MACPAC

Medicaid and CHIP Payment and Access Commission

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building and International Trade Center
1300 Pennsylvania Ave., NW
Washington, D.C. 20004

Thursday, January 23, 2014
9:41 a.m.

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

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

PROCEEDINGS [9:41 a.m.]

CHAIR ROWLAND: If we could please convene, I want to call to order this meeting of MACPAC, and I'm pleased that to begin this meeting we're going to focus on one of the issues that MACPAC has considered to be a critical issue on our agenda, and that's not only what does the Medicaid program do, but how is it managed and how can we really look at the administrative functions of the program and try to figure out what the resources necessary to effectively manage a high-performance Medicaid program will be. We know Medicaid has many challenges as it tries to do substantial changes in the delivery system as well as some of the increased focus on high-cost, high-need populations, as well as the expansion of Medicaid coverage in many of the states. And I'm very pleased today to be able to welcome Eileen Griffin from the Muskie School, along with Darin Gordon from the great state of Tennessee, and Chuck Milligan from the great state of Maryland, who both are Medicaid directors, and Darin is the head of NAMD, which is the Association of Medicaid Directors.

So please share with us the work that you've been doing, Eileen, as well as, Darin and Chuck, your perspectives on this critical issue of how to really convert Medicaid administrative functions into very high performance systems. Thank you.

Session 2: Administrative Capacity of State Medicaid Programs

* MS. GRIFFIN: Thank you very much for having me here today, and as you said, I'm here to share the findings from our report on Medicaid program administration, and I want to acknowledge the contribution of my co-authors, in which I include Trish Riley, Vikki Wachino, and Robin Rudowitz, and the funding from the Kaiser Commission.

At the Muskie School, we have worked a lot with Medicaid agencies to help develop, implement, and evaluate Medicaid policies and programs, and it's because of that experience that we wanted to shine a light on the relationship between Medicaid responsibilities and the administrative capacity they need to fulfill

those responsibilities.

Medicaid has undergone significant changes in the 50 years of its existence, and the pace of change has picked up considerably, yet we do not focus on what it takes to keep up with the pace of change and stay current with opportunities to evolve and expand.

Medicaid is often cited, one of its virtues -- one of the virtues of the Medicaid program is its lean administrative costs, but we have to -- our goal was to examine whether or not we're actually investing enough in program administration.

I confess to being a little bit intimidated talking about Medicaid program administration sitting between two Medicaid directors, but my job today is to set the table for a more on-the-ground discussion with them of what it's like to run a Medicaid program. And I'm going to start by talking about the evolving role of the Medicaid program, some of its core functions, and then some of the challenges that Medicaid faces.

Our study is built on a policy review and a literature review and interviews with six state Medicaid directors, and we basically -- I guess I need to do that. The Medicaid program combines a unique set of responsibilities. Partly it's a private -- it's like a private sector health plan, and in addition, it has the responsibilities and accountability of a public agency. It accounts for a major portion of the state's budget, and it has an important impact on vulnerable populations and the providers that serve them.

In order to administer these programs, the Medicaid agencies need to be nimble. Unfortunately they face a number of challenges in trying to meet the capacity needs to administer these programs.

Over the last several decades, Congress has significantly expanded the options available to states in terms of the populations and the services that can be covered and the delivery systems or payment systems that they use. These options are made available through waivers, state plan options, and the CHIP program, and over the years the Medicaid program has come to be understood as really three programs: a

traditional health insurance program for low-income children and their families, a more complex health plan providing services to a more complex population of persons with disabilities and older adults and persons with mental illness, and a wrap-around program for low-income Medicare beneficiaries.

There is a common denominator across all of these populations, and that's the barriers that these vulnerable populations face when accessing and benefitting from health care and other services.

The Medicaid program has to address non-traditional needs like transportation, accessibility, cultural accessibility, language accessibility, literacy, and coordination with social services. And as the complexity of the service needs increases, the job of meeting those needs also increases.

The expanding role of the Medicaid program is reflected in its expanded enrollment relative to the Medicare program. It formerly was smaller enrollment, and now by 2022 it will exceed Medicare by $11.5 million.

At its most basic, the Medicaid program's job is to provide coverage to eligible individuals, to enroll eligible individuals, provide services, and pay for covered services. Over the years Medicaid has been asked to shore up the delivery system, including safety net hospitals, the community health centers, community mental health system, and others. It has also been used to rebalance the long-term services system to de-institutionalize persons with disabilities, which has required building home and community-based alternatives and implementing diversion and transition programs.

As the scope of the populations have increased, their overlap with the populations served by sister agencies has also increased and required a lot more coordination. Medicaid agencies are required to engage stakeholders, ensure program integrity, and manage use of services, implement their management information systems, and take a leadership role in health information exchange and health information technology. And now Medicaid agencies are required to provide no-wrong-door access to Medicaid, CHIP, and the exchanges.

This slide provides a sampling of the different reforms, the various reforms that have impacted Medicaid over the years. Based on this slide, you might think that Medicaid is in a perpetual state of reform, and I actually think that might be true. Some of these reforms have been imposed, and some of these reforms are part of incentive programs or part of grant or demonstration projects. These reforms have focused on improving cost-effectiveness, improving quality, improving services, improving accountability, and some states have used waivers to implement some reforms, including payment reform and global waivers.

The current wave of payment reform and delivery system reform has significant implications for Medicaid agencies. In the traditional fee-for-service world, the job is paying claims and -- adjudicating and paying claims. In a managed care world, for those states that have shifted to managed care, the focus is on developing sound capitated rates, ensuring access, and improving quality.

In the new payment and delivery system, delivery models, the focus has shifted to accountability for outcomes, requiring a realignment of incentives, and in many cases forcing a realignment of delivery systems. Under these new models, Medicaid agencies require high-level analytic, financial, and clinical expertise to sit across the table from private sector plans and providers as they negotiate and manage sophisticated payment models and hold providers and plans accountable for quality and performance.

This slide is a little bit dated, about a year old, but it shows how states are responding to the opportunities for innovation. These show the number of innovation projects under the Centers for Medicare & Medicaid Innovation, how many innovation projects each state has taken on, and it just gives you a sense of where the action is. But it does not -- it only shows those projects under the Innovation Center's domain, and so there are other projects out there that are not reflected here.

Having talked about the evolution of the Medicaid program, I just wanted to quickly run through what it takes to keep the trains running on time, the core operational functions of the Medicaid agency.

Beneficiary management requires front-line staff and supervisors who can apply enrollment and eligibility policies and procedures and beneficiary protections. The provider contracting and management requires a different kind of front-line staff that can help providers navigate the claims systems and the contracting systems. The provider payment involves adjudication of claims. Utilization management requires the clinical expertise, and program integrity requires analytic and investigative capacity. The Medicaid Information Systems are used for a variety of operation and analytical functions, including claims management, eligibility, and enrollment, budgeting performance and quality management, program evaluation and program integrity. Financial management requires the ability to project costs and account for costs and being held accountable by the governor, the legislature, and CMS. And performance and quality management require measuring and monitoring quality, and hopefully are integrated in the other operational functions.

What is not reflected here are the governance functions of leadership and policymaking and compliance, and these functions are important both as an integrative force and for setting the parameters within which the Medicaid program operates.

A number of Medicaid agencies aspire to more than minimum requirements of operating their Medicaid program, and in addition to the no-wrong-door access to the Medicaid, CHIP, and the exchange, a number of Medicaid agencies are working on no-wrong-door access to long-term services and supports and integrating or streamlining financial and non-financial eligibility determination for those services. Medicaid agencies are also reorienting their approach to beneficiaries and focusing on health status and improved experience of care.

Provider contracting and management, provider payment, performance, and quality management all are being realigned around quality and realigning the payment to respond to quality and performance.

Program integrity, I think one of the aspirations is to attend to program integrity upstream rather

than focusing so many resources on identifying and catching problem downstream. For information systems, Medicaid agencies are working on -- some Medicaid agencies have developed claims-based electronic health records, electronic prescribing initiatives, remote disease monitoring initiatives, and are taking a leadership role in the health information exchange networks. Financial management hopefully is data driven and built on anticipating both indirect and direct costs and long-term as well as short-term budgetary considerations.

This slide is from the 2010 NAMD survey of state Medicaid programs, and it just gives you an idea of how Medicaid agencies share responsibility with other entities, including sister agencies and contractors. And just as an example, the second column is, 15 states reported that their DD waiver was administered by the single state agency, and 23 states -- or 22 states reported that another state entity administered the DD waiver.

In our conversation with state Medicaid directors, we talked a little bit about the challenges of sharing administrative responsibility and the mismatch between the Medicaid agencies' accountability and their control or authority over the state Medicaid -- the sister agencies' program administration. And just a quick scan of a year's worth of OIG reports, we found that a healthy percentage of the recommended refunds from OIG findings were related to sister agency programs, programs administered by sister agencies. And Medicaid programs also have a difficult time sometimes managing expenditures in sister agencies who sometimes work around the Medicaid agency and go to the governor or the legislature to get more resources. I know that's…well…

[Inaudible comment/laughter.]

MS. GRIFFIN: This slide is also from NAMD, and it shows how Medicaid agencies outsource their functions, certain functions, including eligibility and enrollment, and their MMIS system. Outsourcing can make sense in some situations, and for IT support, for example, it might make sense to

buy the expertise where a vendor has experience in other states and can produce more predictable costs and possibly better value than building the capacity in-house would.

The problem with outsourcing is a loss of control, and sometimes there's a different set of challenges with resolving problems and making modifications.

In addition to their core functions, Medicaid agencies have responsibilities and opportunities beyond the boundaries of the Medicaid program, including budget negotiations, and they necessarily operate in a political sphere that requires staff who can navigate both internal and external politics. Medicaid agencies have the opportunity to coordinate with population health goals with other state agencies, including housing, labor, transparency, corrections, and public policy. There are opportunities to ensure, for example, that the housing authority's investment in housing for Medicaid beneficiaries actually aligns with the Medicaid program's plans for providing services in those facilities.

Medicaid agencies also have the opportunity to take a leadership role in multipayer payment and delivery system reform, and they are doing that in a number of states.

This slide provides a sampling of the kinds of expertise Medicaid programs need. They need a unique combination of expertise, some of which is relatively generic, like organizational development and leadership, some of it specific to Medicaid or specific to the responsibilities of a state agency like Medicaid: policy or administrative procedures and procurement, and a lot of expertise related to the specific needs of their populations and the delivery systems around them.

This slide is a sampling of the kinds of skills that Medicaid agencies need, and yesterday when I was looking at this, I had to acknowledge that these are my priorities, not necessarily those of the Medicaid agencies. As an outsider looking in, I often place a premium on the ability to manage systems change and translate the operational details of the new policy into practice, and training the workforce and actually effecting change that programs -- that Medicaid agencies are trying to change. But one of the top priorities

that we heard in a number of arenas is the need for analyzing and using data, managing quality and performance, and provider contracting.

Now that we have talked about the core functions, I want to shift gears to talk about the gap or -- the challenges Medicaid agencies face from when they try to acquire or access the expertise they need to meet their responsibilities.

The Medicaid agencies are subject to a higher level of public scrutiny and accountability that often limit its control over some of these core functions, like hiring, contracting, policy, budgeting, and program implementation.

A Medicaid agency's mission is too important and its budget is too big for it to escape the public accountability and scrutiny. It expends both state and federal dollars, provides care to our most vulnerable populations, and shores up vulnerable providers. And it has a big impact on state budget and the state economy.

Because of its prominence, the Medicaid agency is highly regulated and answers to many masters, including CMS, the governor, the legislature, court, sister agencies, advocates, and the public at large. As a major player in the state budget, Medicaid is often a target, and the state Medicaid directors are required to defend and protect their budgets in a sometimes tough environment.

Medicaid agencies are subject to many regulations and processes. CMS reviews and approves their state plans, their waivers, their MMIS, their managed care contracts, and so on. Like other public agencies, their rulemaking, procurement, and hiring decisions must be conducted in compliance with state law. Their decisions can be subject to public scrutiny, judicial review, and political second-guessing. Initiatives can be rushed, stalled, or jettisoned in response to changes in administration, politics, the lack of resources, and so on. And in the next slide, I'm just going to focus on some of the things that we talked about with state Medicaid directors.

Hiring decisions and the ability to deploy and redeploy workforce and modify their job descriptions are some of the challenges that a state Medicaid agency faces.

Civil service codes will set job classifications that are not necessarily calibrated to reflect the level of responsibility in a Medicaid agency. A sister agency that administers a $30,000 contract isn't necessarily comparable to a $30 million contract, and it's not always clear that those -- the difference is well reflected in the salary that can be paid to the people managing those contracts. I'm probably exaggerating on that example. But collective bargaining agreements also can limit the ability for Medicaid agencies to reconfigure their job descriptions, and we heard from one Medicaid director who was having trouble figuring out how to redeploy eligibility specialists in the context of implementing the new eligibility processes under the ACA.

I want to reiterate that though I'm talking about the hurdles imposed by these procedures and checks on the system, I think it's important to remember those checks are there for a reason. It's just the reality within which the Medicaid program operates if they have to leap over some of these hurdles.

States vary in how they manage their procurement processes. We heard that governors are sometimes involved in reviewing contracts, and in other cases Medicaid agencies are exempted from the procurement processes that apply to other state agencies. In those states where procurement is highly regulated, there is a cost imposed on Medicaid when it comes to accessing the services they need, both in terms of the protracted RFP process, the delays associated with appeals, and the limits on contract modification without going back through the bidding process.

When we talked to Medicaid agencies, they talked about some of the considerations they take into account when deciding whether to buy or build needed expertise. Sometimes they're not authorized to make new hires, whether because of hiring freezes or because their collective bargaining agreements might limit the opportunity to go out to hire.

They also, as we talked about, have challenges offering competitive salaries to attract expertise, and some of the areas where they're competing with private sector employers, they are potentially losing their employees to -- some of their highly qualified employees to private sector competitors.

For a small number of states -- in the small number of states that we talked to, we did observe that there seems to be a difference, when deciding whether to build or buy, whether or not the state is in the early stages of a program development or if they have a more established program and they know they want and need that sustained -- they have a sustained need for expertise, so they build it inside, they acquire it inside.

And I just added -- I hadn't realized this, but this came up in our conversation with Medicaid directors, that when you contract with a managed care organization, a managed care organization is effectively reimbursed for their administrative costs at their FMAP rate, while the state is reimbursed at 50/50 match rate, which I think is a different -- it's an interesting difference.

Whether because it's political expediency or wishful thinking or uninformed decision making, Medicaid agencies are sometimes required to take on responsibilities with inadequate resources. They don't always have the luxury of budgeting for or anticipating the additional level of effort that goes into implementing a major system change, and some of these responsibilities get absorbed into existing staff.

When existing staff take on these additional responsibilities, other functions sometimes end up suffering, and we heard about backsliding on customer service and there are, I am sure, other things that Medicaid agencies have been forced to cut back on because of other responsibilities, new responsibilities.

One of the themes that came out of our conversations with state Medicaid directors is the lack of counterweights on the downward pressure on administrative cost. There are no minimum standards that Medicaid programs have to meet for their Medicaid administrative capacity, and there are no natural constituencies to protect administrative capacity. In many cases, when there's a Medicaid expansion, as we

talked about, they expand responsibilities -- they have expanded responsibilities, but do not have expanded administrative capacity. And when there are Medicaid retractions, it often comes out of the administrative budget, but not necessarily reflected in reduced responsibilities.

And this slide just gives you a sense, even though it includes local governments, it gives you a sense of where's the impact that the economic downturn has had on state and local government workforce. Basically, 60 percent of the 323 state and local governments responding to this 2013 survey continued to have a smaller workforce than they had before the 2008 economic downturn, and this is during the period when Medicaid agencies were responding to the new responsibilities under the ACA.

As I said at the beginning, the relatively low administrative costs of the Medicaid program are often cited as one of its virtues, but we have to ask ourselves when we've reached the point we're investing too little in administrative capacity and where the good buy isn't a good buy because inefficient operations and missed opportunities are actually costing us money.

In our conversations with state Medicaid directors, there seem to be some concessions that state Medicaid agencies needed some counterforce to work against the downward pressure on administrative capacity, and we talked about an incentive program that had appropriate standards for Medicaid program administrative workforce and some sort of reward for complying with those standards as a tool that state Medicaid agencies could use in their negotiations in their state with their legislature and their governor to demonstrate that these are important capacities for them to have funded.

We also talked about the need for training programs, particularly basic training on the Medicaid program's policies and so on and so forth, and analytic capacity. I know that there is a Medicaid Integrity Institute which provides training for the program integrity staff, but this is focused on addressing downstream problems rather than improving upstream performance.

And, that is the end of my presentation. I have no idea if I've exceeded my time or not, but…

CHAIR ROWLAND: Thank you, Eileen. You've given us a lot of material to digest, and I think that many of the Commissioners have previously made the same point that you made about investing in better program management instead of going down the route of having to go afterward on the program integrity side. And so the purpose of having you all here today is really to try and talk about how to better achieve that kind of balance.

I'm going to turn it to Chuck and to Darin to give us the on-the-ground Medicaid director perspective and then open it up to the Commission members for discussion.

* MR. MILLIGAN: So, I'll be brief. Eileen laid out a lot of good points. I do want to just maybe add a little bit of flavor to it on the personnel side for a second.

This is my second stint being a Medicaid director. I was a Medicaid director in a different state in the late 1990s, and the complexity of the work has grown in Medicaid and I just want to sort of put some flavor on that.

A lot of what Medicaid agencies are doing around the country right now isn't inside just a Medicaid financing system. There's a lot more all-payer-type reforms. And so the ability to understand delivery systems, commercial insurance, Medicare, I mean, it's not just dual eligible initiatives. It's all-payer reforms about patients that are medical homes. It's a lot of the work that CMMI is financing in SIM grants and that sort of thing.

So, one dimension of the complexity growing is Medicaid isn't just Medicaid anymore, it's really part of a much more integrated delivery system and financing model as people move across coverage, in and out of different programs, all of that.

There's another dimension to complexity, which is there's a new phenomenon with the federal Government in terms of using enhance FMAPs to try to incent states to do things, and I want to mention seven different matching rates that we're operating in Maryland right now for different initiatives that we

have to keep track of separately from an auditing and accounting point of view, federal reporting point of view, and the inevitable OIG audit point of view.

We have -- we're now dealing with not only the enhanced matching rate for the expansion population under the ACA, but there's an enhanced FMAP for the primary care physicians for the two-year time period to raise the rates up to Medicare, and how you identify which providers and which codes and which visits are eligible for that and which ones aren't is a very complicated accounting and accountability element.

On January 1, Maryland launched the Community First Choice Initiative, which is a long-term care effort to do more community-based attendant care. We get a six percent enhanced FMAP for that. We have to distinguish that service, and it requires nursing facility level of care. So, there's all of the accounting related to that.

We launched on October 1 a Health Home Initiative. This is a two-year time-limited enhanced FMAP for various kinds of health homes that's part of the ACA.

We were one of the states that got a Competitive Balancing Incentive Payment Program Award, which is a two percent enhanced FMAP for a whole variety of community-based long-term care services.

CMS recently allowed states to get a 75 percent FMAP for certain eligibility worker activities, but let me just distinguish that. Eligibility work that's about outreach doesn't count. Eligibility work that helps people get into the system counts, and then the work after that to help somebody choose an MCO or the post-eligibility kind of counseling part doesn't count. So, you have to cost allocate a given eligibility worker not only nowadays across TANF and SNAP and everything else, but within Medicaid, you have to cost allocate it between outreach, actual eligibility work, and then post-eligibility work about MCO counseling.

There's an enhanced FMAP for the Money Follows the Person Initiative that we have in Maryland.

And then there's all of the cost allocation that we're doing with our state-based exchange and all of

our sister agencies.

