009, 32 states and D.C. had only a quarter or fewer of their disabled population in

17 comprehensive risk-based managed care programs.

18 However, states have shown increasing interest in using managed care for their high need, high cost

19 populations as a way to moderate costs and better coordinate care.

20 Enrollment into managed care plan is a critical step in the interaction the enrollee has with the

1 Medicaid program, and this increasing trend of using managed care for high need populations focuses a
2 spotlight on how state enrollment policies take into consideration the complex health and support needs of
3 these enrollees.

4 Enrollment of individuals with complex health care needs into managed care may require different
5 enrollment policies and considerations than from non-disabled individuals as they often have additional and
6 unique needs. Unlike non-disabled children and parents, who may have had relatively little contact with
7 the health care system, persons with disabilities may have a high need for medical care and prescription
8 drugs. They may already have established relationships with providers who are familiar with their
9 particular care needs. They may already be mid-course in treatment for complex conditions, which would
10 raise special concerns about continuity of services and coordination of benefits. Or they may require
11 increased access to specialty care.

12 Because of these potentially unique issues for these types of populations, there are additional
13 considerations that states may have when structuring their enrollment processes, including the time period
14 the states take to implement a managed care program for high need, high cost populations, whether the
15 state will mandate enrollment for populations with high needs, ensuring appropriate communication and
16 outreach to individuals about enrollment and disenrollment processes, as well as how to navigate services
17 and providers in and out of network.

18 Providing enough time for enrollees to make a choice among plans offered, which can range from a
19 number of days to several months. Individuals with disabilities may require additional time to choose a
20 plan compared to non-disabled populations. And for mandatory enrollment, designating criteria for

1 auto-assignment processes that are particular to their needs.

2 So in order to inform the Commission's understanding of current state policies and practices for

3 enrolling high need, high cost populations into managed care, the Commission is undertaking a study of 10

4 states that have experience in enrolling these types of populations. The project, which is still ongoing, will

5 identify and examine their specific enrollment policies, practices, and administrative systems used for

6 enrolling Medicaid beneficiaries. Of particular interest is how the policies and practices for individuals

7 with disabilities compare to those policies for non-disabled children and adults.

8 The project will also identify and help the Commission determine whether there are best practices

9 and particular policy issues around enrollment processes for special populations.

10 MACPAC is working with a contractor to interview state program officials, enrollment brokers, and

11 beneficiary representatives in each state to learn both about the specific enrollment policies as well as

12 perspectives on the strengths and weaknesses of these approaches.

13 To date, interviews have been held with state officials in all 10 states, enrollment broker

14 representatives in two out of the four states that use enrollment brokers, and beneficiary representatives in

15 four of the 10 states. The states are listed.

16 The project, which is still underway, has resulted in some early preliminary findings from the

17 interviews with the state officials, enrollment brokers, and beneficiary representatives. Some of these

18 findings include that while most states don't not substantially vary their enrollment strategies by population,

19 some states do provide additional services such as enrollment brokers or outreach materials that focus

20 specifically on enrollees with disabilities.

1 Four of the 10 states interviewed outsource some of their enrollment processes to enrollment
2 brokers, often because the enrollment broker is perceived by the state as an objective partner in these states,
3 and the broker also has the ability to hire staff more quickly than the state agency.
4 States found that a plan's provider network and supplemental benefits provided by the plan are
5 important factors in an enrollee's decision to select one plan over another.
6 Factors considered in the auto-assignment algorithms generally focused on plan performance and
7 whether the plan meets basic quality standards in order to be considered for auto assignment, although
8 several states did consider beneficiary factors such as provider history and family history with a particular
9 plan.
10 State officials offered some overall effective practices and lessons learned from their experience,
11 such as making sure that there is adequate time for phasing in the managed care program and involving all
12 stakeholders when designing the enrollment process.
13 The final report on this case study of state enrollment policies and practices will be completed by
14 April. We plan to present the final report findings for inclusion in a potential chapter in the June 2013
15 report. These final report findings can provide the Commission a richer picture of the enrollment
16 processes and practices in states that have experience in enrolling high need, high cost populations into
17 managed care.
18 The issues raised from the findings, including state and other stakeholders perspectives on the
19 lessons learned, will help inform the Commissions future discussions on providing services through
20 risk-based managed care, particularly for those with complex needs. For example, in terms of developing

1 the enrollment process, do the findings of the lessons learned from the study lead to questions over whether

2 states should be encouraged to have special enrollment policies for certain populations, particularly those

3 with complex health care and support service needs.