So, on the financial side, the complexity is immensely different than the last time I did a Medicaid director job, and the financial management, recordkeeping, financial reporting, and audit -- we've got multiple audits all the time, and many states do, to find out if we're drawing down the enhanced FMAP inappropriately.

The complexity also, then, gets to the fact that all of the -- the Innovation Center at CMS is funding a lot of really cool innovations, and a lot of researchers at a lot of think tanks and universities are really trying to explore. They all need Medicaid data, almost all of them. So, even the innovation work that we're not leading or we didn't write the grant for, we're getting a lot of requests from Burt and others to look for data to say, what are the outcomes and what happened?

I'll stop there. There are a lot more audits than there ever used to be.

The second point I want to make about personnel is there is tremendous labor market competition.

CHAIR ROWLAND: Chuck, I just want to clarify one thing, though.

MR. MILLIGAN: Sure.

CHAIR ROWLAND: You're not opposed to enhanced matching, are you?

MR. MILLIGAN: Enhanced FMAPs?

[Discussion off microphone.]

MR. MILLIGAN: Well, we're not…

CHAIR ROWLAND: You're talking about there could be a simpler way of doing it, but sometimes having additional resources helps.

MR. MILLIGAN: Yes. Thank you for the leading question.

[Laughter.]

MR. MILLIGAN: Yes. I mean, it does help. And, in fact, one of the things that's really

interesting is there are FMAPs on the personnel side that go back -- skilled medical professionals, states can match at 75/25, and it's easier for states to hire physicians and others because of that. The state investment is lower.

The complexity is that with all of the variety of FMAPs, CMS -- and on the federal side, the General Counsel's Office gets involved and the Inspector General's Office gets involved to figure out how we get approval on the front end. The very slow launch of the primary care fee increase last year was attributable largely to the fact that they wanted to make sure we didn't overreach, states didn't overreach, and that became very problematic and that's definitely part of it.

So, yes, enhanced FMAP helps, but the devil is in the detail. The devil is in the detail. Thank you.

And there is tremendous labor market competition. I mean, health care is very hot. I mean, tremendous delivery system reform, coverage expansions. The ACA is driving a lot more people into care. Delivery system reform, all-payer, is great and interesting work. States have trouble in any labor market in the country competing to keep folks.

And I do want to say, and I should have said this at the beginning, the people who are drawn to this work at state agencies are every bit as smart as people in the private sector, are every bit as committed. They are mission driven. They work hard. They work nights and weekends. These are not, in spite of a lot of what the public might think, these are not folks who are just kind of punching a clock in a government bureaucracy. These are committed, mission driven, values based employees in every Medicaid agency I have dealt with, and I did some consulting work and I've worked in a lot of different states about this.

This is a good workforce, but this is a workforce that we're constantly getting headhunters trying to recruit our folks to pull them into the private sector and into other places constantly in every -- not just

specific to Baltimore and Maryland, but every labor market in the country.

The other point I want to emphasize, and then I'll stop, is I want to pick up on something Eileen said. When you're dealing with it at the state personnel side, it is hard to get adequate resources, and I just -- I'll give the Maryland example for a second. We've been through the recession, like every state. It's probably been a little bit not as bad in Maryland. Some of the other dynamics in Maryland have mitigated. We didn't bottom out as much.

But what that meant is we have, in the last eight years, added -- we have grown our Medicaid enrollment by about 60 percent and we have reduced the Medicaid FTE by about five percent simultaneously. And that's partly because when there have been hiring freezes and no more authorized positions, it's an across-the-board approach because the Governor's Office and others don't want to pick favorites among their cabinet secretaries. And so we have been operating with fewer FTEs.

But it's even more challenging than that because one of the things that happens is, and I've seen this in other states, too, if our organic vacancy savings rate organically is six or seven or eight percent, meaning at any given time, we have turnover we can't immediately fill, so at any given time, we're running at six or seven percent vacant. They budget those savings and then they say, we need you to have more savings, so we're going to budget you at ten percent vacancy savings. So, we're going to sort of slow down your hiring ability. We're going to kind of -- when somebody leaves, we're going to wait a month before we let you start the recruitment to kind of titrate more savings out through vacancy savings.

As Eileen did mention, in many states, the way the classification systems work is that there might be a position, a classification like Health Policy Analyst or Program Manager or Contract Manager, that's the same classification system used in a lot of different agencies or different programs, and so somebody who's managing a program in my area that might be a $1.2 billion nursing home program is at the same classification system as somebody who's managing a $3 million federal grant that has, you know, seven or

eight nonprofit agencies downstream and not cost allocation, not federal rules, federal oversight. So, it's -- but at the classification system, it's treated similarly.

And the other point I do want to emphasize, also -- and this, I'm going to draw on my previous state experience -- in Maryland, the FMAP for service on the admin side and the service side is 50/50 in both places. We're a wealthy state. Maryland is a wealthy state, so our matching rate for services is 50 percent, as is the standard rate for admin.

The state I previously worked in was New Mexico. At the time I was there, the service FMAP was about 75 percent because it was a poorer state. But the admin FMAP is 50 percent, because that doesn't vary by per capita income, and what that meant is whenever the state was in flush times, if you put a dollar into services, you could grow a program by four dollars, and there was always pent-up demand for expanding eligibles, benefits, rates, all of that.

And when you're in a recession era and you want to save one dollar in a place like New Mexico, you'd have to pull four dollars out of service to save one dollar for the state, whereas you'd have to pull two dollars out of admin to save one dollar for the state. So, the ratcheting is it's easier to ratchet up on the service side in good times, because you get more bang for the buck, and it's easier to ratchet down on the admin side because you don't have to take as much out of the agency to get the same general fund savings.

And that dynamic, especially in states where the FMAPs vary quite a bit between service and admin, exacerbates the point that Eileen mentioned, which is you don't have a natural constituency defending growing admin. No governor is ever reelected by saying, "I grew state government on the admin side." I mean, it just -- but they are rewarded by saying, "I'm covering more kids."

So, I'll stop there. There's lots more to talk about, but maybe that'll help tee it up a little bit, too.

CHAIR ROWLAND: That's great.

Darin.

* MR. GORDON: This is incredibly therapeutic. I appreciate it.

[Laughter.]

MR. GORDON: I appreciate the opportunity.

Eileen and Chuck hit on a lot of the key points. I don't think Eileen emphasized enough, at the very bottom of many of her slides were the, "dot, dot, dot, and more." And so it didn't encapsulate quite everything, nor could that be done in the time allotted.

You're talking about programs here that represent, in some cases, a third or more of an entire state budget, you know, and that's hard to get your arms around. Many state Medicaid programs would be a Fortune 500 company, if you look at the size of these programs versus the revenues on Fortune 500 companies. In fact, I always find this very interesting, that the New York Medicaid program would be the 75th largest economy in the world. That's pretty impressive. My program in Tennessee in would be the 130th largest economy in the world. So, these are incredibly large, complex programs being run within this, and within the circumstances that Eileen and Chuck so eloquently laid out.

A couple of points that I want to hit in regards to this. So, we talked about, and, you know, as Chuck was talking about all the different match rates and we talk about the complexity of the Medicaid program, I say we're all funny about this in government, that we create our own chaos. And so a lot of times when we're passing new laws and new programs at the federal level -- and sometimes at the state level, as well, they're not immune from it -- we do so in a very siloed fashion, not in the context of everything else that you have going on or the bandwidth constraints or are timelines realistic. And I think that's creating some of the challenges that are experienced, given the overall context that we just went through.

I'd say, at its core, the thing that helps a high-functioning Medicaid program, and it's no different, I think, than any private enterprise, either, is sustained focus. The problem is that sustaining focus in a context where you have frequent changes in political parties within the legislature, which can change your

direction, frequent turnover in Medicaid director positions -- in our state, we averaged a 13-month tenure for Medicaid directors, 14 months for the executive team. The sad thing about that is that there's multiple programs that require two to three years' worth of implementation and effort.

So, whenever you're having a discussion with an IT vendor that's coming in saying, hey, I've got this great system I'm going to deploy, we can have it up and going and operating at full speed, from start to finish, from soup to nuts, in three years, how many people say, well, I don't think my lifespan is going to be that long here, so why would I use that time to do that, which then continues to put you back several notches as you're trying to move the program forward.

So, there's really -- you know, if you look at it, there's this investment in human capital development and there's also an investment in technical capabilities of the organization. Both require some form of sustainability within both.

You look on the human capital side -- you know, I have to give kudos to CHCS and Robert Wood Johnson Foundation. The first time I have seen in 15 years, and I'm sure it goes back further for those who have been acquainted longer, it's the first time I saw someone step up and try to invest in the development of the leadership of these Medicaid directors across the country. That is vital. If you think about all the things that Eileen listed, there is very, very little time, if any, for you to look outside of your four walls and the crises that are coming across your desk, to look outside, look at what's going on in the private sector and other industries to really help you think of innovative solutions to the problems you encounter.

That program was, I think, very good at pulling you out, putting you in rooms with your peers, with other experts in the field, to really think about some of the problems out there, how other people have approached them and solved them, and I think that's vital, having some program with that capability.

You also have to be looking at bench building. Unfortunately, a lot of times when Medicaid

directors change and leave, it isn't always that the replacement isn't always promoted up within the organization, so there's a great deal of a learning curve and you're starting from scratch and there's very little opportunity for overlap to train your successor. So, you really need to invest in bench building because those are the people that are going to help to try to have some semblance of sustainability and continuity.

Recruitment, as Chuck said, is increasingly more and more difficult. I can't say more than what Chuck did with regard to the dedication of the people you have. You find this great combination of mission driven folks. But at the same time, you can't be insulting to them from a financial perspective, and I think some of the civil service things that Eileen was talking about, you know, we've addressed some of those in our state, but still find it very challenging to get the right folks into the program to help advance the program and address all the many things we're asked to do.

But, on the other side, on the technical side, because of the fact that we're always being asked to do more with less, we have to have some good investments in the technical capabilities of the program, and this isn't -- you know, a lot of times when we think about that in terms of Medicaid, the first thing that comes to mind is MMIS, you know, or T-MSIS. That's not it, guys. That's not the thing that's going to allow you to process PAEs more efficiently and not need a very manual process with 50 staff, which you can do it electronically with maybe ten.

Those are the types of investments you need to be thinking about, and we've been trying to do it within our program, but the only way we've been able to do it effectively is because I've been in this role for almost eight years. I was CFO two years before that. My executive team, the average tenure is nine years. So, we've been able to start making investments in eligibility that will -- we have a project management group that comes and helps do lean events. They're Six Sigma experts that come in there and they actually do not automate bad processes but look at how we can do more with less.

Those are things that we need to be investing in, and I think the comment about the enhanced

match, I think Chuck is right. That gets into the chaos of some of the accountability they put around that. But there's also -- I don't think either of us are opposed to enhanced match. That's very helpful. But there's a way to do that that doesn't overcomplicate it and does allow for us to invest in some of these things that recognize we all have to do more with less.

With that, I turn it over to the Commission for any questions.

CHAIR ROWLAND: Well, thank you very much.

I'm going to turn first to Trish, and then Sara, and then Patty, and then Richard.

COMMISSIONER RILEY: Well, I guess we've talked so often about the focus on program integrity and all the investment and finally we're getting to talk about the need to invest in the administration. I thought it was a great presentation.

I would say, in our study, we talked about states, and it's probably fair to say a similar panel could be held about CMS itself. So, when we think about the administrative capacity of the Medicaid program, it's probably important to think about the CMS side, too, but so be it. Our focus was on states.

It is striking, how much gets done and has gotten done without more investment and attention to management, but I'm struck by the comments about turnover, and Darin has -- you know, the dean of the Medicaid directors with his longevity. But, we also focus -- the CHCS work and much of the work is on the directors, who tend to stay for two years, I think was the average turnover, and when you think about the infrastructure that is Medicaid, there's got to be more focus and attention to those people who -- what skills do they need to come in? How do we support them?

But I thought for MACPAC, the best guidance that we got from the panel was the discussion about there's no natural constituency for the administration of this terribly important program, and I think there is one and it's called MACPAC, and that we really ought to take seriously our responsibility to think about how the Medicaid program is run, administered, what supports it needs, what's a reasonable set of

expectations. If we're to achieve access and payment reforms that we propose, we can't do it without hand-in-glove work around administration. So, I would hope, and maybe the panel can talk more about what we might do as MACPAC to help be that natural constituency for the advancement of the Medicaid program administration.

But, thank you.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: I have three questions addressed to any of you, really. The first is whether you can provide some insights, which I think is always important in an issue like this, as to some of the downstream effects on the people who actually really need the care by having understaffed agencies. I certainly remember the toll that it took, particularly on things like being able to get a timely determination on a coverage issue or whatever. So, that's number one, and I think it would allow people to see, in addition to the human effects inside the agency, the human effects outside the agency.

Two, as Medicaid is, you know, you all said it so well, sort of reimagined -- it's been going on for a while -- as really in the trenches on health care delivery, I think it's inevitable that you're going to have to work with an array of companion agencies. So, questions about how those relationships might be structured to be more productive and less friction-filled than they are.

And the third is, I'm really interested in your recommendations around federal financing, not so much the variable rate issue that Chuck mentioned, but the question of if we were, as MACPAC, to get into recommendations on financing the program administration, are there things that we ought to think about tying to specific kinds of incentives, specific kinds of changes, just like, you know, when the federal financing rate goes way up for adopting certain kinds of technology, and you made the point, Chuck, and I think you're absolutely right, or it was Darin, one of the two of you, that you don't need another computer incentive. What you need is a human capital incentive. And so I'd be interested in knowing what kinds

of positions, what kinds of functionalities you would, given your incredible experience, incentivize the most.

MR. GORDON: Go first?

MR. MILLIGAN: Sure.

MR. GORDON: Talking about the downstream effects and a lot of that, I could point to a thousand different measures that get impacted through a lot of change.

But really, the two global measures that we look at, which, one, will not feel like it's really downstream, but I believe it truly is, and then the other will be more clear.

But when we -- prior to having some consistency and leadership -- and, again, when I say that, let me very clear. I'm not talking about me so much as having an executive team with that level of tenure, to be clear on that.

But, prior to that, when we had the really rapid turnover in leadership, the program was looking at double-digit annual inflationary growth, which really does make you a larger target and one in which case you have to typically -- you're typically asked to make reductions in your program spend. The more money you need the more they expect you to reduce your program spend.

So we were at double-digit growth. Our quality indicators were all going south.

Since we've had some sustained continuity, trends have averaged about 3 percent year-over-year, every year for the last 10 years, and all our -- we had -- almost 88 percent of our quality measures all have increased over the last 6 years.

So I think there is a direct correlation with regards to how the program functioned and, ultimately, the people that we serve by having some of that continuity.

But you're also right with regards to accurate determinations. You can look at data there as far as our error rates decreasing whenever you had sustained continuity.

So there are plenty of measures you can look at that really help reinforce that. I think it's a good

one.

Our relationship with sister state agencies -- I do think the complicated thing there -- we continue to work through that. One way, in our state, that they've addressed some of that is they just put more under me, which I don't know if that solves the problem. It's just a different problem at that point.

CHAIR ROWLAND: Do they give you additional staff to do it?

MR. GORDON: No, no, that doesn't -- so like the exchanges and ownership of exchanges was always put under us because we thought that that would allow for a greater continuity between the different programs, but that's not always the case.

I do think that the relationships with other states agencies are somewhat complicated because of the fact that from a federal perspective -- and I think it's one of the smartest things the feds have ever done in defining a single state agency, a single accountable entity. I think it's vitally important, and I think it's one of the smartest things that they've done. However, within the state work structure, it doesn't always necessary reflect that.

So we have kind of an oversight role that shows a very different organizational structure than you do from a practical perspective, but that really gets to your skills as a leader within your organization, to develop those relationships and help people to understand what -- you know, where -- you're not trying to -- you know.

As I tell the mental health folks, I'm not trying to be the mental health authority. That's their obligation. However, I have these responsibilities, and I would -- you know, it would be foolish not to invite their insights and perspectives, and we work together on that.

But I will tell you I've served three governors, and it can be very challenging. But I don't think there's an easy way to fix that because it's really within some of the structures and how each governor sets up their organizations.

Match for various changes is very effective. You know. If you want to get people's attention, you put a higher match rate on that, and people tend to go in that direction.

Heretofore, I think most every enhanced match has been on the services side.

COMMISSIONER ROSENBAUM: Yeah, I was thinking of like the skilled medical professionals' financial. That's a favorable rate to bring in…

MR. GORDON: Exactly.

COMMISSIONER ROSENBAUM: …the highly skilled medical professionals.

Are there other areas? Like, should there be one for CIO?

MR. GORDON: I would tell you we've been on a national search for CIO for about a year now, and it's hard to get them.

We had a fabulous CIO that worked at Boston General, or Mass General. He worked in a lot of different consulting capacities. Greg was with me for eight years.

He came in there and said, you know, we're going to get here. We're going to get some of these projects done, and then when things settle down we can cast a greater vision on what all we can do from a technology perspective.

And when he came to tell me in his eighth year, I'm moving on to something else, that time never came.

And so it puts a big demand -- he said, it's the most rewarding job.

But it's hard to get those folks.

But I would say IT, but I would also say analytics. Health care analytics is -- I mean, we started our analytics group 12 years ago. Fortunately, I have two of the first three people I hired in that. That was a group that I started.

But I will tell you what we ended up doing is going to the colleges and getting folks, and we tell

them, in two years we'll train you to where we can't afford you.

And the highest turnover I've had in that was three in one week got lost, but typically, I lose a couple a month out of that area, in which case, again, from an efficiency perspective, we're spending a lot of money training up folks and dealing with the turnover just to have them leave.

But I'd say analytics is vitally important. You hit the CIO. And, finance for some of the higher-level finance. You already have the clinical covered. But I think those are the areas that we see most of our challenges.

MR. MILLIGAN: Just to add a couple of comments -- I mean, Darin did a great job. I would add a couple things.

In terms of downstream effects, there is also an opportunity cost of things that we just can't get to.

I mean, in Maryland, we would love to be working on more initiatives about dual eligibles. We would love to be working on other kinds. We would love to do a more proactive job in terms of outcome and quality measures with our Medicaid managed care oversight.

But, you know, we're scrambling with other kinds of more of the day-to-day, sort of hand-to-hand combat issues. And it has affected our timeliness with eligibility determination. I mean especially the long-term care eligibility determinations, which are more complicated because of the look-back and all of that stuff.

On the sister agency side, it is a tricky issue.

I mean, Darin has a very unique situation in Tennessee in terms of the governance model in the state.

I think in a lot of other states -- and I think there's a healthy tension, quite honestly. Other agencies have missions that are school-based, like the special ed in schools or the foster care systems or the mental health agencies in DD and so on.

The problem tends to be that they treat Medicaid as a financing source without it being treated as a series of programmatic rules, federal oversight, federal requirements, terms and conditions. And it's very hard to sensitize sister agencies to the fact that it's not just a way of displacing state and local funds because they'll hear from consultants that, say, here's a way to save money; maximize this.

And the Medicaid agency is constantly in the position of being the one to say no, you can't do that.

But their mission is valid. Those agencies have valid missions.

The federal financing -- and I just want to add a couple things.

I think that in terms of enhanced FMAP, the skilled medical professionals help.

Some of the systems -- that enhanced match for MMIS operations and enhanced FMAP for the fraud and control units -- all of that helps.

The CIO kinds of things help.

A lot of project management on the IT side helps -- people who have a PMP kind of credential.

The analytics is an area where we have especially a lot of trouble competing in terms of really good analytics.

Actuarial was in Eileen's slide deck, which is another area.

So there are particular targeted areas, but I will tell you the area that I have the most trouble competing would not easily fit into something that we could use a credential or a license or a degree to get at, which is really health policy analysts -- really, really solid people coming out with a master's degree, who know how to write and who know how to use data.

I mean, that's the workforce everybody wants.

COMMISSIONER GABOW: Well, first of all, I want to thank Trish for perseverating on needing to look at this because I think it was more important, and the panel, I think, did a great job in putting out the issues.

I think the comment that was made by one of the panelists that we could do this with CMS as well -- and maybe Trish made that -- is worthwhile as we try to complete the pictures because if the state gets better and CMS gets worse, in its ability to administrate because their complexity has grown, it's not going to solve overarching problems. I think it would be good if could do the same thing.

I actually think one addition, Eileen, to your lovely slides and data would be if you could -- and maybe this is beyond possibility, but I'll throw it out nonetheless -- is what it would look like in a private insurance company because I think Darin's comment that this would be a Fortune 500 company in most states.

I don't think people have a good understanding about:

If this were Aetna or WellPoint or whatever, what would it look like?

What would the resources be?

What is the kind of dimension of the people?

What are their salaries?

What things aren't they doing in a private insurance company?

I think that adding richness to this tapestry like that would be very good in this.

The other question I would ask the group, which sort of tees off Sara's question about what could we recommend, is I think it would be hard to pick out, well, we need an enhanced match for the CIO and for the actuary and for the X, Y and Z.

Should we just say we need an enhanced match for administrative function that in some way enables you to have discretion with salaries -- because one of the good parts about singling out the medical person and the CIO is that it lets you actually deal with that particular skill set whereas, if you say enhanced match, that still may not mean at your state that they're going to let you pay more for the CIO.

So how we would construct this without listing 27 things or people who should have an enhanced

match but still lets you focus it on specific people, if you have advice about that, I think it would be helpful.

The other comment, Darin, that you made about error rates as you become constricted in your administrative costs -- if there were hard data about why we should move money from fraud and abuse at the back end to the administrative function at the front end, that were real examples to push that, because everybody loves the money in fraud and abuse, but it obviously is at the wrong end of that parade. But good data on why we should do that would be, I think, useful.

So I'd like to thank everybody for that.

But, if you can give us some concrete guidance on what a recommendation would look like that would…

CHAIR ROWLAND: I also think that one of the things that would be helpful is to know what the resources are at the state level for fraud and abuse versus the resources for program management. That's been something we've talked about a lot.

And we've also looked at -- you mentioned training, Darin, and we know that in program integrity there's a national institute. And whether you can give us some ideas about what training and what training capacity would be if we were going to look at sort of how do we build a better workforce.

So, obviously, salaries and compensation are important, but what skills and what's really needed in the training to have the right kind of workforce would be helpful if you all could make some suggestions to us.

MR. GORDON: Sure. I'll comment on the fraud and abuse.

You know, when I heard Chuck talk about the size of his workforce and the reduction in his workforce, the only positions we've been able to get -- so we had -- it was an 8 percent reduction several years ago, then a freeze. It was a freeze before that and a freeze after that 8 percent reduction.

The only positions we've been able to get have been the fraud and abuse positions, in which case we

don't ask for state dollars because we basically believe, based on how we've been tracking, that we can still -- that they can pay for themselves. And that is a very compelling case, not only that they're fraud and abuse but that we believe that their collections would pay for themselves and that they have.

But, you know, that's an example where there seems to have been a willingness to do that, and I know because fraud and abuse just makes everyone happy. But at the same time you also want to make sure that you don't have $150 million computer system that ends up taking 10 years beyond schedule to come into play and way over budget.

And I think people have a hard time looking in those terms, particularly if they believe the impacts outside of their term that create some of those issues.

But, yeah, I think we can probably offer some comments and suggestions in both regards.

COMMISSIONER CHAMBERS: Thank you all.

Great presentation. As you said, Darin, it was therapeutic for someone who has viewed this issue from many perspectives over the years.

CMS has seen a number of states come through and try to seek ways to more effectively administer the programs, and many, many proposals coming through, particularly in looking at the options of privatization and real constrictions in federal law and state law in being able to do that.

I'm curious if there are any examples of states who have been successful in finding alternatives.

All the challenges that you all -- Eileen, you laid out and Chuck and Darin talked about, at the state level, of restrictions on civil service requirements, state agency requirements, public agencies, all those types of things that have been successful and using those as examples of states that can pursue that.

And is there anything as a Commission that we could recommend as where federal guidance could be more flexible to allow states to come up with other options?

And, when I say privatization, I'm not currently working for a private company. I see it from a

different viewpoint. But it's not really promoting just the privatization of Medicaid administration, but it's privatization with a small "p" -- of innovative ways of running programs that would make it more amenable.

MR. GORDON: I'm sure Chuck has -- I mean, he's consulted with a lot of states. So I'm sure he has some perspective.

I think some of the states that have tried the authority -- health care authority -- approaches have been able to address some of the issues, particularly around some of the procurement, some of the hiring outside of the civil service realms. So I think some of those have seen some success there, but some of those haven't been sustained either.

So I think you've got mixed results there.

One thing I should say -- and I've been meaning to say it on a couple things, and I think this is a good opportunity. When we talk about -- you know, we contract. We're 100 percent managed care and have a great relationship with our health plans. We have a lot of different consultants and advisors that come in, and I think they can be good assets to Medicaid programs.

But, if you have good consultants and bad administrator staff, then you're still going to have a bad result because they're not going to implement it for you in a lot of cases.

And we've seen that with health plans, you know, where we didn't have the capabilities and the strength to help really manage them effectively and help them be successful. We had a lot of turnover in health plans early on, and we've had much more sustainability, and I think much more interest in partnering with us because of that sustained capability.

But I just wanted to get that in there before I forgot, but I'm sure Chuck has some other perspectives.

MR. MILLIGAN: Just a couple of things. A lot of what you see states do are work-arounds, and there are different kinds of work-arounds I'll just mention.

One, I was part of, where different states have relationships with their public universities that have health research centers of different types that are essentially staff extenders sometimes. And the university systems are often in a different kind of classification of pay scale. I was executive director of one of these kinds at a University of Maryland campus.

Different states use that as a staff extender to have, you know, pretty good ongoing expertise that's really a state employee. I was a state employee when I was at that organization.

Another approach some states use is really a procurement with some kind of vendor that really is their staff extender although a lot of times you can't -- in some of these states that use this model, those folks are co-located with state employees. They have the state employee e-mail address. They have state phones. They're in state offices. You can't tell them apart, but they're brought in through some kind of pretty broad scope of work.

And it's a way of scaling up and scaling back resources counts and FTE, using it through a contracted approach. And you see that in some states.

And one other idea that I want to just mention -- that I don't necessarily endorse, but I've heard it talked about -- is some way of going to an accreditation model for a Medicaid agency, and if a Medicaid agency got accredited, it would then be entitled to an enhanced FMAP across the board if it met some kind of accreditation criteria.

And you see that happening in the public health side of state government, in public health agencies, where Robert Wood Johnson Foundation, and organizations like the National Association of County Health Officers and ASTHO and others, are looking at really professionalizing and accrediting public health. There is talk in the Medicaid world of doing an accreditation model that might have enhanced FMAP.

But to your point, Richard, I think that one of the work-arounds that states use is really -- and California is a great example where UCSF has a model that the California Health Care Foundation helped

launch. In other states, there are similar models.

And then other states go a very different direction, which is often a long-term vendor relationship with co-location and really staff extension.

COMMISSIONER CHECKETT: Well, thank you so much for coming to speak to us.

And I want to say that this is an entire commission of people who are interested and committed to Medicaid, and I know every one of us recognize, Darin and Chuck, that you and your staff could be out doing lots of other things and have chosen to stay for the long term at your programs. And I think that continuity has really driven your states in particular to a very high bar.

So my question is actually about what do you see for the states who aren't here. You know, is there something they would say?

The little states. The rural states. You know, is there anything in terms of administrative capacity or issues that you think has been left unsaid?

So that would be one question.

And then the second is, you know, if Chuck and Darin, like if you could have one wish, not that we could remotely grant it, but we would if we could -- but we could write about it -- what would that be, in all seriousness?

I mean, if there was like one thing on this issue, what would that be?

So, two questions. Anything left unsaid for those who aren't here and then what would be one thing you'd really like to do or have us recommend?

MR. GORDON: You know, we actually meet with a lot of states on a variety of different topics, and I remember at one session -- I won't necessarily share the state, but there were three people there from that state, including the Medicaid director.

And they talked about some of the salary discrepancies because they were talking about -- it was like,

you know, you have an incredibly sharp team. And he said, you know, I'm looking at -- you know. He was sitting in our meeting, looking at what some of those people made online while we were talking, which was interesting.

But, anyway, the point that he made, which was really -- you kind of felt for the guy. He was like, other than me and these other two people, a total of three people, no one in my entire agency has that college education.

COMMISSIONER CHECKETT: Wow.

MR. GORDON: So it's hard for some of those states to be successful with those dynamics going on.

You have other situations where you have -- and Chuck has talked about it -- an incredibly skinny administrative staff, like a handful of administrative staff, and a lot of stuff contracted out, which in some of those states their problems are slightly different than ours.

But a lot of what we hear from states and what they say their needs are in this regard -- a lot of it is we all deal with similar problems. Some have had some success addressing those problems; others, not so much.

But we don't -- it's a very -- it's something we're trying to do at the association, to better try to plug people into folks that have encountered or have had more experience with a particular area, and then we try to facilitate kind of bringing them together to help them work through that.

And it's hard when you look at all the things that Eileen went over, for people to have the bandwidth to be able to look up and find out who else is doing this, because you really do feel like you're on an island. There are thousands and thousands of CEOs around this world. There are 56 of us -- a very narrow peer group and one that oftentimes, from travel restrictions and the like, can't get to someone else to say, you know, how did you solve this problem?

But I think having talked to some of the states and having the ability to do that, which gets to my response to your last question, because I think it's the thing that keeps giving, is some kind of way -- that MLI-esque kind of approach where there are investments into these organizations and development.

It's not just basically your ship, but you know, I've done a lot of different -- I've been in other fellows programs, fellowship programs, where I can't tell you how much value there is in being pulled out of your four walls and the crises that are crashing all around you, with other experts, whether in your particular field of expertise or not, and talking about how to approach different problems, things that have been done, different innovations that have transpired. How valuable that is when you put back into your environment, that you come with a different perspective and different ideas and opportunities, to make it work better.

Not only do you get to set that, but I also see that, you know, when we've done that -- and we have mentoring programs that we develop within our organization.

And I've required of all my executive team to do leadership development, at least one thing every six months. They can pick what it is, and I'll pay for it.

But we got to be able to do something broadly because I know that's rare, and it was rare in our state for a very long time. But that's the type of thing that's going to continue to help build capabilities long after we're long and gone.

MR. MILLIGAN: So, your two questions, Donna.

For the states that are represented here, I think one of the points I want to emphasize is that as the complexity of Medicaid has grown, with what we've been talking about, in a lot of states, what that means is they're one deep in knowledge in any area. They've got the one expert who knows how to send in a CMS-64. They've got the one expert who really understands how to deal with prospective payment for nursing home rate setting.

I mean, they're -- so I think what you would hear is that in those areas, the workforce and turnover and the fact that a lot of those positions are filled with soon-to-retire people in a lot of states and that they're one deep -- I think that's what you hear.

In the states that have smaller programs and smaller administrative agencies, they might have 60 or 80 FTE in their Medicaid agency, and they don't have any cross training, and when they lose somebody they're basically going to be scrambling.

In terms of one wish, this is a really tricky area in terms of just the federalism of all of this because I think, you know, trying to mandate a solution at a MACPAC level that states would not bristle at, at a federalism level, is going to be tricky.

I think the FMAP stuff we've been talking about would be helpful.

The accreditation think which, again, I'm not endorsing, but as a different kind of approach which honors sort of state sovereignty.

The other version of that would be if the single state agency notion in the federal law was defined in such a way that there were expectations of what that single state agency's competencies are, to try to draw attention to what it means to be a single state agency from a skill and competency point of view, and then let states figure out how to solve that in ways that are unique to the state environment because it is an important issue, but it is a hard needle to thread given a lot of the federalism that underlies all of Medicaid.

MR. GORDON: Then you'd be audited on that.

MR. MILLIGAN: Yeah. And I want to discourage all of you from having a similar conversation about the CMS needs because they're only five miles from my office.

[Laughter.]

COMMISSIONER CHECKETT: Thank you both. Those are great comments.

MR. MILLIGAN: Thanks.

COMMISSIONER CHECKETT: I appreciate it.

COMMISSIONER MOORE: Okay. I will be brief even though I'd love to talk about this and ask you questions for another hour or two, because this is very dear to my heart, this subject.

There was, for the record, an initiative to deal with resources in state Medicaid programs in the 1970s. It was around for about three or four years, then went away. And there were probably some in the 1980s and 1990s that I don't remember, but that was the first one, I think. So this is not a new subject, but I think it's much, much more important given the complexity that we've all been talking about.

Thank you very much for this study, excellent study. Thank you very much for the comments. You guys have been just very, very terrific. I have a couple of specific questions that we can talk about briefly and maybe we can deal with a little bit in more detail at another time.

It took me probably a decade, or maybe even two, to really understand and appreciate -- that is, of my time in the Medicaid world -- the role of counties in many states and the intergovernmental problems that states face like the state-federal problems that I knew quit well from having been a federal official. And I am curious to know what ACA is doing to, for, or about that. I asked the Medicaid director in the state of New York that question at the NAMD meeting, and I kind of got, "Well, geez, I didn't want to bring that one up." And --

COMMISSIONER COHEN: You should ask me this.

COMMISSIONER MOORE: Yes. And, you know, when you automate, when you centralize, then you have a whole new set of intergovernmental problems at the state level. And I do think it's something that we can't ignore, because it is a very, very big deal, both politically and practically, in many, many states. So I want to put that on the table, and if you all want to say anything about it, that's okay. But we can do it at another time because I think we're running out of time.

The other question I have is -- and this is one that maybe we can look into or something I'd like for

folks to look into, but maybe Eileen knows the answer. Do other federal grant programs have administrative standards that they impose on state food stamps, unemployment insurance, you know, those kinds of programs? Or are we talking about something that might be unique to the Medicaid program, we're starting something that would be a banner for others to follow?

MS. GRIFFIN: I can't speak to other -- like food stamps or programs like that. I know that child welfare has a periodic review. They have standards that they look at the performance and so on and so forth. I'm not sure if that's exactly the same thing that --

COMMISSIONER MOORE: I think it's an area we could look into. I'd be curious to know a little bit more about it. Thank you. Thanks very much, all of you.

VICE CHAIR SUNDWALL: Okay. I'll be brief, too. Thank you. I'm sorry I missed your presentations, but I get the gist of this, and I, like other Commissioners, think this is a really, really important issue, and I hope that we come with some recommendations that will help address it. I don't know what they are. I don't want to complicate your lives. But I think we can help.

When I was Director of the Health Department in Utah, Medicaid was part of our agency, and one of my more painful memories is when we hit the recession and our enrollment went way up, and then the apparent problems went up, and so we put in a request and the governor granted it in his budget for more administrative support.

Well, the legislature, in their wisdom, found the money to create a new oversight separate from the Health Department for fraud and abuse, didn't give us any more administrative money, but isn't it odd they found the money to do that when we desperately needed the administrative funds?

So this is a really important issue, and I can understand the tussle for resources, but thank you for your help on this. I hope we can come together on something that will be useful.

COMMISSIONER COHEN: I also will be brief because -- thank you, Chuck -- you raised the

very issue that I wanted to ask about, which was the idea around accreditation and whether or not that had gotten some consideration. I guess I would just ask two follow-up questions, first of all, just to get -- and I'm almost going to say for the moment putting the federalism issues aside, like as to whether it would be a requirement or an incentive, but just the idea that you could have some like health insurance companies, health plans do, and also like health departments that's being sort of, I think, considered or in the process of implementing that for them, whether or not they're -- what kinds of standards would you think might be sort of appropriate in an accreditation. I'm not being specific, more like categories of standards, and then just sort of any reaction to this idea, which obviously will have burdens for people in your seat, you know, undeniably. But, on the other hand, if you lack a constituency for a professionalized, you know, and really effective administration, you know, one way of dealing with that is to sort of create objective standards that are minimums or at least like highly incentivized standards, and that sort of does help address the structural problem.

So I'm interested in your reaction, Darin and Eileen, and then any categories that you think it might particularly work or not work for.

MR. GORDON: Yeah, and, you know, when I hear about this and about the standards, you know, because, you know, my old communications person used to say, "This is a sticky wicket," because, you know, we went through -- we have a, you know, state -- you have the Baldrige Criteria that's out there, and each states have -- or I don't know if every state now has, but I know our state has one that's been around since Baldrige Centers of Excellence. And we went through to get a level of accreditation there, and this was -- there's four levels, and we did just a Level 2 application. It was incredibly staff-intensive, and I would tell you that I thought it was very helpful, and, you know, as I had to sell it to our executive team and get everybody excited about it, it's really to help you see where there are some opportunities. Are we as good as we think we are? And it had you ask a lot of different questions. It's somewhat geared

more toward the private sector, although pretty adaptable. But I think going through that process, which really did hit a variety of different areas -- and, you know, the whole issue of Baldrige is an interesting one. And so I think there's some things out there that you could probably glean from ways of measuring operational capabilities and organizational strengths. But I will say it was -- I know another agency did it at the same time I did, and we talked about are you -- you know, we both talked, are you going to go for the Level 3 award? And we're, like, looking like this is not the year for us to do that with everything else we've got going on. But there's different levels of progression to show really a mature, strong, robust organizational program. But doing something like that and requiring that of states in the context of everything else you have going on could be smothering to a great degree and really then impact some of those programs, direct service programs, and implementations we have to do, which -- so that's the balancing act that you have to try to gauge if you're going to make recommendations to that…

VICE CHAIR SUNDWALL: And, Chuck, I'm sure you're aware that the public health accreditation movement is a real sticky wicket, too. There is not a broad consensus on that, and the cost and added layer of responsibility is problematic.

COMMISSIONER CARTE: While I think the accreditation idea has, you know, some good elements, I just wonder about what other ideas there would be to expedite this or to bring it up to a higher level. You know, at the risk of offending 45 states, you know, could we not look at what high-performance Medicaid programs look like or maybe point out five good, strong models? I really like the idea of focusing on the core competencies. I really think -- you know, I don't know if we need to get together with a group of retired Medicaid directors or something, but to more quickly point to what could help address some of these issues, including I like the point about, you know, special revenues positions, the ability to have a leadership cadre within a single state agency that is perhaps competitive in salary with the private sector. I think there's all kinds of possibilities that -- and including managing a high-performance

Medicaid program Part 2.

CHAIR ROWLAND: Okay. Well, I think that you have given us a lot of the information that we hoped to gain in this session. I think you can tell that this is an area that this group really feels is a fundamental responsibility of ours as a Commission that's supposed to look at and make recommendations on how to improve the Medicaid program, making sure the administration of it gets the resources and sustainability that it requires.

I would encourage you to continue to think about the issues that you raised today and to please continue to communicate with us on any ideas you have or any recommendations you would like to put forth for us to consider in terms of how to really shore this up. The training responsibilities and how a training institute might work are all areas that I know this Commission has talked about, and we're also obviously very interested in the kind of staff that you feel you need and the competitiveness in the labor market that you raised I think is a very important one, and we may want to get some additional information from you on kind of your staff salary levels versus what the private sector is offering since those comparative studies I think can be very informative.

So I thank you all for joining us today. I would share Judy's point that we wish we could keep you for another hour or two to further enlighten us, but we k now that it will be an ongoing conversation. So thank you very much.

And we will now turn to our next panel.

Our topic for the next panel, we are going to be looking at both an ongoing study and a recently completed study by the General Accounting Office that focuses on benefits in the Children's Health Insurance Program in contrast to what may or may not be offered in the private market.

[Pause.]

CHAIR ROWLAND: Okay. If we can reconvene, this panel is going to switch from state

Medicaid administration to the Children's Health Insurance Program and two studies that are ongoing or have recently been completed with regard to the benefit package and array in the CHIP programs. And I'm going to start first by turning to Joe Touschner, a senior health policy analyst with the Center on Children and Families at Georgetown University; and then second we'll turn to Susan Anthony, the assistant director of health care at the U.S. Government Accountability Office, otherwise called GAO.