4 Thank you, I'm interested in your thoughts on these preliminary findings.

5 CHAIR ROWLAND: Molly, does this study also include the opt-out procedure? So that if

6 someone is enrolled, how do they opt out? And are we getting any numbers from the states on how many

7 people utilize that?

8 MS. McGINN-SHAPIRO: Right. States have different processes for their auto assignment and

9 some do immediately auto assignment, actually, and then they give an individual a certain amount of time to

10 choose a different plan. And then we've been following up with how many people are choosing -- what

11 are their rates for choosing the different plans and whether they have lock-in or lock-out?

12 COMMISSIONER GABOW: I was also going to ask about the opt-out. I think it's not just the

13 percent, but the reasons for opt-out because most states do have the reason and I think that's useful, as well.

14 I wonder in who you're interviewing, why you -- did you consider interviewing the largest plan in the

15 state that has the highest number of these patients? I think that would be important because they

16 probably, depending on what they will share, may have the most data and the most information and I think

17 would be highly useful.

18 It's like if Richard were still running his plan in Orange County, talking to him about his many year

19 experience with his population I think would have been useful. We won't talk to you now, but --

20 COMMISSIONER CHAMBERS: Thanks, Patty.

1 COMMISSIONER GABOW: In the past we would have talked to you.

2 [Laughter.]

3 COMMISSIONER GABOW: I think trying to get some of that perspective would be very useful.

4 COMMISSIONER ROSENBAUM: I had the same question about whether we should be talking

5 to plans. And actually, I'd like to get a sense from them, as well, as to their preference. There are

6 different models for doing this, and in terms of setting people with higher health needs into networks and

7 into care arrangements, it would be good to know how plans see this and what they see as pluses and

8 minuses of various approaches.

9 The other question I had, and I realize it's hard to say at this point because you're mid-stream, you

10 say that states often include performance. So is often like three out of 10, nine out of 10? So how

11 dominant is the inclusion of a performance factor?

12 And the other question I had was whether quality performance algorithms can override an

13 established care relationship? Whether the decision is that actually the performance factor is a better

14 measure than care relationships that might have been established?

15 And my final observation, of course, is if we're going to get into that, it probably would be a good

16 thing to talk to some Medicaid participating providers who see people with disabilities to get sort of a sense

17 of where they are on this.

18 COMMISSIONER RILEY: I actually wondered if we could switch gears a little bit. I'm

19 increasingly concerned about the capacity of beleaguered Medicaid agencies to take on more and more

20 responsibilities. I'm intrigued by four of the 10 states outsource. Six don't. If we could dig a little bit

1 deeper to try to figure out how each is performing that function.

2 Within the states that do it directly, who does it? Do they feel like they have adequate capacity?

3 Can they train them?

4 In those that outsource, what do those contracts look like? Are they performance based? What

5 are the measures? And if we could, the cost differential.

6 But I'd love to know something about the capacity of the states to really manage this.

7 COMMISSIONER CHAMBERS: I just would echo what Trish said because across states there's

8 all kinds of arrangements of using enrollment brokers and I think they've cropped up for various reasons.

9 In California, it was a lot of the abuses that happened back in the early '70s and early '80s of direct

10 marketing by health plans, giving away TVs to enroll into health plans. The State of California really went,

11 I think, the opposite way of the spectrum of when they did a major conversion was going to an enrollment

12 broker.

13 But it would be interesting to understand what are the positives? What works together? What

14 links folks up more accurately to existing relationships of providers, as Sara talked about, on the quality side.

15 There's a number of issues raised in this that I think are worthy of examination. I think it would

16 be helpful to have input by plans, potentially talking to ACAP and AHIP for the other side of health plans.

17 And particularly, as larger health plans that have multi-state presences, like Molina Healthcare is in 10 states.

18 We have experience across those 10 states. The variation, those single plans could probably give multiple

19 perspectives.