Joe, do you want to really give us an overview of the study that you have ongoing?

Session 3: New Studies Focused on CHIP Benefits

* MR. TOUSCHNER: Okay. Good morning. My name is Joe Touschner. I'm with the Georgetown Center for Children and Families, and I am happy to be here this morning and to share with you some preliminary findings from work we've been conducting on the benefits and cost sharing in separate CHIP programs.

I have some slides. I'm planning to move through them fairly quickly, but please feel free to stop me if you have questions, but I think we'll also have some time for questions at the end.

The work that is ongoing that I'm here reporting on today is a joint project between the National Academy for state Health Policy and those of us at the Georgetown University Center for Children and Families. I think many of you may be aware of NASHP, but it is an independent academy of state health policymakers dedicated to helping states achieve excellence in health policy and practice.

The Center for Children and Families, where I work, is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. Funding support for this project comes from the David & Lucile Packard Foundation.

I wanted to start out by just running quickly through the goals of our work. We have a number. As you can see on the slide, it's to examine the benefits and cost sharing in separate CHIP programs; we wanted to consolidate the benefit and cost-sharing information into a single source. Right now they're

available from each state, but it's hard to get them in one place. We wanted to summarize those benefits into consistent categories.

All of this is to, of course, inform policymakers and stakeholders as they're considering the role of CHIP as health reform is implemented and as the program moves towards reauthorization in coming years.

Before I get to the states that we covered, I do want to say a quick word about the methods for our study. We examined the states' CHIP plans that are filed with the federal government that outline 28 different benefit categories that CHIP programs cover. We sought clarification and confirmation of the information in those documents from supplemental documents, maybe benefits books or other things from states, and also with state officials themselves. Because in these different documents benefits are described in a wide variety of different ways, we did have to make some judgments as far as summarizing the various descriptions to make them more consistent and comparable, as that was one of our goals.

So now to the map on this slide, we considered 42 separate CHIP programs in 38 states. Four of the states do have two separate CHIP programs, and three of them, there's different programs for kids at different income levels, and in one state, in Florida, there's a separate CHIP program for younger kids than there is for older kids, and so we considered those. Those programs do often have different benefits, so we considered them separately.

Also, as you can see in the center of the map, we included Arkansas because its children's coverage waiver has different benefits than in Medicaid, but it's not technically a separate CHIP program.

So we'd also note the states that aren't colored in obviously have Medicaid expansion programs, but there are other states that are combination programs where there might be Medicaid expansion up to a certain income level and then CHIP above that income level. So in these states that we considered, the separate CHIP programs don't always cover the same income level kids.

So as you know, setting benefits at a high level, CHIP programs have several choices. They can

choose a benchmark to model their benefits after of an existing plan in the state, or they can seek the Secretary's approval for coverage for a benefit package. I think a lot of us who look at this list and are familiar with the essential health benefits under the Affordable Care Act see that there's a lot of similarity, at least conceptually, in the method of setting those benefits. I did want to point out, though, that the list of benefits does have some important differences, the list of benchmark choices that are available.

In CHIP, programs can choose that Secretary coverage option, but that's not available for the EHB side; whereas, for EHBs states can choose a small-group health plan as their benchmark. But that's not available for state CHIP programs. In fact, when we look at the choices that states have made, those two options that don't overlap are the ones that were commonly selected by states. So, in fact, there's not a lot of overlap between the benchmarks in the CHIP program and those that were selected for EHBs.

So the choices that states did make when they chose to set their CHIP benefits in separate programs are on this slide, and as you can see, the Secretary approved coverage options by far the most commonly selected choice with 24 programs making that choice. If we drill down on that a little bit more -- so these are just the Secretary-approved programs -- we see that Medicaid is pretty influential as those states set their benefits. In nine of those programs, they use the same benefits as Medicaid, and in an additional three, they use most of the Medicaid benefits with some small alterations. A common change is to remove the coverage for non-emergency transportation services.

But it's not just the programs that use Medicaid in place of a benchmark where Medicaid influences the benefit design in CHIP. Some programs also use the early and periodic screening, diagnosis, and treatment standard for determining the availability of services. It's those nine programs that use Medicaid in place of their benchmark, but also an additional four programs offer that EPSDT benefit in their separate CHIP programs, even though they're not required to there. So in all, it's 14 programs in 13 states that offer those EPSDT benefits.

So before I talk about some of the specific benefits that the Commission may be interested in, I did want to say a couple of words about utilization management. As I'm sure you're all aware, you know, a health plan's approach to utilization management can affect how enrollees access services, and it can include a medical necessity standard, prior authorization, or other means.

When we looked at the CHIP plans that states file with the federal government, there was not consistent information on prior authorization, medical necessity, and these kinds of practices that some of those plans may use, so we did not include that in our study. We assumed that enrollees met any medical necessity standard that a state applied, and if prior authorization was needed, we assumed that it was obtained in order to get the service.

I would note, too, that in addition to controlling access to benefits, in some cases a plan's approach to utilization management can make more benefits available. For instance, as we studied those state plans, there were instances where the CHIP documents mentioned that there are listed limits, but those limits can be exceeded when they are medically necessary for enrollees.

When we were counting whether benefits were covered in states, we counted those as being covered if it was possible for enrollees to go beyond the listed limits.

So moving on, I did want to go to just a few of the categories of benefits that we looked at, and hopefully these are of interest to the Commission. I should note again that the findings I'm going to share are at this point preliminary. We've confirmed them with state officials. But we're still doing our own checks, you know, to ensure that everything is accurate and consistent. So we'll have a final published paper within the next month or so, which should have the final results.

So the first area I wanted to talk about was mental health and substance abuse services. I think folks know that CHIPRA applies the parity requirement that exists for private health plans to CHIP as well, but that is a requirement for parity and not always for -- not necessarily for coverage. If mental health and

substance abuse services are offered, they have to be offered at parity.

But when we look at what is actually covered, in fact, most programs do offer full coverage for mental health and substance abuse services. There are some limitations that exist, and they vary based on whether the services are offered inpatient or outpatient, whether they are for the mental health side or the substance abuse side.

Oral health services is the next group I wanted to talk about. I would say that in separate CHIP programs these services are somewhat in transition because there was a requirement for coverage of these services in CHIPRA, but we don't yet have regulations from CMS that define exactly what that means. There is a state health official letter that provides some definition but doesn't go as far, I think, as some state officials would like. But we did find that most programs do offer full coverage of non-orthodontic services, oral health services. There are some dollar limits in a few states, but in most cases it is full coverage. On the other hand, orthodontics are very frequently limited, and in many cases those are limited to what plans describe as a severe or a disabling malocclusion in order to get the orthodontic services.

Next I wanted to mention prenatal care and pre-pregnancy services. So these are widely available in all but one program. Prenatal services are available without limit. In most cases in CHIP itself but in some cases when an enrollee becomes pregnant, they move over to Medicaid and can access prenatal services there.

It is somewhat tough to tease out the difference between the prenatal care and other services that are delivered before someone becomes pregnant because they are reported together as prenatal and pre-pregnancy services. But this is what we found, as you can see, in most cases full coverage for this category in the state CHIP plans.

And finally, just quickly, I wanted to mention our treatment of habilitative services and devices. When we looked at the state CHIP plans, those weren't defined separately, as they often are not in private

health plans to date as well. But we know that they are of interest, you know, due to their inclusion as part of the essential health benefits. So we didn't have clear information, but we know that they may be covered in a couple of the categories that are reported in state CHIP plans: the physical, occupational, and speech language therapy, or in durable medical equipment. And you can see that most programs cover those, some with some limits. But I think whether they are covered for an individual enrollee may depend on the medical necessity standard, which, as I mentioned earlier, we didn't have complete information to evaluate that. I think GAO may have done some work to actually look at the difference between habilitative and rehabilitative, so there may be some more information there.

I wanted to spend just a couple slides going through some information on the cost sharing we found in separate CHIP programs. As you know, separate CHIP programs do often charge premiums, and those tend to rise with family income. You can see the medians for a single child on the slide here. And in general, you can see the size of them. They're substantially lower than what families are expected to contribute to health plans if they enroll in qualified health plans, even when subsidized.

And then in addition to premiums, there are the per service charges. In most cases these are co-pays, but there are a few programs that use co-insurance or deductibles. Again, it's common but not universal that separate CHIP programs would use these. About 26 of the 42 programs employ them. You can see it varies a bit by the type of service.

Finally, one interesting finding I wanted to mention on the premium cost-sharing side is the number of programs where the federal 5 percent of family income cap on cost sharing isn't actually effective because it's not possible for a family to reach that cap. In 11 programs there are no charges beyond the premium, so even if there is, you know, an enrollee who has a high need for health services, they're not going to get up to that cap. And then in seven additional programs, they have decided that they wanted a cap that's lower than the 5 percent and so established that for their states. But in the remaining programs, of course, the

federal 5 percent of income cap applies.

So I'll leave it there and turn it over to my colleague, and I'd be happy to take questions later.

* MS. ANTHONY: Hello, everyone. Can you hear me?

As Diane mentioned, I'm going to share some information on a recent GAO report that examined coverage and consumers' costs for select services in CHIP and benchmark plans in five states. This report was issued at the end of December, and it was based on fieldwork that was done throughout 2013.

In terms of overall objectives of this engagement, they were really twofold: first was to provide a baseline of how coverage and consumers' costs in separate CHIP plans compared to the benchmark plans; and the second piece was looking forward, how might this coverage and cost change in 2014 when qualified health plans were available on the exchanges?

In terms of scope, we focused on five states. They're Colorado, Illinois, Kansas, New York, and Utah, and in those states we identified the largest separate CHIP plan by enrollment and the benchmark plans that were selected. As Joe indicated, these benchmarks were a little bit different. The benchmarks are to be the model by which QHP benefits are based. I want to emphasize that they're not to be the model for cost sharing. They're the model for benefits. And also as Joe had mentioned, for most of our five states as well as nationally, the most commonly selected base benchmark plan was the largest small-employer plan by enrollment.

Because these plans typically did not include coverage for pediatric vision or dental services, states then also had to select or have HHS select for them supplemental benchmark plans for those services, and in doing so they could either select from a separate CHIP plan in their state or the federal employees dental and vision insurance plan to supplement those. So collectively, those were the benchmark plans that we looked at in these five states, and from each of these plans we examined the evidence of coverage, which describes in detail the coverage, and the costs associated with each of these services.

In terms of looking forward and expectations, you know, in addition to the laws and regs, we talked to state officials, exchange officials, CHIP officials in terms of their expectations of how coverage and costs would change moving forward.

The next slide shows you the services that we looked at. There were 34 categories or sub-categories of services that we reviewed for coverage. Within this group is essentially services that would fall within the ten essential health benefit categories as well as the 28 categories that Joe talked about that are eligible for CHIP reimbursement.

We also looked at limits on these services, and the limits that we focused on were day visit and dollar limits. Again, as Joe had pointed out in his presentation, there are other limits, and we didn't include in the scope of ours some significant limits like medical necessity. It was just too difficult to quantify those for the purposes of this study, so those were not limitations that we examined specifically in this engagement.

If we were looking at our bottom line in terms of coverage for the baseline analysis, we determined that the CHIP and benchmark plans were similar and that most generally covered the services that we reviewed. However, there were some exceptions. The outpatient therapies for habilitation and certain pediatric hearing and vision services, like corrective lenses, hearing aids, were not always covered by the state's CHIP or the benchmark plans.

If you look at the next two slides, it really kind of shows you a picture of what our coverage analysis looked like. The checkmarks indicate that that plan covered that service in some capacity. These squares with the X's indicate where there was not coverage. As you can see, the outpatient therapies for habilitation both there were examples of CHIP plans and examples of benchmark plans that did not cover those services. And if you go to the next page, it's a continuation. You can see it for pediatric vision and hearing services as well.

Also, we found that the CHIP and benchmark plans were similar in terms of the services on which

they imposed day visit or dollar limits. As you can see in this slide, the plans were -- both types of plans were similar in that they typically impose limits on pediatric vision, dental, hearing, as well as outpatient therapies. You'll see those are the ones on the far right. What's not on this table but they were also similar in that both types of plans typically did not impose any limits on ambulatory patient services, preventive care, prescription drugs, and emergency care.

One sort of distinction that you see here is in home and community-based services where four of our five state benchmark plans did limit those services where only one of the CHIP plans did. And to sort of give you a flavor of what those differences look like, in Colorado the CHIP plan had no limits on these services, but the benchmark plan limited them to 28 hours per week. Utah, similarly, the CHIP plan didn't have any limits on these services, but the benchmark plan limited it to 30 visits per year. So that is an area that we did see some differences in terms of the limits that the plan types placed on the services.

I pretty much covered this slide already, but I wanted to focus on the third bullet down, where I pointed out before where they were similar and imposing limits on outpatient therapies and those pediatric services. When we really tried to look at comparing the types of limits they placed on those services, it was just difficult to really -- they were just characterized so differently, we couldn't really ascertain comparability. And I have two examples, and I'll just talk to one.

Colorado's CHIP limited outpatient therapies to 40 visits per diagnosis, where the benchmark plan allowed 20 visits per therapy type. And so, you know, depending on each enrollee's or consumer's need, it's going to really affect potentially what they would need.

In terms of expectations for 2014, in terms of coverage, CHIP state officials in all five states expected their CHIP coverage to remain unchanged, largely unchanged in 2014. Not surprisingly, on the QHP side, the state officials expected that coverage would reflect the benchmark plans, and the QHPs would model after the benchmark plans per the Affordable Care Act requirements, and that, you know,

where the three plans that didn't cover outpatient therapy for habilitation that they would.

They also, though, did spend some time to point out certain PPACA provisions that they thought could create some differences among states depending on how it was implemented, and the first of those was the stand-alone dental plans. As you all probably know, the law allows for the availability of stand-alone dental plans in exchanges. In states where there's at least one stand-alone dental plan available, however, other qualified health plans participating in the state do not have to include pediatric dental services within their benefit plan.

You know, at the time of our study, it wasn't clear -- I mean, we knew all of our five states were going to have at least one stand-alone dental plan, but the officials noted that down the road this could, you know, pose some challenges or complexities. It's good in the fact that -- the availability of stand-alone dental plans, because it provides a broader set of options for dental services for consumers. But by the same token, they pointed out the potential that there could be some consumer confusion. A consumer potentially could buy duplicate coverage by buying both, or they could mistakenly buy a QHP that perhaps excludes pediatric dental services when they, in fact, may need them.

Another example of an area that they thought would be worth further examination is sort of the definition of habilitative services and devices. At the time of our study, 22 states had selected benchmark plans that did not include coverage for habilitative services or devices, and HHS' implementing regulations allowed states three options in terms of how they could define habilitative services in those cases: one, they could define them at parity with the rehab services; secondly, they could specify which services would qualify; or, third, they could defer to individual QHP issuers to define these terms. And the majority -- 12 of the 22 states at that time had deferred to the QHP definitions, so in those cases you could have differing interpretations within a state as well as differences among the states.

In terms of cost, it was a different story. Unlike coverage which we saw general similarity,

consumer costs were almost always less in CHIP plans than in the benchmark plans. When we looked at costs, we looked generally at deductibles, premiums, and cost sharing, which would be co-payments and co-insurance. And just to give you a flavor -- and Joe had much more detailed information on this -- you know, four of our five CHIP plans did not have a deductible. All of the benchmark plans did, and the deductible ranged from $500 to $3,000 for an individual for a year.

In terms of cost sharing, again, four of our five CHIP plans had no cost sharing on any services or on less than half of the services that they offered, and it varied by income level in certain cases. And the benchmark plans, on almost every service they had some kind of a cost-sharing provision. They did not vary those amounts by income level of the enrollee, and in the event that both the CHIP plan and the benchmark plan imposed a co-payment, it was consistently higher on the benchmark side.

The next slide really gives you an example of how this plays out. If you are looking at Colorado, a visit to a primary care physician or a specialist would cost an enrollee $2 to $10, depending on their income level; whereas, an individual enrolled in the state's benchmark plan would pay $30 a visit for a primary care physician visit or $50 for a specialist visit.

COMMISSIONER ROSENBAUM: Excuse me. Is that without cost-sharing reduction assistance or with cost-sharing reduction assistance?

MS. ANTHONY: This is before cost-sharing reduction...

COMMISSIONER ROSENBAUM: Before cost...

MS. ANTHONY: Yes, is available. This would be as the benchmark, again. So in terms of 2014 costs, again, CHIP, just like coverage, they expect that the CHIP costs will remain largely unchanged in 2014, and, you know, as Joe mentioned, the statutory 5 percent cap will still be in place.

In terms of QHPs, I just want to underscore again that, you know, states expect that the costs could differ from the benchmark plans. They're not a model for cost sharing. I mean, there's actuarial

equivalent requirements, but there could be some differences there. And then there are a lot of provisions within PPACA that will, you know, seek to standardize costs and reduce cost sharing for certain individuals. There's the limits on underwriting. There's out-of-pocket maximums. There's the actuarial -- you know, let's have the four metal tiers that standardize actuarial value among plans. The premium tax credit is available to individuals between 100 and 400 percent of the federal poverty level, and the cost-sharing subsidies to defray some of those extra costs are available to those between 100 and 250 percent of the federal poverty level. I mean, collectively I think there were expectations that these provisions in total could narrow some of the cost gaps that we had identified when we were looking at the benchmark plan.

So, in closing, you know, Congress, HHS, states -- a lot of people have a lot of important decisions to make regarding the future of CHIP, not to state the obvious, but HHS, you know, has to work on defining the parameters by which QHP coverage would be considered comparable to CHIP. Assessing this comparability, as we found, it will require monitoring a complex array of factors and will be affected by individual states, issuers, and families' choices. I touched upon a few of them -- habilitative services, stand-alone dental plans, where consumers -- what plans they actually pick. But these will all affect sort of the coverage and costs moving forward and I think would warrant a lot of additional study in the near term.

The last bullet is a link to our full product, which has for all of the services, it details all the costs and the coverage, as well as includes an objective that looked at access between CHIP and other sources of insurance as well.

That concludes my comments, and I'm happy to take any questions.

CHAIR ROWLAND: Thank you, and since GAO has completed this report, is this an ongoing area? Is there further study planned, or…

MS. ANTHONY: This job is complete, or this product. It was available on December 20. But, I think there is interest on the Hill in terms of further examining this topic. You know, obviously, it could

be very complicated. It might be little bite-sized pieces of where there's particular interest, but I think there's a wealth of possibilities.

CHAIR ROWLAND: Okay. I'll start with Sharon, and then Sara.

COMMISSIONER CARTE: I'm glad to hear you say that there's further interest on the Hill in looking at some of those areas. I think one area of concern, as you noted in your conclusion, some of these coverage choices that families make will really define children's access to service, and one of those areas, I know from my state, will be dental. We're fortunate that in the exchange that the Silver Plan does include dental. However, as CHIP families move into the exchange later on, if there's no CHIP there as a choice, I can see children losing access to dental just because the Silver Plan is going to be not as affordable to some, even with the protection. So, I would hope that dental would be something that gets further looked at. And Burt didn't even tell me to ask this.

[Laughter.]

COMMISSIONER ROSENBAUM: Well, first of all, my hat is off to both of you, because there is nothing more awful to try to do than a benefits and coverage study, and I think both studies are incredibly rich.

Without seeing -- I mean, in the GAO study, of course, we have, and when we see the full NASHP study, the full NASHP Georgetown study, I'm sure we'll have a lot more questions. But, I just want to try and get -- make sure I'm understanding a couple of points.

On the Georgetown NASHP study, I think I heard you say that many states use the EPSDT benefit at least as a guidepost in designing their separate state plan. In other words, they're not using one of the commercial benchmarks. There are, what is it, a dozen states are using EPSDT. But, when you say that, you don't mean it's all of EPSDT, all dimensions of EPSDT. What you're saying is they generally key off the EPSDT, or do you mean the benefit classes? Do you mean -- because you don't mean the medical

necessity standard we don't know.

MR. TOUSCHNER: Right…

COMMISSIONER ROSENBAUM: The amount, duration, and scope limits, we don't know at that granular level of detail, so I'm not sure what you mean when you say they follow they EPSDT benefit. The benefit classes, I assume you mean.

MR. TOUSCHNER: Well, I would describe it as two different choices that states make. The first is what is our list of included benefits.

COMMISSIONER ROSENBAUM: Mm-hmm.

MR. TOUSCHNER: And…

COMMISSIONER ROSENBAUM: Benefit classes.

MR. TOUSCHNER: Yes, benefit categories or classes.

COMMISSIONER ROSENBAUM: Right.

MR. TOUSCHNER: And benefits the same as the state offers to children through its state Medicaid plan is one option through Secretary-approved coverage that states can use.

COMMISSIONER ROSENBAUM: But I'm not sure what that means, you see. You say, "benefits the same as." It could be that the benefit classes are the same as.

MR. TOUSCHNER: I think it's the benefit classes.

COMMISSIONER ROSENBAUM: Okay.

MR. TOUSCHNER: Separately, you know, a state can choose to offer EPSDT services …

COMMISSIONER ROSENBAUM: Right.

MR. TOUSCHNER: to the kids who are enrolled in CHIP. They don't necessarily even need to use the same benefit classes in order to do this.

COMMISSIONER ROSENBAUM: Absolutely.

MR. TOUSCHNER: Right.

COMMISSIONER ROSENBAUM: Right.

MR. TOUSCHNER: So, I think -- again, we didn't look into the full medical necessity standards, but when programs filed their state plans, they would list their coverage in each benefit category, or the classes, and they would say, and children receive EPSDT. What that means in that state may vary…

COMMISSIONER ROSENBAUM: We don't know.

MR. TOUSCHNER: but this is something that states have reported to CMS, that is, coverage available under their separate CHIP program.

COMMISSIONER ROSENBAUM: And just one question for GAO -- I mean, I have so many, but I'm going to stop -- is we don't fully understand from your study, going to the question I asked you as you were presenting, how the cost sharing reduction assistance alters your cost sharing table. So, no one has asked GAO to do a follow-up yet where you would actually calculate, given the -- assuming the family chose the Silver Plan -- what the actual out-of-pocket would look like in its entirety.

So, what we have, and just to get clarification, we have now is that, at least on the face of things, CHIP does appear to protect families considerably more at point of service cost sharing. But in order to get a full sense of that, you would need to go back and do some additional research around the issue of the reduction assistance.

MS. ANTHONY: Correct. For the individuals and families between the 100 and 250 percent, they would be eligible for reduced cost sharing amounts. You know, we had -- in the process of doing this study, we had played around a bit with HHS's actuarial calculator, tried to figure out if we could do that, and it just became way too complicated at that point.

But, yes, down the road, it would be important to sort of see how that cost sharing would play out for the different income levels of CHIP enrollees.

COMMISSIONER ROSENBAUM: Well, and in fairness, I mean, one of the things that I think is a big question for the Commission is that because there is cost sharing reduction assistance does not necessarily mean that all plans will use it in the same way. You know, there may be more favorable cost sharing reduction assistance given to adults with chronic conditions than for acute visits for pediatrics. We just don't know at that point because it's an actuarial test.

MS. ANTHONY: It's an actuarial test, and I'm not an actuary, and yes, but you're right. Who's to say that those cost reductions would be targeted to pediatric services or the services most likely used by a CHIP enrollee. It's very -- you know, it's incredibly complicated when you look at these, but I would imagine that's yet another area that could be pursued further.

MR. TOUSCHNER: And I would mention that at Georgetown CCF, we are working to do a study like that separately from our work with NASHP, where we looked at all of the separate CHIP programs. It does become very complicated, so I think we're looking to do that work more on a state-by-state basis. So, the first state that we're working with is Arizona and working to compare the cost sharing that a typical family would incur under the CHIP program there, compare that to qualified health plans with the cost sharing reductions in effect.

COMMISSIONER ROSENBAUM: So, I'm going to call it the Georgetown study. When you talked about prenatal care and pre-pregnancy services, I guess my question is, my understanding was that CHIP really didn't cover that much maternity care, but what I'm understanding is that once that child of that age range becomes pregnant, then they're qualified for Medicaid coverage and now possibly exchange coverage, but that most CHIP programs don't usually cover pregnant women unless it's under a special waiver or something along those lines. Is that correct, or…

MR. TOUSCHNER: Right. I would say they cover many fewer pregnant enrollees compared to Medicaid. It depends on where the eligibility thresholds are for that particular state. In many cases, the

Medicaid eligibility threshold for pregnant women may not quite be as high as the CHIP program, so when an enrollee becomes pregnant, they'll move over to Medicaid, up to that income eligibility threshold, but there may be some enrollees who are over that eligibility threshold for pregnancy Medicaid but not for CHIP, and so they'll remain in CHIP.

COMMISSIONER ROSENBAUM: Got you. And then my other question was the pre-pregnancy services. I'm assuming that that would cover, like, family planning for a teenager that needs birth control, but not necessarily counseling, like reproductive life counseling to get in there and talk to those preteens, to talk to them about, let's not get pregnant until you're ready, how many children do you want to have in your lifetime, do you want to go to college first, you know, those kind of services, which would be really important to provide to a CHIP child, may or may not be covered under CHIP, isn't that correct?

MR. TOUSCHNER: Yes. You know, our study didn't get into that level of detail…

COMMISSIONER ROSENBAUM: Details.

MR. TOUSCHNER: …as to what kind of family planning services are provided. As I mentioned, some of it is complicated by the category being kind of double-barreled, right. We talk about prenatal and pre-pregnancy services kind of in one benefit class or category.

COMMISSIONER ROSENBAUM: Okay. Thank you.

COMMISSIONER GABOW: This is a naive question, so I'm sorry if it's too naive, but, Susan, when you said that doing the calculation of what the cost share would be was so complicated, it wasn't really within the scope, were you referring to it was so complicated because you were looking across all states, or it's intrinsically so complicated that the individual family would be impossible to know -- I mean, the average poor person who is at the level of literacy and education that this group generally is, that it would be so complicated that it would be unrealistic that they could make a wise judgment as to which was more

appropriate, or it was because your scope was so large?

MS. ANTHONY: I'll try to answer this. It was difficult for us because we didn't have at the time of our study the actual QHP premiums. We weren't actuaries, so sort of -- or what the cost sharing amounts were. So, sort of adjusting those amounts, it just was too complicated.

However, in terms of what a consumer would face and would they be able to figure it out, my understanding is that the issuers are the ones who automatic -- you know, instead of offering a Silver-level plan that's at 70 percent actuarial value, they have to offer plans that the actuarial value is adjusted to their needs. So, it's 70 -- up to -- I don't even remember the three levels. So, theoretically, I would think that that consumer would be seeing different cost sharing amounts when they purchase the plan and, therefore, it shouldn't be confusing to them, but insurance is confusing, I think, to a lot of consumers, even with higher education. But I don't think that is necessarily a more complicating factor for that.

COMMISSIONER ROSENBAUM: But, we wouldn't know. Just because you know it's 87 percent actuarial value or 90 percent, what you don't know, which I think is really important for us, is how that value is distributed over the benefit design. So, we'll never really be able to know, because it could change from plan to plan, whether -- you know, when a state CHIP program tells us that it's a $5 copay, presumably, that's what they've negotiated with all the issuers. Here, because we're dealing with actuarial equivalency, we could have 40 different plans in the state, all of which have, for their own reasons, distributed their cost sharing differently over each plan.

COMMISSIONER GABOW: And that's sort of what I was getting at. So, to ask the average person to understand that primary care visit is going to be X, CHIP is rather straightforward in what X is, but this may not be so straightforward and, therefore, when a family says, well, I know I'm going to need these kinds of services, they may not know which direction is going to be within the scope of their ability to pay, really, and this seems yet again a complexity in our current system that is neither desirable nor

appropriate.

CHAIR ROWLAND: Well, and as we discussed, there's also the stacking of premiums and what gets counted toward your affordability level.

Trish.

COMMISSIONER RILEY: I was intrigued, Joe, about your cost sharing study. I don't know if you can say more about that, but do you know -- because it seems to me it would help inform our deliberations -- what's the time schedule for some results from that?

MR. TOUSCHNER: For the full results of our study?

COMMISSIONER RILEY: Yes.

MR. TOUSCHNER: I think we're looking in February or March, and so…

COMMISSIONER RILEY: The Arizona.

MR. TOUSCHNER: Oh, the Arizona?

COMMISSIONER RILEY: The Arizona one. I'm sorry.

MR. TOUSCHNER: Oh. That one should actually be a similar time frame, I think.

COMMISSIONER RILEY: Okay. Good.

COMMISSIONER WALDREN: So, this conversation and one we had about maternity care brings up an issue. So, as I think about the data and being able to look at this and answer some of these questions, it seems like that I need to know at least three pieces of data: The service that was rendered, so a CPT-related kind of code; what was the diagnosis related to that, because it seems to vary, even on a particular service, so I need the ICD-9 going to be 10 code; and then it depends on who is providing that, so is it a primary care provider or is it a specialist providing a 99213 visit.

So, the claims processing systems have to have that data saying that these three pieces of data relate to -- this is the remittance to the provider, this is the copay amount, these are the rules relative to what are

the limits. I just wonder, are we able to get a look into that particular type of data as opposed to particular classes of service, like maternity care? Then we're wondering, well, is a consultation code for 40 minutes covered or not covered. Can we get to that level of data? Is that data out there, or is it just stored in these mainframe systems that are doing the claims processing? Do you know, or does staff know, or is it something we could look into?

MR. TOUSCHNER: Yes. I mean, I would say our approach was much more of a document review of, like, what states have filed for their coverage. I think that states that have an all-payer claims database may have an advantage as far as pulling that information, but it's not something that we looked at.

CHAIR ROWLAND: Well, thank you very much for sharing your study in progress with us, and we hope you will make available as soon as you finish the study the full study for the Commission and we'll send it to the Commission members.

MR. TOUSCHNER: I'll do that.

CHAIR ROWLAND: And I'm sure they'll have additional questions. And I hope you will keep us informed of the work, ongoing work at GAO, but this study that you put before us now, it's really very helpful in our deliberations, because we're one more group looking at what the future of CHIP ought to be and any advice and information you can give us would be helpful. But, thank you for joining us today.

With that, we'll adjourn until one o'clock. Thank you.

[Whereupon, at 12:04 p.m., the meeting was recessed for lunch, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION [1:09 p.m.]

CHAIR ROWLAND: Okay, if we can reconvene, please, we're now going to turn to -- continue our discussion of Medicaid managed care plan programs and to look at some of the key characteristics as we pursue developing a research agenda in this area, and so I'm going to turn to Moira Forbes and April Grady to kick off our discussion.

Session 4: Characteristics of Medicaid Managed Care Programs

* MS. GRADY: Thank you, Diane.

As you just mentioned, today we're going to talk just a little bit about the role of managed care in Medicaid, which most of you are very familiar with, and cover some key data points to inform the specific projects that we're working on right now related to encounter data, capitation rate-setting and managed care oversight. I'll also briefly touch on some other models for service delivery and payment at the end of the presentation.

As you all know, for a given set of benefits, Medicaid managed care plans generally take responsibility for provider networks, care coordination, utilization management and provider payments.

states may turn to managed care plans for a variety of reasons. For example, there may be potential cost savings and predictability in budgets and contractual guarantees of beneficiary access, which has been an ongoing concern for states, and also access to expertise that may not be readily available otherwise.

As you heard this morning, administrative capacity and the ability to effectively manage the Medicaid program is an issue of concern for all states. And managing Medicaid managed care plans, in particular, requires its own particular skill set.

Although states do shift primary responsibility for many aspects of service delivery and payment by contracting with Medicaid managed care, they also take on these new responsibilities that we discussed

related to plan procurement, capitation rate-setting, data collection and analysis, and also performance monitoring and reporting, which are all aspects of some of the projects that we have going on right now at MACPAC.

Just to cover briefly our managed care agenda and our past work, of course, we had our June 2011 report which was focused entirely on managed care. We had a March 2013 chapter that focused on rate setting for integrated plans serving dual eligibles. And we have an annual enrollment and spending update in our June MACStats that's ongoing.

And today's session, again, is about key data points to inform the current projects. These projects were first introduced to you in our December 2013 meeting.

So starting with encounter data analysis, as we've discussed in many previous sessions, all states with managed care programs obtain encounter data in some form that provide a record of the services that are provided to enrollees in Medicaid managed care plans.

There are some recent analyses from CMS and Mathematica that show some improvements in the encounter data that are reported through the federal Medicaid Statistical Information System, or MSIS, where we get a lot of our information and statistics here at MACPAC.

So, using 2010 MSIS data, MACPAC is currently assessing the completeness and quality of the encounter data for enrollees in both comprehensive managed care and behavioral plans. The goal here is to identify states that appear to have reasonably clean and complete encounter data for analytic purposes and to understand any deficiencies that may limit possible analyses.

I know that commissioners, on a number of occasions, have requested that we get inside that black box and really describe what's being provided to enrollees, and we hope to be able to do that for a fair number of states.

And that brings me to my first data point, which is that the number of states with various managed

care arrangements varies. In 2011, there were 37 states that contracted with comprehensive risk-based managed care plans, and there were 40 that contracted with a limited benefit or some other plan type that was not a comprehensive risk-based plan.

The most common type of limited benefit plan was nonemergency transportation followed by behavioral health and a variety of other plans that include dental, disease management and specialty medical plans.

And I do want to point out here that although only 3 states reported using limited benefits or standalone plans to provide long-term services and supports, other sources indicate that about 16 states right now are providing some form of managed LTSS, which may be part of a larger comprehensive plan, not a standalone LTSS plan.

You will also see here at the bottom that 40 states have primary care case management programs, which CMS often includes in its managed care statistics. So we have them here just for your reference.

And these PCCM arrangements differ from managed care contracting with plans in that health care providers in PCCM programs are paid a small monthly fee to coordinate a limited set of benefits for enrollees, but the bulk of the care for those enrollees is still provided on a fee-for-service basis.

Here, we are showing the percent of Medicaid enrollees that are in various managed care arrangements. And, as you are familiar with, about half of all Medicaid enrollees right now are in a comprehensive risk-based plan, and those percentages vary by eligibility group. Nondisabled children have the highest participation in comprehensive risk-based plans, about 62 percent of them in fiscal 2010, and a smaller number of aged and disabled enrollees participate in these comprehensive plans.

Interestingly, the limited benefit plan participation is a little bit more even, and actually, individuals who are eligible on the basis of a disability have participation rates that are similar to other groups.

What we don't have here is the detail on the types of limited benefit plans that these different

eligibility groups are enrolled in, and that's something that we can bring back to you in the future.

So this is the current picture of Medicaid enrollment, but I also want to talk a little bit about trends over time.

Between 2000 and 2011, the share of enrollees in comprehensive risk-based plans increased from about 40 to 50 percent, and that increase has been fairly steady over this period of time, 1 or 2 percentage points a year, with some exceptions. For example, in 2007, there was a 3 or 4-point up-tick, probably driven by the recession. So there was a large growth in program enrollment among the eligibility groups that are most likely to be in managed care. So we saw a little bit of a jump there.

In terms of spending between 2008 and 2011, the share of spending on managed care plans and PCCM programs increased from 21 to 25 percent. The bulk of that spending is on comprehensive risk-based plans. I think limited benefit plans and PCCM programs together comprise maybe 3 or 4 percent of that total. So it's being driven by the comprehensive plans.

And, of course, as you know, most of the individuals who are gaining eligibility in 2014 are expected to enroll in managed care, which will cause both the share of enrollees and the share of spending on managed care to increase in the near future.

Another factor that we have to consider for an encounter data analysis is benefit carve-outs because in order to assess the completeness and the quality of the data, we have to know what we're looking for and what services we would expect to see in the encounter data. The most commonly carved-out services from comprehensive managed care plans include dental, behavioral health, nonemergency transportation and prescription drugs.

These carve-outs may be partial; I'll just note here. A state may not carve-out the benefit for all populations, or it may be carved out only under certain circumstances. Nursing facility services is one of the common examples where plans may typically cover up to 30 days, but after 30 days the service is carved

out as a long-term care benefit.

The reasons for carve-outs are many and varied.

They may include a perceived lack of plan experience with these benefits, and the state sort of thinks it's safer to go it on its own.

There may have been past access problems within plans, and the state decides that it's in a better position to take that over.

There may be other state and local agencies involved in the provision of these benefits, and that's an important factor as well, particularly for behavioral health services. Child welfare, public health agencies, and other state agencies may be involved, and there may be financial and budget reasons to keep those benefits carved out of the plans.

And then the final thing I'll touch on is the drug carve-out. Until 2010, drugs that were provided under managed care plans were not eligible for rebates from manufacturers, and that changed under the ACA. So we're seeing a number of states start to carve that benefit back in now that the rebates are available for drugs.

So now I want to move on to talk a little bit about some key data points that are related to our capitation rate-setting project.

As we've discussed before, states use a variety of methods to set rates for their risk-based managed care plans, but all must pay within an actuarially sound range. Most of the states use an administrative process in which they determine a specific rate, with certain allowable adjustments, and they set that rate and offer it to the plans as a sort of take-it-or-leave-it with maybe some negotiation but minimal. And then a smaller number of states use a competitive bidding or a negotiation process that's more interactive.

Regardless of the process they use for the rates, there's also the issue of how they get to the specific rate itself. At least 24 states are using health status as a factor to risk-adjust their rates rather than relying

on demographic factors alone, like age, sex, geography and eligibility group.

And I'll point out that risk adjustment based on health status is most common in the states that enroll a substantial share of high-cost enrollees in managed care. So, for example, among the 24 states that risk-adjust based on health status, 17 had comprehensive risk-based managed care participation of at least 20 percent among their individuals eligible on the basis of a disability.

This is not surprising, that they use risk adjustment, because these populations can be very expensive and both states and plans want a capitation rate that's appropriate for the level of need within that population.

The other point I'll make here is that although the majority of Medicaid managed care plans receive risk-based capitation payments -- meaning if their costs exceed their payments from the state, they're on the hook for that cost -- 10 states did pay at least 1 plan on a nonrisk basis in part or in whole in 2011, and there may be a variety of reasons for this.

One example is Connecticut, which we've discussed previously. The state, for many years, had risk-based managed care and decided that for a variety of management and other reasons that they would move to a model where the plan is still involved in managing care and providing administrative services, but that the state would ultimately be taking the risk and managing the payments side.

Another example is Utah, where there are risk-based comprehensive plans, but there's also one nonrisk plan that's associated with the university. So there may be reasons for that as well.

MACPAC is currently planning a roundtable on capitation rate setting that will involve a variety of participants, including CMS, states, actuaries, plans and beneficiary stakeholders.

Another project that we have going on involves a review of managed care oversight activities, and that's the final item on our agenda that I'll discuss today.

Obviously, as I've gone through describing these different arrangements, the program design affects

both federal and state oversight responsibilities. Depending on whether it's a comprehensive plan or a limited benefit plan, there's a different scope of oversight that may be going on.

The other issue is that specific activities vary across states. So, even for a given type of managed care, the specific activities that states are doing may vary, and I'll provide a couple of examples that are illustrative of that variation.

Among 20 states highlighted in a recent study for HHS, there were 3 of the 20 states that did not impose a managed care plan standard for beneficiary wait times for a routine, nonurgent appointment. And among the 17 states that did impose a standard, it varied from 7 to 45 days. So, again, even when there is something in place, it can vary significantly.

The same study found that there was wide variation in how states enforced their provider network standards. Some of them require plans to report on a regular time frame, but that time frame varies, and the content of those reports may vary.