20 There's all kinds of reasons for auto assignment. We find still in California, there's auto assignment

1 of approximately 50 percent of enrollees, which is -- in mature managed care markets, to try to understand
2 why that still happens, but with the dual eligible demonstrations coming, there's all kinds of efforts
3 underway of making sure there's continuity of care. California is in their transition of the AABD
4 population was a requirement the plans had to provide continuity of care with non-contract providers for
5 up to a year, which provides actually for managed care plans an opportunity to engage the provider not only
6 in setting up care management, but also trying to get them contracted into the plan because that's the
7 established relationship that members have.
8 There is, again, lots of good issues raised here that I think, as things have developed over the years,
9 and would be really helpful to see what's the best practice, again, particularly as we move into more
10 vulnerable populations, what's the best way to get them the care.
11 So I really applaud this effort, and I think it's really good of being on a short time frame to publish
12 something by June, because there's so much happening right now with the enrollment efforts. I just really
13 applaud moving forward with this.
14 COMMISSIONER MOORE: Just to pick up quickly on one thing Richard said, this is a really
15 complex but very, very rich and very, very important area. But if we can be cognizant as we go along into
16 trying to pull out best practices that we could highlight, I think that would be really useful. Because when
17 you're doing 10 states and we're all over, and there are lots of other states getting involved in this, making
18 pronouncements about what's -- the way everybody should go, is not going to be in the cards, certainly not
19 in the short term. But maybe highlighting best practices is something we'd be more able to do.
20 COMMISSIONER COHEN: Two thoughts. First of all, I agree, great subject area for us to be

1 looking at.

2 The first one, and I slightly hesitate to say it and I hope we don't get a call from MedPAC as a result,

3 but I think that Medicare's managed care enrollment practices should be something that we also look at and

4 compare to. Sometimes it's apples to apples, and sometimes it's apples to oranges. But it's a mechanism

5 that is well known and well understood, probably, by many providers. And I just think it's a good

6 comparison point. We should always look outside our program when there's other places to look that may

7 have some insights or best practices to offer.

8 My second point is probably 50 points wrapped into one --

9 CHAIR ROWLAND: We should also find out of MedPAC has done any comparable work.

10 COMMISSIONER COHEN: That may be the way to look at Medicare is just to sort of -- but I

11 would always like to look not just within the program but externally to see if there are lessons learned that

12 can be drawn.

13 The second point is -- and again, this may be a New York specific issue, but I suspect it will come

14 up in other states if it hasn't already -- which is sometimes people are offered different types of plans to

15 enroll into like a specialty plan, a behavioral health plan, a carve-out plan with a mainstream plan.

16 I'm curious how those issues are dealt with, especially in terms of counseling and whether or not

17 there's complete objectivity.

18 I guess the other thing is when there are carve-outs or when states are moving to expand the benefit,

19 to pull in a carve-out into managed care, I worry sometimes that the provider relationships that are the basis

20 for a lot of discussion are primary care relationships. Depending on the nature of your condition, that may

1 or may not be the most essential provider relationship that you have.

2 And so I just wonder whether any states have been able to get more nuance than just looking at who

3 your PCP is, including look at do you actually see your PCP? And that sort of thing. That's just another

4 constellation of issues to add to, I'm sure, a rapidly growing list.

5 MS. MCGINN-SHAPIRO: Yes. I think just in some of the preliminary findings, state officials

6 mentioned that there was -- in one state, at least, they were talking about how the enrollment broker doesn't

7 just ask about primary care providers but, particularly with individuals with disabilities, they will ask about

8 specialty providers that they're accessing.

9 So definitely keep that into consideration.

10 CHAIR ROWLAND: That cues Robin up for her comments.

11 COMMISSIONER SMITH: Well, this is near and dear to my heart, of course. And it is so

12 important because, as I said before, it impacts the daily lives of the enrollees, far more, I think than general

13 health insurance does. This covers so many aspects of just being able to function in daily life.

14 So one of the things that I would love to be able to see is how the enrollees are informed about the

15 different programs, if they do a passive enrollment or a mandatory enrollment, if they're put into one plan

16 and then given an option to switch how that is -- how they're informed? What kind of follow up? How

17 active are the enrollees in coming back to whoever, whether it's brokered out or not, how active they are

18 themselves in following up and finding out about the different plans. If it's explained correctly? Are they

19 finding out then they go to the doctor and the doctor says well, we're not on this plan so we can't see you

20 anymore. Or are they actually getting it ahead of time.

1 I don't know how that's working in other states.

2 MS. MCGINN-SHAPIRO: So we've been asking state officials, as well as the enrollment brokers,

3 about how they're dealing with continuity of care issues and providers. So we'll try to make sure to include

4 all of those types of findings.

5 COMMISSIONER HENNING: So to kind of follow along with Robin's point, I would really like

6 to see us explore the reasons why people opt-out. Is it because their providers aren't part of the plan?

7 Or is it for some other reason? Are these assignments being made just carte blanche? Are they some sort

8 of actually targeted and smart assignments because of what they are already using?

9 And then I'd also kind of like to see a little bit of discussion as to credentialing, becoming part of the

10 plan and how difficult that is for providers and, in particular, nurse practitioners and nurse midwives.

11 Because that's been a big issue with us. If you're a physician, usually it's not a big deal to become part of

12 the health plan. But a lot of times, as a nurse practitioner or a nurse midwife, getting credentialed is the big

13 stumbling block.

14 MS. MCGINN-SHAPIRO: To be included in the plan network, provider network?

15 COMMISSIONER HENNING: Yes.

16 MS. MCGINN-SHAPIRO: I think, as we're going to start following up with some of these plans,

17 then we'll include that.

18 COMMISSIONER CARTE: Molly, having listened to some families and consumers that have

19 explained what efforts they sometimes have to make to get arrangements for care for children with special

20 health care needs, will the study -- will they be asked to provide concrete examples of how families -- some

1 practice or protocol assures family with consumer interests are taken into account? Will it be that specific?

2 MS. MCGINN-SHAPIRO: In terms of choice of plan? I mean, we have been following up with

3 the beneficiary representatives, so we're kind of getting their perspectives. And then what particular steps

4 the enrollment broker or the state takes to take into account the beneficiary's perspective.

5 COMMISSIONER CARTE: Thanks.

6 COMMISSIONER ROSENBAUM: Listening to Robin's question, it occurred to me that what I

7 would guess is going to emerge is that there are two sort of distinct conceptual pathways going on here.

8 One is that a fair amount of work is done prior to the moment of enrollment in order to do the needs,

9 preferences, those questions ahead of time.

10 And then the other is, of course, the model in which you use a default enrollment and then it's on

11 the plan to essentially go through, run the traps on what you need to do to figure out whether this is a good

12 fit or the person might be advised that it might be a good idea to move, or the person wants to move, or

13 whatever.

14 And so if you can -- I'm thinking that maybe the way to organize this -- I don't know if you've given

15 thought to how you're going to set it up. But what would be helpful, I think, for the world to see -- and

16 there may be a third pathway for all I know.

17 But in other words, how patients or members travel along this pathway into finally being

18 card-carrying members of plans, and where the burden of measuring the needs, the preferences, deciding

19 whether the impact is right, having the discussion with a family member, where all that happens, who's

20 responsible for it.

1 I suspect what we're going to find is that there's no -- and it goes to Judy's point -- there's not one
2 way of doing this. But depending on what pathway you travel down as a state agency, there are going to be
3 important elements that corp up no matter where. Someone has got to do these things and there may be
4 ways to do it very well with an auto enrollment, then immediate contact and then an opt-out. Auto
5 enrollment has real pluses, in my view, actually for all other kinds of reasons. But it may also be much
6 better, under the circumstances, to take a pre-enrollment approach and not use default enrollment.
7 And then I think the question for us is, as a Federal policy matter, regardless of the model that states
8 might use, do we have recommendations to make? Because I can't imagine that we're going to find, based
9 on the work you're doing, that one thing jumps out as totally the preferred pathway. Nor should we.
10 But I think we may have some observations about the elements that have to go into either model.
11 COMMISSIONER HOYT: I was going to suggest that I think a best practice from a plan
12 perspective, and they're always going to be concerned with matching payment with risk as accurately as
13 possible, would be that a state have a fully active and robust dataset to develop rates from. And by that I
14 mean not just the encounter data from the services they provide but a plan would like to know -- if
15 behavioral health was carved out -- maybe behavioral health diagnosis, blood factor products, something
16 like that, and then a risk adjustment methodology that is well communicated, understood by the plans, and
17 takes those factors into account.
18 CHAIR ROWLAND: Norma.
19 COMMISSIONER MARTINEZ ROGERS: Actually, Mark stated what I was going to state
20 because I was going to talk about behavioral health and how we need to look at this in terms of continuity

1 of care and whether or not somebody opts out and what happens.