And the last example I'll give is while recent federal efforts to encourage voluntary reporting of a core set of adult and child health quality measures have been put into place that may lead to more consistency over time, right now, states also vary widely in the number and the calculation of the quality measures that they use for their Medicaid managed care plans. And to examine some of these issues, MACPAC recently engaged a contractor to review some of these on a variety of topics.

I'll just wrap up by pointing out that although Medicaid analyses are often presented with a fee-for-service versus capitated managed care dichotomy, in part due to lack of data on the payment models and specifics of these programs, it may be useful to consider the program as having a continuum of approaches with varying levels of risk and state responsibility.

The models that we have up here as additional examples -- primary care case management, patient-centered medical homes, accountable care organizations. They're not mutually exclusive, and they

may involve a variety of contracting and payment arrangements between states, vendors and providers. And I think you're going to hear a little bit more about this in the following session on advanced payment models.

So it's just something to consider in terms of our managed care agenda and how we formulate these discussions and our research plans.

I will conclude there and look forward to your comments and questions.

COMMISSIONER GABOW: I was wondering; do you think it would be useful or, in any way, illuminating to take the Medicaid managed care characteristics -- you know, the percent of patients, the rate, PMPM, the carve-outs, the risk-adjusting, the standards, all the things you've been talking about -- and compare Medicaid to the state employee program in terms of these characteristics?

I personally think it would be an interesting way to look at how the state is handling another large captive population and get an understanding of how they either treat Medicaid the same or differently.

But maybe -- I'm asking more, do you think it would be illuminating?

I would think it was interesting, but maybe that isn't equating to illuminating.

COMMISSIONER HOYT: Good luck with that.

[Laughter.]

COMMISSIONER HOYT: We tried to do that years ago. Maybe it's gotten better.

I've run into a number of state employee plans that didn't even know how many people are covered under the plan. It's the way the premiums are set up. It could be, you know, employee plus one, employee plus spouse, family coverage. They have no idea how many kids are in there, no data collection.

The rate negotiations were fascinating to me -- just a straight negotiation with plans about how much do you need and why.

And really, Medicaid -- at least in my experience, Medicaid was head and shoulders ahead of state

employee plans on data collection and any kind of factual basis for rate increases.

But, maybe it's gotten better.

CHAIR ROWLAND: It might be worth looking into.

COMMISSIONER HOYT: Could be, yeah.

CHAIR ROWLAND: I know that a number of states are looking at how to use their state employee contracting and Medicaid and the exchanges so that there may be some effort going on to really look at across-state payment policy.

Okay, Burt.

COMMISSIONER EDELSTEIN: Yeah, April, a couple of things about the dental carve-outs.

You went through the list and very persuasively explained why a state might want to carve out these other things -- behavioral health, nonemergency transportation, drugs -- but dental is really a core health service. And so it didn't fit your definitions of why a state might want to do that except for what I've reminded the Commission about so many times -- historical legacy or historical idiocy, whichever way you wish to look at that -- because, here, it's not really dental services; it's really the mouth that is excluded.

But you note that 25 states have carved it out but list only 7 states that have limited benefit plans.

But most of those 25 states are not running the programs by the state. They're running the programs in some form of a variant of dental managed care.

And I think the reason they don't show up as limited benefit plans is because the Deltas, for example, exist under different state regulations and different authorizations for their very existence and there are some dental plans that are considered in some states to be full insurance companies.

So I think we've got a terminology issue that's challenging here, in trying to figure out what is going on with these carve-outs for half the states that do so.

MS. GRADY: And, if you have any suggestions about where to find out which of the additional

states above those seven are perhaps falling into that category, it would be helpful.

COMMISSIONER EDELSTEIN: And then I think, in the end, we can't really use the same analysis for the dental that you're doing for the rest of the medical and that this is one place where it's worth doing a separate analysis just on dental plans and see how they are administered by Medicaid programs across the country.

COMMISSIONER ROSENBAUM: So I have two questions as much for us all as for you.

Thank you for this. It's excellent.

The first is, so how should we, as the Commission, be thinking about the premium assistance programs that are going to start, assuming that Arkansas doesn't melt down, but we'll see this in other states?

I mean, really in the end, the premium assistance program is a variation on the same theme. Do we include them as a -- and I realize that legally and statutorily there are things called Medicaid managed care. But, in terms of the functionality, should we be thinking about the premium assistance programs as they come online as we're thinking about Medicaid managed care policy?

That's number one.

And, number two, should we also be expanding our work in this area to be looking at how states are dealing with this question of multi-market plans because of the dynamics of enrollment in coverage, what multi-market plans look like, what the range of variations are?

I mean, some companies may really be offering essentially the same plan across both markets, with the same provider network and everything else.

Other states may -- in other states, they may be companies that are fielding on both sides of the divide, but they may not necessarily be totally aligned.

How are those plans even identified for people? Are there special standards?

But it's all sort of this -- you know, the problem we're in right now is that the lines are blurring big-time for us in terms of something as dynamic as Medicaid managed care.

And the question, I think for us, is whether as the Commission we start educating Congress about the range of possibilities. It's not just Medicaid managed care as defined in the statues and regs. We're talking now about a conceptual approach to the integration of financing and care. How should we be thinking about it?

COMMISSIONER HOYT: Given the scrutiny that the program in general is under, and MCOs in particular, I was thinking it would be worthwhile to try and collect financial data, if we're not doing that already. I think it's pretty common now for states to require plans to report annual financial reports on their Medicaid book of business in that state, maybe quarterly, unaudited data, but just so we could get a larger view on how they're doing, especially with expansion going on and all of that. That data should be out there.

I know CMS has had -- it's been forbidden to do cost-plus rate-setting, but it's a useful piece of information that I think fits in the context overall of what you're doing.

COMMISSIONER CHAMBERS: Thanks.

Of course, I'm always excited when we talk about this, but two things.

One thing is, as I was watching the slides, 2010 and 2011 kept coming up, and I know that's because the data are old. But, is there any way we can have data to inform the Commission as to what's really going on -- because, you know, the world has changed since 2011 in many ways, in many states.

And I just think as we look at, like, percentages of populations that are actually in managed care, different populations -- I think it's -- particularly with seniors and persons with disabilities, there's been a lot of change over the last years.

And then also, if it's a way of even tracking the states that are going out with RFPs -- I know there's

a number of states because our company is looking at bidding on RFPs in a number of states that are procuring managed care and don't have it today. I think it would be worth understanding that even if it's not like the official CMS-reported data because it's so old, that we would just have more current information.

So, just a thought of trying to figure out how it could be done to be able to inform us.

The second thing is when you had the review of oversight activities. Something I'd be interested in knowing is where in many states there are multiple regulatory agencies -- like in the state of California there's the Department of Managed Health Care, in which, as a managed care plan for Medicaid, you're required to have a license, and so they license managed care plans, and then you hold a contract with the Medicaid agency that has contractual oversight.

Just from a managed care organization's perspective, it's very frustrating as to who's enforcing what requirements. The licensing agency enforces the -- is the one that really enforces the access standards and making sure of network adequacy, but at the same time there are contract requirements that are being enforced, maybe with different standards.

So just what I'd be curious to know is if we're talking about the subject of oversight, how it really varies and are there any models of how it's done more effectively and efficiently because at the plan level it's not always very efficient because you're constantly having regulators come through, looking at the same things, and there's not joint audits and stuff.

But what would be interesting is if we're talking about what are our models, good models of oversight for managed care, how we could look at how it's done state by state.

Just a thought. It could be so difficult and so time-consuming that we don't want to do that, but just a thought.

MS. GRADY: Well, I'll have Moira follow up on the oversight if she wants.

But one thing I wanted to mention about the recency of data -- you are correct; we suffer from this problem and data lags in the Medicaid program.

One thing CMS is doing now is collecting monthly information from states. It's a pretty limited set of information on Medicaid enrollment, but it's more recent than anything we've seen before.

And, as I understand it, there have been some hiccups in standardizing the collection of that data. states are sort of overwhelmed with a lot of other responsibilities at this point, but I think going forward that's at least going to be something that's a more recent gauge of what's going on in the Medicaid program.

COMMISSIONER CHAMBERS: Just a follow-up is I get an e-mail newsletter from HMA that puts it out on a regular basis, and they do a whole section on what current activities are going on with states procuring managed care plans for different populations, if they're expanding, going from just TANF for SPD populations, or a state like North Carolina pursuing full managed care once again.

So there might be some other sources that aren't really official but just would help us be informed about what's happening.

COMMISSIONER CHECKETT: Actually, I enjoyed reading the paper. And I was so struck by, on page 3 out of 7, the share of Medicaid benefit spending on comprehensive risk-based managed care overall increased from 18 percent in FY 2008 to 22 percent in FY 2010.

And I read that like five times because, like you know, I thought I know my math isn't great, but am I really and understanding that correctly because I was so struck at how small that number is.

Yeah, I was just really taken aback by it.

And so I wonder in our look at this issue, if we don't need to look at -- I guess, in particular, I know some states have PCCM programs that they believe in, that are very successful. Georgia actually has an RFP out right now, where they're taking their entire ABD population and it's going to go into an ASO.

I think we just need to really continue to look at other options that states are doing. And I know in

our past we have looked at what's happening to all these people who aren't in anything, you know, who are in fee-for-service.

But it is just amazing to me that we have that small number of expenditures are under some type of comprehensive management program. So, just an observation.

COMMISSIONER COHEN: Thanks.

I also really enjoyed the paper and good -- you know, just sort of clarified some of our follow-up issues really well.

A couple of observations and questions -- and I have to recall to myself what they were.

So one of them was one of your examples about sort of varying oversight -- the example about -- well, one of your examples was that some states actually have a standard for wait times for appointments and some states don't, but then there was really significant variation even within those that did have standards, variation within that.

And I was thinking that we do have to be really careful in kind of evaluating difference in the standards because I think that may very well reflect a different attitude about oversight and minimum standards, and it may reflect the health care infrastructure that's beneath it, and it may be -- you know.

So, in that case, to really make a judgment based on those differences, you really have to have some comparative information about what private, you know, insurance wait times might be like or other sorts of things.

So I just wanted to flag that caution.

I also think that -- oh, I wanted to say I think this sort of like changed conception maybe of looking at all of at-risk on a continuum is so important and so good because in every, what we might call, comprehensive risk-based managed care program there are kick payments for a certain kind of service and little mini carve-outs here and there and there might be risk corridors or other things.

I mean, there really is no pure-risk, and there's no no-risk. And to think of it more on a continuum, I think, is really important. And to figure out some ways to describe that and talk about, I think, is really important. So I love that.

One feature there, of which I would say my own understanding is maybe a little elementary at this point -- one issue that I think is kind of interesting to understand is sort of timelines in setting premiums because I think in many states premiums are set and readjusted annually.

And that changes the nature of sort of like the risk, if experience is different than what was expected in multiple plans. Say, for example, rates are adjusted on the basis of that, but I assume there are also areas where the rates are set for longer periods of time and sort of risk is held longer.

And I just think that's sort of an important factor in thinking about really what is the risk here because risk is supposed to be the impetus for thinking about to maybe invest in services or other things, you know, up front that could potentially save money down the line. But, if your time frame is a really short time frame, that really changes the calculus of what the risk really means.

So I was just thinking that that sort of timeline and thinking an analysis might contribute to our understanding of that, if that made sense.

COMMISSIONER GABOW: I want to go back to the carve-outs for a minute. You were listing reasons why there may be carve-outs.

I think one thing that should be touched on in particularly, I would say, the behavioral health, substance abuse and pharmacy, is -- are those different delivery systems, and if they're different delivery systems, what is the data-sharing across them?

And the reason I think this is important to discuss is it actually gets to the core of quality of care so that when you look at the percent -- let's just take behavioral health, probably to include both psychiatric and substance abuse.

The percentage of Medicaid patients, as we know, who have those issues, is very high. If they're in different delivery models and there is no guaranteed mechanism for data-sharing -- which, usually in my limited experience, there is not -- this really has a huge impact on the quality of care that is provided.

Similarly, if you're a physician and you're taking care of a patient and you have no access to the pharmaceutical profile of the patient because the drug delivery system is in a different one, your ability to create high quality care for that patient is drastically impaired.

So it's not only managing the cost that becomes an issue. It's the actual delivery.

And, since we're really concerned about that, I think that understanding what really is meant by these carve-outs -- different delivery model, data-sharing. I think ultimately this would lead us to a conclusion over time that this is not in the best interest of the population being served, but we have to get more information.

CHAIR ROWLAND: Well, clearly, we are interested in learning more about a lot of the aspects of managed care.

And, as you go forward, I would also urge you to keep track of how the managed care plans differ by the population groups that are served. I thought that that slide was very important.

But, obviously, the range of services that some of the people in the disability community need are very different than some of the low-income children that are in there -- so, to really also be able to break that out by the populations that Medicaid serves.

But, thank you, and we look forward to continuing to be updated with more current data and more information. Thank you.

We're now going to turn to a discussion of Paying for Value in Medicaid: Lessons Gleaned from Advanced Payment Models in Four states, and I'm going to turn to Jim Teisl to both kick off this discussion and introduce our presenters.

Session 5: Paying for Value in Medicaid: Lessons Gleaned from Advanced Payment Models in Four States

* MR. TEISL: Thank you very much, and good afternoon to everybody. I'm joined today by Lynn Blewett and Julie Sonier, who are from the State Health Access Data Assistance Center at the University of Minnesota, often known as SHADAC. And SHADAC assisted us with the project that we're going to describe to you today to visit four states who are in the process of implementing initiatives that are often known as advanced payment models or value-based purchasing initiatives.

I'm going to kick off with a little bit of introduction, and then they're going to take over with the details on some of the states that we -- on all of the states that we visited, as well as some of the themes or lessons that sort of emerged across the states.

So the common goals that we're talking about when we're talking about these states implementing these programs is that they seek to contain cost growth and at the same time they're seeking to improve outcomes. They're typically looking to move away from paying based on volume, which is paying for each individual service that's delivered, and they also seek greater coordination in their health care delivery system or, you know, specifically we're largely talking about initiatives within Medicaid programs, but as you'll hear, some of these reach a little bit beyond.

Not surprisingly, states are taking a variety of different approaches to achieve these same common goals, which is the very reason that we decided to undertake this project. It was intended to better understand the specifics of a few different state approaches and identify some common themes, and I really do want to emphasize that our primary objective with this project was learning -- learning for ourselves, being able to bring the information to help all of you learn and better understand some of the things that states are doing, and to use it as a jumping-off point for work that we might want to pursue in the future. It wasn't intended as a formal research study or an evaluation of any of these programs or initiatives. So

we very much look forward to your thoughts on where we go from here.

I also should mention probably up front our intent is to provide all of you an overview of each of these programs, and also please let us know if there are details within each of these that you'd like to know more about. We spent two days in each of these four states. We met with dozens of different stakeholders and learned about I don't know how many different moving parts in each of these different programs. So to the extent there are things you'd like us to dig into a little bit further, we can certainly do that.

So health care payment reform clearly is a challenge for all payers, but as you're all well aware, Medicaid has some characteristics that may make it particularly challenging. You see a few listed here on the slide, including the populations that are enrolled, the limits on things like cost sharing, lower payment rates, although I would mention here -- and I think we'll talk about this a little bit more -- while lower payment rates might make it difficult to attract and engage providers, the prospect of even lower payment rates actually seemed to serve as an impetus to bring them to the table in search of something better or a preferable alternative.

I'd also keep in mind that all of the issues that we heard about in this morning's session regarding Medicaid administration very much play into the amount of work that underlies all of these things and the different things that states have to consider when trying to implement these type of big reforms.

So where did we go? We conducted site visits to four different states -- Arkansas, Minnesota, Oregon, and Pennsylvania -- to understand the factors that affected their choice of model and design, what was required to launch the initiatives, how does it operate, and how ultimately do they intend to evaluate it.

We tried to pick states that were some amount of the way into implementation, states that had gotten past the "talking about it" stage and were actually beginning to implement the reforms that they had in mind.

We also sought some variation in the types of approaches that states took as well as things like geography, et cetera. You know, it's not to say these are the only four states we're interested in. I could probably list off the top of my head ten more that we would like to go visit and learn about, but this is where we started.

We conducted interviews with state officials and stakeholder groups over two days in each state. We really tried to get a broad range of perspectives from a whole bunch of different stakeholders, and this is actually a good opportunity for me to thank the state staff that we worked with as well as all the individuals that gave their time very generously. We met with everyone from cabinet-level officials to staff on the front lines of these implementation efforts. We met with representatives of providers, we met with plans, we met with actuaries, other state consultants, and everybody was both candid and very generous with their time, so we thank them.

And with that, I'll turn it over to Julie to talk through each of the four.

* MS. SONIER: Thanks, Jim. So I will give some specifics on the models for each of the states, and then Lynn will tie it up with the themes that we observed across the states. So I'll start with Arkansas, and as Jim mentioned, in each of the states that we visited, it's important to think about the background and context for each of the states.

And so in Arkansas, there's no history of a comprehensive Medicaid managed care contracting and relatively little provider integration, and as the state sought solutions to a budget crisis, a stakeholder process resulted in a compromise agreement to implement an episode-based payment system to contain costs and improve quality because the stakeholders really thought that they weren't ready to go to something like an accountable care organization-like entity. They weren't ready to go to something that would really upend the whole payment system. They wanted something that was a little bit more sort of incremental in nature and that was going to help them make progress, but that would be still transformational but not sort of

something that -- something that they could -- something that they could do and make progress, but not overwhelming.

So the episode-based payment system that they implemented is statewide and it's multipayer. Eight episodes were launched during 2012 and 2013, and at the time of our visit in the fall of 2013, Arkansas was planning to launch six additional episodes in 2014, and I believe they have launched some additional ones early this year.

The episode-based payment system is part of a larger initiative that's called the Arkansas Payment Improvement Initiative, which also includes a patient-centered medical home and health homes for individuals with developmental disabilities or who need behavioral health services or long-term services and supports. Those two components were not a focus of our site visit because they haven't yet been implemented, and as Jim mentioned, we were trying to focus on things that actually have been implemented already.

So the episode payment model. The episode payments are retrospective, which means that during a specified performance period, payments are made at the normal fee-for-service rates, and there's a settle-up payment -- or there's a settle-up afterwards based on cost and quality performance.

Claims data are used to identify a principal accountable provider, or PAP, for each episode, and the PAP's performance on quality and average costs per episode are compared to benchmark levels. So providers whose…

CHAIR ROWLAND: Just for the record, would you give some examples of what the episodes were?

MS. SONIER: Sure. So, for example, they had eight episodes. One, for example, was a perinatal care episode, which covered all care up through, including prenatal care through delivery and postpartum care. So there was another one that was knee surgery, and there were others that were, like,

much smaller scale things, like tonsillectomy or upper respiratory infection. There's a full list. I don't know. Do they have a copy of that? So there's a full list on page 14 of the report. Do you want the whole…

[Comment off microphone.]

MS. SONIER: So total hip and knee replacement, attention deficit hyperactivity disorder, upper respiratory infection. So a wide range of complexity of conditions.

So once the claims data analysis has been done, the provider performance is compared to cost and quality benchmarks, and providers whose performance meets both cost and quality benchmarks -- so that means that they meet a minimum level of quality and their cost performance is better than average -- those providers are eligible to share in savings. Providers whose costs are deemed not acceptable must return a portion of the excess costs.

One other notable feature of Arkansas' model is that it's a multipayer model. So, in addition to Medicaid, two commercial payers that together represent 80 percent of the commercial market participate, although they don't participate in all of the episodes. So, for example, some of the episodes might be things that are much more common in a Medicaid population than in a commercial population. That might be a reason why they're participating, choosing to participate in some episodes and not others. But this is the only statewide example of a multipayer episode-based payment model in the country.