2 In Texas one of the biggest problems we have is overmedication with psychiatrists with adolescents,

3 children, adults, and big investigations in that. But in particular, I think that when people opt out of being

4 enrolled, there is a reason for that. That's something that I think we need to look at.

5 COMMISSIONER CHAMBERS: Just as I was listening to the conversation, is to make sure as we

6 look at enrollment of individuals, it's a bifurcation between individuals who are currently in Medicaid and

7 being transitioned to managed care versus beneficiaries who are new to Medicaid and required to enroll in

8 managed care.

9 Because from a health plan's perspective is when there's a conversion, particular in the AABD

10 population many states are doing is you have the advantage of having fee-for-service Medicaid data as to

11 understand who their providers are, what their conditions oftentimes are. You get the ability to intervene

12 quickly, particularly in very vulnerable populations.

13 When someone is new to the roles, you have no information. The number of states who require

14 initial health assessments within usually 90 or 120 days, is which plans really want to get the beneficiary

15 hooked up with their primary care or specialist quickly because that's where they can be evaluated by a

16 health care professional versus some telephone initial health assessment.

17 We're finding the same thing as on the dual eligible transitions, there's fee-for-service Medicare data

18 which informs you about beneficiaries. But the data oftentimes -- particularly state Medicaid data -- is very

19 sketchy. It's usually out of date. It doesn't have current claims data all the time.

20 And of course, we all know the challenges with accurate addresses and phone numbers, with

1 understanding ethnicity and language preference. All of those things are real challenges in the auto
2 assignment, or even helping -- helping individuals decide what's the best plan for them.
3 But ultimately, I think from a plan's perspective, it's getting people linked up to the right providers
4 as quickly as possible into systems of care, and trying to figure out how we can make sure that happens.
5 Spotlighting the best practices of states that have figured out how to do that most efficiently would be very,
6 very helpful.
7 CHAIR ROWLAND: I think that that division of looking at what happens when you're
8 transitioning an existing population versus a new population is really an important one. And if, in the
9 report, it could be clarified whether there are different rules and different procedures that operate for those
10 two populations, I think would be very helpful.
11 COMMISSIONER GABOW: I think it's good that we're going to do this. I think there are a
12 number of caveats that we need to think about. One is our other work that shows high need, high cost
13 enrollees are not one group. So I think we need to be cognizant of that as we go through.
14 But I think the biggest caveat to being able to talk about best practices is we have no outcome data.
15 So just looking at opt out, while I think we need to look at it, and the reasons don't tell you whether opt out
16 was a good idea for the patient or a bad idea. I mean, it may be a good idea from their perspective but
17 what if you opt out because your current provider is not in the network but, in fact, your current provider is
18 suboptimal?
19 I mean, as a physician, I can say this: there is a bell-shaped curve. I mean, seriously. We know
20 from the RAND study that 50 percent of people -- and that's just straight non-high need people -- are not

1 getting what they need or getting things that they do not need.

2 So since we actually have no bar set up of what it is that we're trying to achieve in each of these

3 disparate high need, high risk, high cost population, we really don't know what is the outcome that we're

4 trying to achieve, first of all. And secondly, whether we're achieving it.

5 So I would just be very -- I think we should do this, but I would be very cautious about concluding

6 best practices in the absence of any quantitative outcome data, either short or long-term, that we're going to

7 have from this study.

8 So I just think that, as is often the case in health care, the real end point that we want is not at our

9 fingertips.

10 COMMISSIONER COHEN: I totally agree with your larger point.

11 I do want to say I think there are a couple of things that we could draw from data. For example, if

12 people are moving around multiple times within plans, I think we can -- you know, it's fair to say that we

13 can conclude that's probably not -- that shows some problem with the system, like multiple change and

14 multiple churn. I do think there are a few things we can at least look at as sort of like flags for problems.

15 That's all.

16 CHAIR ROWLAND: Trish.

17 COMMISSIONER RILEY: I, a thousand percent, agree with Patty, but I also raise the question

18 about what the purpose of this work is because I think this is a good example of what question are we trying

19 to answer.

20 Are we trying to talk about how best to manage care for these complicated populations who are

1 multiple populations, or are we trying to look at enrollment practices?

2 You know, what questions do we need to answer in this particular piece of work -- because I think if

3 -- this has been a lovely conversation, but Molly, quit your job now.

4 [Laughter.]

5 COMMISSIONER RILEY: Or, you have work forever.

6 But I think we need to really discipline ourselves to try to figure out what are we trying to answer

7 here.

8 And I thought it was more focused on what are the procedures for enrollment, how do they differ

9 for these populations from other populations, and you know, how far down do we go into -- and then

10 what?

11 CHAIR ROWLAND: I think we laid out phase one and then we went to two, three and four and

12 five, but -- I think it's a pathway that we want to go down and that this is one piece of it, but it obviously is a

13 lot of other pieces.

14 I was going to ask Richard, I thought that there was actually a more thorough evaluation going on in

15 California of the enrollment procedures for the disability population into managed care, kind of trying to

16 track what happened to them and how many opted out and why, that the University of California at

17 Berkeley was conducting.

18 COMMISSIONER CHAMBERS: I think you're correct. I think that's underway because the

19 enrollment started for the ABD population in June of 2011 and when it was staggered over a 12-month

20 period by birth month. Or, I think it was the date of your redetermination for Medicaid, and so it was over

1 a 12-month period. So it just really ended -- what -- about eight months ago.

2 And so they're looking -- because what they really wanted to do was to see what went right and

3 wrong as -- embark on the duals demonstration and the enrollment and passive enrollment about those

4 populations.

5 So I think that is -- I think you're correct; it is underway

6 CHAIR ROWLAND: So I know that that was not a state in this study --

7 MS. MCGINN-SHAPIRO: Right.

8 CHAIR ROWLAND: -- but it might be useful to also see what information can be gathered from

9 the researchers there.

10 MS. MCGINN-SHAPIRO: Okay.

11 CHAIR ROWLAND: I think the California Medicaid Institution is doing some of that evaluation,

12 and Andy Bindman would be a good contact.

13 MS. MCGINN-SHAPIRO: Okay.

14 CHAIR ROWLAND: Sara.

15 COMMISSIONER ROSENBAUM: I was just going to say that I agree completely with Trish,

16 which is why I was thinking that what we would come out of this study with is some pathways to show

17 people how folks get connected to plans and become members of plans.

18 Patty's question is absolutely the ultimate question, but I -- and I think if we do this work upfront

19 then we can begin to, you know, answer what Patty really wants to know, which is the right thing, which is,

20 does it matter how you connect to your health care system in terms of the quality of care you get and the

1 health outcomes you receive?

2 And may -- you know, we may be very surprised, but this is, I think, terribly important preliminary

3 work.

4 CHAIR ROWLAND: Richard.

5 COMMISSIONER CHAMBERS: Yeah, I just wanted to add -- is, you know, I agree there are a

6 thousand questions here, particularly in Patty's, you know, ultimate outcome on outcomes. But I just hope

7 we don't let the perfect be the enemy of the good because there are a lot of practices going on today.

8 As we drill down is -- again, I'm sorry I always harp on California, but that's my experience.

9 But California; they originally set up the managed care system as they created this -- a number of

10 plans which were set up for the sole purpose of protecting the safety net and public hospital system. It

11 was a fear that if you went to traditional Medicaid managed care with for-profit -- evil for-profit plans like

12 the one that I run in California today -- is that it was -- you know, it would decimate the safety net system.

13 And so they created these public plans, and they set up the auto assignment policy in which they

14 defaulted to that plan for the purpose of protecting the safety net. I'm not saying it was good or bad. It

15 just was that was the way it was set up.

16 To this day, it still is run that way. It tilts towards that. And it's just sort of, is that good or is that

17 bad?

18 I mean, it gets back to the outcomes -- is we may be protecting the safety net system, but are

19 patients getting the best care?

20 This is way deeper than we're going to get

1 CHAIR ROWLAND: Patty says, yes.

2 COMMISSIONER CHAMBERS: Yes. But the point being is there are things going on today

3 that I think is there are at least surface questions that we could dig deep enough into as to say that at least --

4 so I just wanted to add that.