Other notable features of the Arkansas model are that it is flexible in the sense that the core components of the model are standard across payers while there are others that are flexible. So, for example, the same quality measures are used and the same basic methodologies are used across the episodes, but the specifics of the payment rates vary across the payers that are participating in the model. So, in addition, the model can expand over time to additional payers and additional health conditions.

Then, finally, it couples these acute-care payment strategies, the episode payments, with initiatives to

address population health, so the patient-centered medical homes and the health homes that I talked about earlier.

COMMISSIONER ROSENBAUM: Can I ask one question? In this model who is the payee? I mean, in some of these services, arguably there's one provider. But where you need multiple providers, who's the payee? And are there settle-up requirements by the payee with its sub-payees, you know? How does that work?

MS. SONIER: There…

MR. TEISL: I can start if you'd like. So as Julie described before, part of what they tried to do is they didn't want to force providers to establish relationships that didn't exist previously, and so that's what led them away from like the ACO-type model.

The fee-for-service payment model persists. Everybody continues to submit claims and get paid based on their fee-for-service. Based on claims analysis, a single provider, the one most responsible for the cost of care for that episode, is deemed the principal accountable provider, or if you hear Arkansas people talk about it, they frequently call them a "quarterback" of the episode, are the ones who are then responsible or ultimately able to share in the savings or responsible for returning a portion of the cost.

COMMISSIONER ROSENBAUM: And so the other providers just don't get paid? I mean, what if somebody's seeing multiple providers?

MR. TEISL: They do. Those providers continue to be paid fee-for-service for what they do.

COMMISSIONER ROSENBAUM: -- paid, but there's a principal provider that gets --

MR. TEISL: Correct.

COMMISSIONER RILEY: But can we just -- but the principal -- I've heard this from Andy, and I'm still confused. So the PAP, does the PAP have authorizing authority over services?

MS. SONIER: No.

COMMISSIONER RILEY: So they're not -- so they're the metric for the measurement for cost and quality. Everybody else involved in the episode gets just regular fee-for-service, but the PAP, just because they do more of it, is…

COMMISSIONER ROSENBAUM: [off microphone].

COMMISSIONER RILEY: So it seems to me illogical because unless they can authorize the services that are responsible for authorizing what's out there, I don't get this.

COMMISSIONER CHECKETT: This is disrespectful to our speakers, but I'm going to jump in because I really dug in on this. To me it's like baby steps. It's just very incremental payment reform. What can we do -- and when you look at the PAP, I actually -- it looks to me like a PCCM program, frankly, except we have shared savings. But it's moving forward. It's just it's tiny, tiny, tiny steps.

COMMISSIONER ROSENBAUM: Aggregating [off microphone].

MS. SONIER: I think that's accurate to say. In many ways it is a test, and to see, you know, what kinds of progress can be made and then, you know, to see how much it -- and it will evolve over time.

CHAIR ROWLAND: But one of the important aspects is it's also multipayer as opposed to just a Medicaid policy. Theoretically.

We're going to let…

[Inaudible comment/laughter.]

MS. SONIER: Excellent. Well, I'm about to move on to Minnesota, so if there are more questions about Arkansas later, we can go back to that.

So the health care and the Medicaid purchasing environments are very different in Minnesota compared to Arkansas. So, not surprisingly, we see a lot of differences in what Minnesota is doing.

In Minnesota, there's a strong history of integrated health care systems, a long history of Medicaid managed care, and several recent ACO initiatives involving Medicare and commercial payers. So the state

of Minnesota's Medicaid advanced payment model, which they call the Health Care Delivery Systems Demonstration, or HCDS, encourages the voluntary creation of ACOs within Medicaid. It's modeled on the Medicare Shared Savings Program, and very much so in order to encourage greater provider participation, in order to reduce the burden on them from participating by not having a parallel program that has different -- you know, slight modifications and different kinds of requirements that providers need to meet in order to participate in the very similar programs.

So in Minnesota's model, participating HCDS providers are responsible for the total cost of care for their attributed patient populations, and there are actually two forms of the model, depending on a provider's readiness to assume financial risk. So there's what's called a virtual model for smaller providers where there is upside shared risk only, which means that they get only shared savings, and there's an integrated model for larger providers where there's both upside and downside financial risk. In both of those two models, the shared financial risk depends on both cost savings and quality performance with the HCDS providers being held accountable for 36 clinical quality and patient experience measures.

I mentioned earlier that Minnesota has a long history of managed care contracting in its Medicaid program, and the HCDS initiative has been implemented both in the fee-for-service and the managed care populations as a condition -- and the way that that has been done is as a condition of contracting with the state, all of the Medicaid MCOs must participate in the shared savings component of the initiative.

As a final note on Minnesota, it offers an example then of a way that states can experiment with these new purchasing models for providers without upending their existing Medicaid managed care contracting mechanisms. It offers the potential for the state to combine its purchasing leverage for their fee-for-service and their managed care populations because they want to be sending a consistent signal to the provider marketplace and sort of leverage the size of their Medicaid population to the degree they can, as well as to test these new ideas before making major changes to their existing contracting arrangements.

COMMISSIONER ROSENBAUM: I'm sorry. Can I ask you one specific question on [off microphone] Minnesota? So essentially the state is going in and organizing the delivery system for the MCOs. Essentially the MCOS under their contracts, I assume, are expected to use this more organized system. The MCOs sort of take on a financial management role, but it's the state that's sort of doing this, whether it's direct contracts or via the MCOs.

MS. SONIER: Yeah, they're doing both. It's like a side-by-side model.

COMMISSIONER ROSENBAUM: Okay.

MS. SONIER: So moving on to Oregon, like Minnesota, Oregon is another state with a long history of managed care in its Medicaid population. However, like many other states, there was a growing frustration with cost growth and lack of accountability for quality and cost.

In Oregon, the context that led to the development and implementation of its coordinated care organization, or CCO, model began several years ago and is the product of very extensive stakeholder consultation. A significant state budget shortfall was also a major contributor to the enactment of Oregon's CCO legislation in 2012.

What CCOs are is they are community-based organizations that are governed by local partnerships among providers, community members, and stakeholders that assume financial risk. They are responsible for providing integrated physical, behavioral, and other covered services for Medicaid enrollees, and they're accountable for cost and quality outcomes.

So one question that I think is important is how are they different from the Medicaid managed care organizations that they essentially are replacing, and there's a few important ways that they're different. One is that they really replace what used to be separately contracted -- so the state used to separately contract managed care for physical and behavioral health, and now they have an integrated financing stream for that, so that goes to the issue of carve outs for physical and behavioral health that was discussed in the

last session. They're accountable for cost growth, which I'll talk more about in a second. There's a quality incentive pool, so that's sort of new compared to what used to exist in the old managed care contracting. And there's also community representation. So all of those things are new compared to the traditional managed care model that used to be in place.

COMMISSIONER ROSENBAUM: [off microphone]?

MS. SONIER: They do have to be a legal entity, and they do take financial risk, and they have solvency standards, yes.

So one of the most well known features of this Oregon CCO model is that the state negotiated an agreement with CMS that committed the state to reducing annual per capita cost growth in Medicaid while increasing quality of care and improving population health. The required cost reductions are one percentage point in the second year of the demonstration and two percentage points per year thereafter. The state is also accountable for 33 quality and access metrics with financial penalties for failure to improve over time.

In exchange for these commitments, Oregon gained federal approval to claim Medicaid matching funds for certain health-related services that have not traditionally been reimbursable, and the goal of these flexible services payments is to invest in things that improve health and reduce costs overall, potentially saving significant amounts of money for the Medicaid program.

The CCOs were launched in August of 2012, and by November 2012 there were 15 CCOs in operation serving about 90 percent of Oregon health plan members. In contrast to Minnesota, the CCO model in Oregon actually replaces its prior MCO contracting model as opposed to being sort of a side-by-side -- operating alongside what they had been previously doing. However, the former Medicaid MCOs have not completely disappeared from the scene. Many of them contract with the CCOs for support functions like claims payment or provider contracting, and some of them own CCOs directly --

some of them own -- yeah, so they're still very much involved.

[Inaudible comment.]

MS. SONIER: Yeah. So the fourth state, Pennsylvania, is another state with a long history of Medicaid managed care, although it has only recently been implemented statewide. One unique feature in Pennsylvania compared to other states is that Medicaid program administrators have significantly flexibility to implement payment incentives and policies without having to gain legislative approval.

So there are two types of payment incentives and policies that we examined in Pennsylvania. The first was pay for performance, which Pennsylvania has put in place both for Medicaid managed care organizations and separately for Medicaid providers. The MCO pay-for-performance incentives are primarily based on meeting HEDIS quality benchmarks. The separate pay-for-performance measures are incorporated into the MCO contracts, and they must be passed through to providers by the MCOs.

The second type of payment incentive that we studied in Pennsylvania was the use of targeted payment adjustments, and if you think about these two types of payment incentives, the first one, the pay for performance, is sort of like a carrot, and the second one is more like a stick. So as with the pay-for-performance incentives I just described, there's a health plan component here, and there's also a provider component here.

On the health plan side, there's an efficiency adjustment that reduces the base MCO rates using claims analysis for care that is considered to be inefficient. So examples of the types of adjustments that have been made include costs for hospital readmissions, overuse of high-tech radiology, and cesarean sections. The state has made different types of adjustments over the years, depending on what's a focus of concern at the time.

On the provider side, the state has also implemented policies affecting payment rates for hospital readmissions and preventable severe adverse events.

Three other notable features in comparison to the other states that we visited include, first, the fact that the reforms in Pennsylvania were largely implemented within the context of an existing Medicaid managed care program; second, the fact that there's significant control at the state agency level which allows the program to be extremely responsive to stakeholder input and changes in the health care environment; and then, finally, the fact that it targets both MCOs and providers and addresses a variety of areas of health care.

So, with that, I will turn it over to Lynn to sort of synthesize the themes across the states.

* MS. BLEWETT: Thank you very much, and we're just delighted to be here. We really enjoyed the study and getting to know these programs.

Just two sort of high-level themes that we learned while we were out there. There were a couple states that were very focused, Oregon in particular, and Arkansas, on the reduction in the FMAP from the ARRA-enhanced FMAP rate. And so there was a looming budget crisis that they were facing that motivated and got players to the table because of that crisis. But there were other states -- namely, Minnesota -- who initiated their HCDS payment reform in the context of paying for value and doing things differently, and it was in a budget -- they basically said we're going to do this in a budget-neutral way, which got the players and the stakeholders to the table. So it wasn't all a budget crisis issue. I think some of the -- you know, Minnesota in particular, Oregon, again, wanting to be lead states and to be out front on payment reform. So there's a lot of different incentives for why the states are pursuing these models, but I think the budget conditions were certainly one, but not the entire motivation.

I think, too, that three of the four states had very well developed managed care organizations and managed care penetration, and what you're seeing is really a change in the role managed care is playing in these different states and very different approaches to the use of managed care. So in Minnesota, you see the state going -- and I think what you're seeing is the state wanting to work more directly with the

physicians and, you know, aligning the incentives at the physician level and getting closer to the point of care. And so you see that in the CCO model where it's at a community-based county level. MCOs are doing more claims processing, TPA kind of activities. In Minnesota, the incentives go directly to the providers and are kind of parallel with the -- they still have their HMO contracts, but they're also now contracting at the provider level. So it's like a parallel function.

And I think in Pennsylvania you're seeing not much of a shift in their managed care, but sort of almost underneath trying to initiate change, you know, underneath this managed care construct. So it's very interesting. While some states have no managed care and are thinking let's go, you know, whole heart into the managed care arena, the states that have managed care are saying, well, what else can we do to get change in our system, both from a quality perspective and a cost perspective?

As I say, the states are really trying to influence provider behavior and change -- align incentives and get providers to think about quality and cost and to get value for the dollars that the states are paying. Medicaid costs continue to grow, and there's increasing -- with the expansion, I think there's intense legislative interest in getting value for the amount that they're spending.

So the data are really key to facilitating the improved care delivery, so in all of the cases, particularly Minnesota, Oregon, Arkansas, the idea is that the providers are going to get more information from the state in terms of their Medicaid claims, where the Medicaid patient is going. And the idea is that the Medicaid patient, as Sara was saying, doesn't always use just the main provider. They use a lot of different providers that are still in a fee-for-service or maybe even outside of the managed care network. But the key provider will be getting and the Health Care Delivery -- HCDS in Minnesota will be getting data that incorporates all of those different pieces. So that was, again, in Minnesota in particular, an incentive for the providers to come to the tables, like you can give us the data -- we only have data on the Medicaid for when he's in our system. But now I can get all of the information on that particular patient. So I think

there's a real incentive for the providers to get to the table because of the data component.

Now, having said that, it's unclear how -- I guess it's still in the developing stages. So Minnesota said they're going to do monthly reports. I think, you know, the devil is in the details, and they're just getting underway now. But I think that's the incentive, is to have states think about data differently and providing the providers the information they need to manage their care.

Another clear message that we've learned is that one payment reform will not fit all states, and you can see we did four different states and very, very different models, a lot depending on where they're coming from in terms of their health care markets, their role of managed care, their leadership, stakeholders. I think in each state we found, you know, key leadership and interest in pursuing these models, but very, very different approaches.

States have then balanced this flexibility with accountability in securing stakeholder buy-in. So states often would come to the table with their approach, but to get the stakeholders to participate, that changed, you know, over time. And all of the states really have involved a lot of stakeholder activity that has influenced how they're implementing, but also is key to whether it's going to work or not, because in all states the players, the stakeholders, the providers, the payers are at the table and participating in the model. So that's a key component.

Several of the states -- two states used state plan amendments. Oregon used the waiver approach. Pennsylvania's doing their models based under existing authority. I think that the state officials have viewed CMS as being very helpful, and it's, again, this balance of having enough flexibility to fit your model into your state. But CMS has also -- for Oregon, Julie mentioned they have to report on 33 quality metrics. They also have, you know, reporting requirements for Arkansas. So there is some accountability built into some of what they're doing with CMS, and so that was another kind of theme, is that CMS has been helpful and flexible, but also requiring some accountability.

And then design -- we heard a little bit of this in the morning of designing and implementing these requires state staff time and resources, and as we all know, there's a lot going on in states these days, and for many of these states -- and Minnesota I can speak personally -- you know, we only have so much of a workforce, especially when it's 15 below and you're trying to recruit analysts to your state. Please come.

[Laughter.]

MS. BLEWETT: That's why we like to come out here. It's nice and warm.

[Laughter.]

MS. BLEWETT: But it does require significant startup costs and ongoing funding and training, and you can see -- I think we think of Minnesota and Oregon of having some infrastructure and having an ability to implement things. Arkansas, you know, they rely -- they have a very large contract with McKinsey, which was stimulated by the SIM requirement -- again, outside contracting. So, again, it really requires some build-up of staff and training to have the capability to implement.

As you are all aware, you know, I think states in this group and others are -- almost all payers are trying to figure out what's -- you know, how can we leverage our payment policy to transform the health care system and get more value out of what we're paying for. And so I think you're seeing -- what we've seen is like states are still trying to figure out what works, what doesn't work. Is it managed care? Is it pay for performance? And I think states are trying to do different things and leverage and get closer to the point of care, aligning the physician incentive with their own incentives to increase quality in an efficient way.

And so most of the significant -- but, on the other hand, most of the significant cost drivers -- behavioral health, long-term care, disability -- they're still outside of the framework, although in Oregon they are, you know, folding in the behavioral health and oral health. So some of the tougher nuts to crack are not being addressed, I would say.

And then we haven't really seen a lot of results yet, so it's early in the implementation phase. I think we were all surprised. We thought we might see more sophisticated analysis of what they've done or have more information. They're really just starting to get off the ground.

Some early results in Oregon, some results show some early lower ED use, lower prevented hospitalizations, but, again, that's preliminary, and really we're looking -- you know, we're waiting to see how these things all play out.

And then the data infrastructure, there's kind of two pieces to the data infrastructure. One is the clinical and the claims data for providers to use to manage care, to have more information about their patients, what they look like, where they're going, what the costs are. So that's kind of at the clinic level. But then also aggregate overall, how is it changing the system? And what is CMS going to look at or what are you going to look at in terms of has this changed overall costs? Or what are the cost drivers, and has it changed overall the trend in Medicaid spending?

So lots and lots of -- we learned a lot, but also raised a lot of issues, which are, you know, what are the policy levers that can be used to spur innovation? I think for each state it's going to be unique, but these were a pretty interesting group of -- a mixture of states. I think some of the levers might be useful. In other states there could be some lessons learned. How can CMS encourage states to use the flexibility while getting some information that you can use to compare across states? I think that's always a challenge in Medicaid. How do you compare Medicaid programs that are so different?

And then what is the federal government's role in aligning objectives for payers and programs? I think where we're drilling down to the state level and then to the provider level, and the CCOs are now at the community level, and that's a pretty far long ways from the federal government. So, you know, what's the role of the federal government in providing enough flexibility but also, you know, assuring accountability?

And then how should value be defined and measured to assure consistency in evaluation? That's something we continue to struggle with. And the evolution of managed care organizations, what are they becoming? And where do they fit in these models? And is it still managed care but we're calling it something different, or is there different -- April said there might be, you know, a continuum of managed care, there certainly is, but in the Medicaid programs, and how they share risk and pay providers.

And then how can we think about, you know, integrating the other non-acute services with the Medicaid program? And how can we use payment reform to think about some of those other -- like Oregon's trying to do, which is to expand what they're paying for beyond the acute-care bundle, but to think about as a holistic approach to caring for Medicaid patients.

So, with that, I will conclude, and, Jim, do you want to take questions?

CHAIR ROWLAND: Well, thank you all very much, and we've interrupted a few times, but I know we have many more questions. So I will now start with Mark, and I'll note Mark, Donna, Judy.

COMMISSIONER HOYT: I had two questions. The first was about Arkansas. Given how fundamental maternity is to a Medicaid program, I guess I was surprised that they didn't go broader than just perinatal care. Maybe it's the baby steps answer, but it seemed to just so naturally give itself to an analysis of the overall costs in maternity with maybe the typical kinds of metrics of C-section rate or low-birthweight babies, babies going full term, things like that. Why didn't they do that or aren't they doing that?

And then the second question, if I can, was tied to Oregon.

CHAIR ROWLAND: [off microphone].

COMMISSIONER HOYT: Okay.

MR. TEISL: Yeah, I definitely can't speak to why they didn't make the bundle sort of more extensive. I know that -- and Lynn alluded to this -- a massive amount of work goes into defining these

bundles, convening provider stakeholders to get consensus around the definitions, the costs that are included, outliers, where the thresholds will be set, all these different things.

I think their intention is to build this program over time, so, again, I can't necessarily speak for why they didn't make this one bigger. I actually just heard an anecdote that the governor of Arkansas shared last week at a meeting I was at, but he talked about an OB/GYN in the state who had been practicing for a long time and was very sort of angry about this because, you know, preliminary results showed that he was going to be over the threshold and have to return costs. But it caused him to go back and sort of talk to his staff and with his practice, and he found that he was sending apparently -- and some of you know more about this than me. Every placenta was being sent to pathology, and that wasn't necessary. And by just stopping that one thing, he actually fell below the threshold and will be eligible for savings. So that's an example that I'd pass along, but…

COMMISSIONER GABOW: Just a clarification. That wouldn't be part of prenatal care.

MR. TEISL: Yeah, yeah.

[Inaudible comment/laughter.]

COMMISSIONER HOYT: The second question, I was fascinated by the stories on Oregon, and I asked you some questions about CCOs before. I'm not as current as I used to be on Oregon, but I'm just going to paint that generally as some mature managed care environment, and to me I was just literally shocked that you could refabricate that somehow and drive 1 or 2 percent savings per year on top of what had already been in place. There must be something about the infrastructure of the CCOs that I'm not getting that implies there was either some falling down before that has been fixed or -- how are they designed to manage care more tightly or coordinate care better than was being done previously beyond just the integration of the services?