5 CHAIR ROWLAND: Patty.

6 COMMISSIONER GABOW: I'm not disagreeing with the point that you've got to start a journey

7 with the first step and that -- that's fine. But I'm just saying I would be very careful about best practices

8 because that is really -- relates to what is the outcome.

9 We can describe how it is done, what the difference is, what people have found with these, but we

10 should avoid, I think, putting a star on someone's forehead without outcome data. That's all.

11 COMMISSIONER ROSENBAUM: In some practices.

12 COMMISSIONER CHAMBERS: Can I just jump in on that?

13 My point would be that today is -- you know, in a lot of places -- again, I'll go back to California.

14 In most of the counties, there are two plan choices. You have no choice but to go into one of those plans.

15 How -- so not making a value judgment -- are they the right two plans? Are they doing the right

16 things?

17 At least it's what are the processes of how they get into those plans, which plan, how they get linked

18 up with the right provider, with the -- you know, the staff speak the right language, they're in their own zip

19 code, they have transportation.

20 Those kinds of things, I think, are basic principles that we can really inform in the debate, you know,

1 at just the front end level because that's happening today. And so --

2 COMMISSIONER GABOW: I'm not disagreeing with gathering the data that we can gather and

3 starting at this point. I just think we shouldn't ignore the fact that the end game is looking on clinical and

4 person outcome, that we don't even know what those should be.

5 And so let's be careful. That's my only plea. I'm not -- it's okay to look at all those variables, and

6 we might even look at your plan.

7 COMMISSIONER CHAMBERS: That's it.

8 CHAIR ROWLAND: Your evil plan.

9 CHAIR ROWLAND: Sharon.

10 COMMISSIONER CARTE: Just to add since we can't agree as to whether we can really look at

11 best practices now, maybe we could refine our approach to include consumer satisfaction, especially where

12 you do have a limited choice, which was kind of what -- where I was heading earlier.

13 CHAIR ROWLAND: And, Molly, I think your study has just gotten much more complicated, and

14 I recognize that this is a starting point.

15 And I think where we are is that this is a piece we want you to do as much with as you can, but we're

16 also asking for a broader scope of work that will go on in this area around all of the managed care issues.

17 And as we discussed earlier, managed care is a huge topic that we really need to engage in, and so for

18 our next meeting, let's come back with more of an overarching agenda on next steps for managed care in

19 addition to whatever results from this study we can have.

20 And I would press on this study wherever the states that you're interviewing have information about

1 -- I think it's very important to know the numbers of people because when you're dealing with small

2 numbers it may be much easier to do these kinds of assignments -- the number of people involved, the

3 breakdown that Richard noted of new enrollees to the program being assigned versus people who were

4 being reassigned within a program and also then any kind of data or quantification they have on opt-outs or

5 on people who switch plans or on some of the provider participation issues where they knew that people

6 had to disrupt provider networks, whatever we can get there.

7 Patty.

8 COMMISSIONER GABOW: I think to Richard's point, just so it's clear that I don't ignore him --

9 I think that in states that do have an algorithm that they're using, understanding the flow of the algorithm

10 and what trumps what is important.

11 So, is it that your specialist is in -- does that trump your primary care? Does it trump that it's in

12 your zip code? Does it trump that the provider speaks your language?

13 So I think understanding the components and the flow of the assignment algorithm and the

14 prioritization of the components of the algorithm are -- will be a learning -- something we can learn.

15 Again, I'll just --

16 CHAIR ROWLAND: And Richard.

17 COMMISSIONER CHAMBERS: I can't help myself, so -- yeah.

18 SPEAKER: Do you want me to get between --

19 COMMISSIONER CHAMBERS: No, no, no. But -- you're right, Patty.

20 But there's also things up front -- is like where there could be -- back to the best practices. Where

1 states can do -- can help in like disseminating information to health plans -- is they have new enrollees -- is

2 what can you provide before the patient shows up, that you can have outreach as to make sure, one, you're

3 linking with the right providers but what you know about them.

4 And those kinds of things -- I think states are really spotty about that -- is that some of them just

5 sort of -- they're yours now; you'll figure it out kind of thing. Or, it's -- you know.

6 There are things we could encourage where it would make the transition for the beneficiary without

7 knowing, you know, where we're going with outcomes and quality necessarily -- is like just where we can

8 make it -- is the best it can be.

9 CHAIR ROWLAND: I'd say there are two sides to that too, to go back to Robin's point. We

10 want to know the plans find out but also how the beneficiaries find out about their choices.

11 And then Robin raised her hand.

12 COMMISSIONER SMITH: This may or may not be part of what we're discussing. I'm not sure,

13 but -- what concerns me about taking someone away from the practices they've been seeing, good or bad, is

14 that -- I've explained this before.

15 When we adopted Sam, he was three. We'd had him since he was a baby. I got his medical

16 records as stated by the state, and they were already like this. And now he's 11, and I just can't -- how do

17 you switch to -- oops, sorry -- brand new -- that helps.

18 How do you switch to a whole new program away from possibly the providers you've already been

19 seeing?

20 How did they start to -- I mean, how do you take all that information and send it to somebody new?

1 What exactly do they do with that?

2 Do you -- because that is important information going forward.

3 So that's what concerns me the most -- is the population is so complicated and just popping them in

4 a plan that fits. Then how do they all -- I don't know.

5 Does that make sense?

6 CHAIR ROWLAND: How does this get communicated?

7 Norma.

8 COMMISSIONER MARTINEZ ROGERS: That is related to quality of care also. I just don't

9 see how you can just separate it all.

10 I mean, enrollment -- yes, the process of enrollment is one thing, but why -- it's like if you enroll,

11 dis-enroll, enroll, dis-enroll. What does that mean?

12 It's not just the process. It's, why does this happen?

13 And the other is with what Robin is stating; it has to do with continuity of care. You know. And

14 I think that that's what she is addressing.

15 And how does someone determine, you know, that you're just going to up and with a stack of

16 records like this and go some place else?

17 CHAIR ROWLAND: Well, I think Molly has taken on more than she anticipated when she

18 started with I'm just going to present a few preliminary findings from a survey that we're in process.

19 But I think this has been an excellent discussion that really lays out all of the kinds of issues and

20 challenges that we need to really begin to figure out how to address as we go forward to looking at both the

1 access and quality of care that Medicaid and other low income beneficiaries receive.

2 So the study is a good, as I said, first step. But it's one a ladder, and we're going to keep going up

3 that ladder to get to, ultimately, that end point that we know Patty is driving us to.

4 So thank you, Molly, and good luck.

5 And now we'll open the meeting if there are any public comments in -- please rise and identify

6 yourself.

7 #### **PUBLIC COMMENT**

8 * MS. KUHMERKER: Good morning. I'm Kathy Kuhmerker, the Vice President for Medicaid

9 Policy at ACAP, the Association for Community Affiliated Plans.

10 And I first wanted to just commend MACPAC for addressing the issue of continuous eligibility.

11 It's something that ACAP has been looking at and sponsoring and promoting for way before long -- way

12 before I got here, which has been in the last year and half, so probably for the last four, five, six years, I

13 think even.

14 We also -- I really also wanted to point out and ask MACPAC to consider in the long term the

15 importance of continuous eligibility on a mandatory basis for everyone in the Medicaid program. We really

16 believe that as we all move into this new world of the Affordable Care Act and people having -- hopefully,

17 having -- continuity of care and continuity of coverage, that having 12-month continuous eligibility is

18 extraordinarily important. And people deserve to know that when they go to get medical care they're

19 actually going to have coverage. We really this is a very person-centered issue and, really, people need to

20 look at it.

1 Also, there was a fair amount of conversation today in a number of environments about quality of

2 care. And one of the things that continuous eligibility on a 12-month basis will help the Medicaid program

3 to do, which it does not do today, is develop again another mandatory system of quality measurement,

4 reporting and improvement -- which it's really hard to believe that in a program that covers 60 million

5 people we don't really have that. And 12-month continuous eligibility is an important part of that.

6 So I just wanted to add that to your discussion as you go forward and, again, thank you for -- thank

7 you for bringing it up and talking about it from the exchange and Medicaid perspective.

8 CHAIR ROWLAND: Thank you.

9 Any additional comments?

10 [Pause.]

11 CHAIR ROWLAND: If not, we will stand adjourned from this meeting and reconvene after the

12 issuing of our March report.

13 Thank you.

14 [Whereupon, at 11:53 a.m., the meeting was adjourned.]