MS. BLEWETT: You know, I think the idea is that the community care organizations have

incentive -- have local incentive to control costs and to take care of their population. So there's population health measures involved. And so I think their idea is, again, to get closer to the point of care and having a community group look at the metrics and look at the population and trying to get the population healthy, in addition to, you know, being allowed to provide different kinds of services within that medical care dollar. And so I don't want to -- now we have the placenta anecdote. We could do the air conditioner anecdote that their governor uses. I guess it's very useful for them to have it, but of a person who kept going into the hospital because she had asthma during a heat wave and, you know, ended up in the ER, and their solution was to just buy her an air conditioner and reduce -- you know, prevented this hospitalization.

So I think it's getting to a population health model is their focus and goal, and then putting that budget constraint closer to the point of service, but I don't know if you guys want to add to that.

MS. SONIER: I think that's a good example. It's sort of one of the popular examples, so it's going beyond the thinking about health care as just health care. It's all of the other. So they have this chance to think about social services, particularly in the CCOs that are being run by counties where some of the counties have really viewed this as an opportunity for the counties to achieve savings by integrating with all of these other services that counties typically provide. So, you know, just as services and sort of if they're taking that much more holistic approach to really achieve savings or buy -- and get better outcomes across a much broader range of things.

COMMISSIONER HOYT: So a clarification then. Is the 2 percent savings measured against Medicaid only or is that sort of recalibrated around all the money that's being spent like you just said?

MS. SONIER: It's Medicaid only, so it's against a base -- so it was against a 2011 baseline projected Medicaid spending, and so they've -- so the 2 percent savings is Medicaid spending needs to be, you know, two percentage points below what it would have otherwise been projected to be.

MR. TEISL: One other thing I'd highlight, if I can really quick -- and this is to build on a

comment that Lynn made -- is that the folks at the state really emphasized the importance of sort of moving this budget, this global budget down to the community level and pushing the budget conversation down to that level, so that rather than having providers individually negotiating with the managed care plan, they had a group of providers sitting at the same table negotiating sort of the budget distribution amongst themselves, and they thought that a lot could be gained from that.

COMMISSIONER HENNING: I'm really excited to see more and more states taking a look at quality and associating that with payment, because I think that that's one way we can really get improvement, and quickly, in the Medicaid program, and not just in the Medicaid program because I think it's going to -- if we improve Medicaid, it's going to help the whole health care system improve, because you can't just improve your practice for Medicaid patients and not also end up improving it for everyone else that you treat. And I also think that if you don't measure it, you're not going to improve it. So I'm really excited to see that trend.

As far as maternity care goes, I think the big three are really the C-section rate, reducing pre-term birth -- that has a really large potential to save a lot of money, and not just money but just anguish on the part of families that have to deal with having a pre-term infant and all that they go through for the rest of their lives -- but also breast feedings rates. And I haven't heard a whole lot about breast feeding, but breast feeding -- and maybe that goes into our population health that we're going to be doing later this afternoon. But breast feeding has the potential to really increase the health of our population tremendously, and it's just not -- I mean, it's just not acceptable, the rates that we've got in the United States right now. And there's so much that could be done to help make that better.

COMMISSIONER MOORE: Well, Denise said something that I've been thinking, or a slight variation on it. And listening to you all describe these four states takes me back probably about 20 years to when we had a whole lot of big 1115 demonstrations in Medicaid around Medicaid managed care, and it was

going to save the world or this state or that state or the other state, and we had a lot of national conferences around evaluating them and so forth and so on. But, in fact, we did learn a lot from those, maybe near or maybe not as much as we spent on them, but we learned a lot from them. And it strikes me that these four states are doing things that could impact not just on Medicaid but on the larger health care system. And I may have missed it, but I -- and I don't know about Pennsylvania, but are the other three on CMMI SIM grants? Or are they -- how are they -- I mean, could this be taken as a larger national look at changes to health care delivery being driven by Medicaid?

MS. SONIER: They all are on CMMI SIM grants, so Arkansas, Oregon, and Minnesota are test states, which means they each got $40 to $45 million.

COMMISSIONER MOORE: Oh, yeah. Now I remember reading that.

MS. SONIER: And Pennsylvania was a design state, so they got about $1.5 million design…

COMMISSIONER MOORE: Yeah, I thought I had that in my head, and it was in your paper, right. Okay.

The other thing I wanted to ask about is the lack of attention in changed payment models to -- or the seeming lack of attention to LTSS, and it strikes me that in LTSS you are going at service delivery reform in a different way. You're looking at managed long-term services and supports. You're looking at all the initiatives in ACA and the ones that came in different -- you know, go back a few more years, Money Follows Person and all of those kinds of things. So that that might be part of why you don't see payment reform like this in, say, the nursing home world or something; rather, that states are looking to reform payment in long-term services and supports in a different way.

On the other hand, there are still an awful lot of states that have an awful large nursing home population, and I wondered if you had seen or heard of any payment reform movements and initiatives in some of those areas.

MR. TEISL: Yeah, I think that's something that we'd have to follow up with you on.

COMMISSIONER ROSENBAUM: Yeah, just to follow up, I guess to ask an obvious question, I assume in something like the Oregon demonstration that the terms of the demonstration that they're operating under are letting them plow revenues in real time into things that are normally not allowed as medical assistance expenditures. So can you describe sort of the parameters of the flexibility for me? I mean, is literally anything that one of the CCOs thinks might improve health a permissible expenditure under the terms of the waiver? Or are there limits on -- you know, can they pay rent? Can they buy food? I think about Jack Geiger buying firewood for people, you know, 50 years ago in the first community health center and getting yelled at by the CEO for buying firewood, and food, paying grocery bills, and when he got yelled at, he said, "The last time I looked, the way you treat malnutrition is with food."

So I'm just wondering what the range of permissible expenditures is and whether the demonstration is set up to test different kinds of inputs and whether they affect cost.

MS. SONIER: When we were in Oregon in October, they were still in negotiations with CMS about a couple of things related to that. So as far as we know, they hadn't -- the CCOs weren't able yet to make those payments so -- because they had to work out a way to account for them. But, in general, the payments must be health-related, but they could be for an individual or they could be population health-related. But that question about whether it could be food, we didn't ask, you know, specifically what's the definition of "health-related," but this larger question about how are you going to account for them and all of that, I mean, there's…

COMMISSIONER ROSENBAUM: And bill for them.

MS. SONIER: Yes. So there's a -- there was still quite a bit that needed to be worked out.

COMMISSIONER ROSENBAUM: [off microphone] didn't ask only because they hadn't arrived

at the parameters of the definition yet.

MS. SONIER: Right.

COMMISSIONER RILEY: This is fascinating. I think all four of these are really intriguing efforts and cutting-edge stuff, even though as we raise questions about them.

I'm thinking most of them are multipayer or will be, and I'm thinking about the data -- and Lynn Blewett is -- I'm the chairman of her fan club because she can explain data to me like nobody else can. So I have a data question. As you think about moving in a multipayer platform where you need to get claims data and quality data and get the attribution right about who the individual provider was, how do you do that? And is it a public function or a private function? In our state it's a big debate about who ought to be doing this? Should it be the provider? Should it be the HIE? Should it be this all-payer database? How is it done? And who do you think is the most appropriate arbiter of those claims quality analyses?

MS. BLEWETT: I'm going to let you down, Trish.

[Laughter.]

MS. BLEWETT: So sorry. You know, I think that it's kind of the devil's in the details, like where is that going to happen, because even in a state the claim -- you're right, the claims data is separate from the HEDIS-measured quality and linking those up. So I think, you know, we've been thinking a lot about the all-payer claims databases as the opportunity to de-link those, and that's kind of -- that's where my thinking is at this point.

And I understand that, you know, there is -- the private sector is moving into that arena with Fair Health and then the HCCI and then United Health Labs. But for many states we still -- for many of those, they don't have Medicaid data. For many of those, they don't have state identifiers. And so those I think are not going to be, you know, viable for many states.

So right now I think, you know, if there's a way to integrate through an all-payer claims where you'd

have all of that information…

COMMISSIONER RILEY: [off microphone] Would there be -- do you see any policy issues and concerns about giving a private sector entity access to the Medicaid data?

MS. BLEWETT: I -- I don't know what -- I don't know the -- what do you mean?

COMMISSIONER RILEY: Well, if instead of an all-payer claims ...

MS. BLEWETT: Because they – yeah…

COMMISSIONER RILEY: If they wanted all the Medicaid data, if I'm a private sector…

MS. BLEWETT: You know, I don't see a problem, no. I don't think they're -- yeah.

COMMISSIONER CHECKETT: Well, a fascinating discussion, and I really just want to make a couple of observations.

You know, if you think about it, in state government, which, you know, states are terrific labs of innovation and creativity, but the one program that legislators and governors can do things to is Medicaid. If they like do things to, you know, hospitals and providers, there's this great big pushback because there's -- you know, there are financial and business arrangements, and how much can you overstep your authority as a legislature. But you can come up with these fantastic ideas for your state Medicaid agency.

The problem is so often -- and I think we see it even with some of the payment reform -- that the money that's going with it is so small that I think it's going to be a challenge for some of these initiatives to be as impactful as we would like them to be. When you're paying a P-A-P or a PAP $5 a month, it really is PCCM with shared savings at the end of it. And what Aetna has seen, we've done -- you know, we've participated in a number of stakeholder meetings and plans in states and large payer -- you know, the payers I think are very excited about payment reform. We know fee-for-service is, you know, perversely incentivized, but it is -- also we have to partner with our providers, and it has been I think in reality difficult to get a mass of providers to sit with us and for us to be able to, you know, do the technological aspects on

our end to really have significant change.

I think and I hope we will get there, but, you know, even when I looked at recently, you know, how many ACOs do we have as, you know, one of the biggest insurance companies in the country, where we actually have significant numbers of people involved, it's extremely small. I mean, some of them it's 50 and 100 people. Staying with PCMHs, you know, we've got a handful around the country. We're all for them, you know, and I'm being full disclosure here, but I think, you know, my colleagues from other companies would say the same thing, you know, but in reality the numbers just continue to be very small. We have to start, we have to move forward, but I just think it's a lot to change. So for what it's worth.

COMMISSIONER GABOW: I have two comments. One, to just think about the name, advanced payment model, I wonder what our definition is, because if one of our goals has been simplicity, I would say most of what you described is going backwards in a payment model.

Just to talk about Arkansas for a second and maybe the others, but as you point out, Jim, the amount of effort that has to go into creating a bundle for which there is not even a designated prospective person in charge administering the bundle, and you wonder, the savings has got to be de minimis, but the cost of implementing and managing and settling retroactively, I would say that's not an advance in my view. And just your discussion about Oregon, certainly people would say the more integrated and inclusive we are about what is in the delivery model for health is an advance. But when you can't even figure out what you're going to pay for it a year after you've started the project, it shows the complexity.

So I think we need to think a little bit about -- words matter, I've always believed, and I'm not sure I would call at least some of these…

CHAIR ROWLAND: Do you want to call them new?

COMMISSIONER GABOW: Well, I don't know, but I think that we should point out that these are adding complexity, and for, I think, Donna's point, small numbers of people. So that's my first

comment. And you know I'm a simplicity girl.

The second comment I would make is we have heard over and over again that -- and this whole discussion today underscores this -- the states need flexibility because the health care environments in the states differ dramatically. But I would just underscore somehow or other they're all having Medicare patients, and they've managed to live without flexibility to care for a huge population of often high-cost, complex patients, without reference to the fact that, well, in my state I have this kind of environment, in your state you have this kind of environment. And I don't see most of them walking away from Medicare.

So I just wonder if there is some -- I think there's a problem here. Maybe I can't articulate it well, and maybe somebody who's better in language can do this. But I think we've over permitted this need that my environment is different than your environment, and -- because for some things we've managed to not have a difference.

COMMISSIONER ROSENBAUM: Well, I think -- I mean, the interesting thing is to sort of parse out what you're saying because you made so many, in my view, astute comments. I think the environment issue is not really the environment the way we're thinking about, you know, how many counties and how big is the population. It really is the culture, the underlying culture of medicine in certain localities. So, clearly, in Arkansas, where there has been no Medicaid managed care market at all -- the Medicaid program has just not even done the things that 30 states have been doing for a long time, which, of course, is just one big bundling. I mean, that's really all an MCO contract is. So here I think the environment is this issue of how do you take a culture of clinical institutional providers -- and the thing that I find striking about it, though, is that it doesn't seem to be head on tackling the very issue that you would want in a first step, which is to get people to work together, precisely because there's nobody, you know, really in charge.

But what is striking about it, I think, which tells me everything about why they're doing it this way, is

that it's multipayer, meaning that for every payer in Arkansas, they're all at this very early stage. Nobody in any market seems to have much, you know, of sort of integration going on.

I think the other thing that strikes me about it -- so I think there's that. I think that's to me a legitimate environmental issue. What is the culture of health care in these environments? The other thing that I think is a legitimate and longstanding issue -- I mean, it has been an issue in the Medicaid program for the whole life of Medicaid -- is the frustration that Medicaid programs feel with the fact that medical assistance is defined in a way that parallels insurance. You know, it's medical care, items, and services. It's not food. It's not air conditioners. An air conditioner is not durable medical equipment.

And so it might be helpful as we build on these case models to get more granular in our language and more exacting in, you know, what exactly is going on here, because, I mean, Judy made the point that some of this is, you know, 50 years old in Medicaid. People were upset about no air conditioners or food, you know, as in Jack Geiger's case, 50 years ago. But I think there is a reason why it's valuable to know how wildly different the environments are. I mean, in Minnesota, you know, the thought that you can't -- you don't have integrated delivery systems, I mean, it's hard to believe that Arkansas is in the same country in terms of the culture, the culture of medicine there.

COMMISSIONER GABOW: But they do manage to live with a national plan with a different culture of medicine. So I still think my underlying comments stand.

COMMISSIONER HOYT: One follow-up question on Oregon. Do the CCOs -- are they discrete or do they compete with each other, at least like, say, in the Portland area? Are they paid the same? How does that work?

MR. TEISL: I think that there was one -- I think in most communities, there was a single one, and there were a couple cases where there were more than one.

MS. BLEWETT: Yes. They are county-based, so there is one in each county, and then on the

Western side, there's a multi-county one. But they do compete.

MS. SONIER: Yes, and there is competition, particularly in the Portland area.

COMMISSIONER HOYT: But they're paid the same?

MS. SONIER: Yes.

COMMISSIONER HOYT: Is it a global budget or are they capitated?

MS. BLEWETT: Capitated, per member per month, I think.

MS. SONIER: They negotiate rates with the states, though.

MS. BLEWETT: Yes.

CHAIR ROWLAND: Well, obviously, this topic is one that we're very interested in. I want to commend you on the background paper and on your presentations today. I think they have been very helpful to laying out a lot of these issues and we'll continue to work through them and try and really get some more information on how these models are working as they go forward a little more, and so thank you very much.

We'll now take just a quick ten-minute break.

[Recess.]

CHAIR ROWLAND: Okay. If we could please reconvene, Commission members.

VICE CHAIR SUNDWALL: Take your seats, please.

CHAIR ROWLAND: For the record, let us note that Patty obeys, once in a while.

[Pause.]

CHAIR ROWLAND: Thank you. One of the major issues that we are struggling with is how to better integrate Medicaid and population health and public health, and I am pleased to welcome our panel today to continue our discussion on this important topic, and I'm going to turn to Amy Bernstein of the staff to introduce our panel.

Session 6: Medicaid and Population Health

* MS. BERNSTEIN: Thank you, Diane.

As you may know, last February, we began an exploration of this issue of population health with a presentation from representatives from the state of Washington and their efforts to integrate public health into the Medicaid program and vice-versa. We have been charged with producing a foundational chapter on this topic and I thought I would just leave you -- I am going to leave in a second -- with a definition of -- not permanently, just back to my wall -- a definition of what we might mean by population health in this context.

And just to put the definition into the record, we're referring to population health here, and it's also referred to as the health of the population or the public's health, not public health, as the health of a population as measured by health status indicators and as influenced by economic, social, and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services, and I think you just heard in the preceding discussion that health is more than just the provision of medical services, as in air conditioners and the things that were just talked about.

And so we have assembled this panel to talk about the many different things that influence the population's health and I'm going to turn it over to them. Let me just introduce them briefly.

We have Dr. Sara Wilensky from the George Washington School of Public Health who will talk about clinical preventive services.

We have Dr. Stephen Cha, who is the Medical Director for the Medicaid Program at the Centers for Medicare and Medicaid Services.

And we have Alice Burton, who is presenting work she did with the Nemours Foundation on population health initiatives and integration with Medicaid.

So, I am going to turn it over to them and go back to my wall.

* MS. WILENSKY: Thank you very much. It's a pleasure to be here. I want to talk to you today about a project that we did last year, about June to November of 2012, looking at coverage of preventive services for adults in Medicaid.

We were approached by these funders to take a look at these services, in part because under, as I'm sure you're well aware, under the Affordable Care Act for many insureds now have the requirement that they can receive United States Task Force Preventive Services A and B recommendations without cost sharing, but that is not true for existing Medicaid beneficiaries, and so they were concerned about the potential discrepancy between existing Medicaid beneficiaries and expansion Medicaid beneficiaries, let alone others in private insurance and Medicare, so they wanted to see kind of what was the state of the world at the moment and whether this was going to be a big discrepancy or not.

Specifically, we looked at 24 of the A and B-related services and whether these are covered preventively. And while this may be obvious to a group such as this, what we found out is that there is a significant lack of knowledge about the difference between prevention and medical necessity, and so we really focused on the preventive coverage. For example, every state is going to tell you they cover a diabetic screen, but not every state is going to cover a diabetic screen preventively and so we were trying to make sure that we could understand that distinction.

We looked at a few specific treatment items. We looked at requirement differences between fee-for-service and managed care programs, specifically, comprehensive managed care programs, not PCCMs, because that's where we found the biggest difference in terms of which services would be covered or not. We looked at requirements in order to get an understanding of state policy, not always exactly what managed care companies would do, because many managed care companies go above and beyond state requirements in terms of things they might offer to beneficiaries. We also looked at restrictions such as

cost sharing and prior authorization as well as information provided to beneficiaries to understand what kind of knowledge they might have about the services that are available to them.

We looked at all 50 states and the District of Columbia, looking at both documents available, publicly available documents, as well as a follow-up phone call to all the Medicaid agencies to fill in gaps or further understand things that were not quite clear in their Medicaid documents.

You are probably aware of a Kaiser Family Foundation report on the same issue, looking at coverage of adult preventive services. You will note that we have very different findings in a number of areas because of our methodology is different. We were much more restrictive in terms of what we gave a "yes" to in terms of what equals coverage, and a lot of this, again, has to do with the prevention versus medical necessity discussion that I'll get back to in just a minute.

Overall, we found that it was actually very difficult to determine what states were covering in terms of these Task Force preventive services. There's a number of reasons for this. There's a lack of detail that's provided, whether in the Medicaid provider information, whether it's the manuals and regulations, wherever the state might have it, as well as in the beneficiary information. Beneficiaries usually would get a member handbook that at most would say something like, we cover a variety of preventive services, such as mammograms, and that would be it.

So, in many states, they use language such as "age-appropriate screens" without any definition of what that screen meant, without any standard of care, age-appropriate screen following the Task Force standard of care or following ACS standard of care, just this general language. Sometimes, there was a standard of care generally provided for some things, not for others. There was a lot of variation.

There is also, in terms of this confusion about prevention versus medical necessity, a lot of states provide something along with a quote -- something along the lines of, "preventive care for age-appropriate screening as long as it's medical necessary," and that's literally what they would tell us. And we said, well, it

can't be both. It can't be both the prevention and medical necessity, and the conversation somewhat stopped there.

So, in terms of the personnel in the offices, the insurance language related to medical necessity and prevention has not been clearly translated into the administration of what they might and might not be covering.

Clearly, the confusion about exactly what's covered has implications for population health. I mean, you can't be your own health advocate if you have no idea of what your rights are, in terms of saying, this is the type of service I would like to receive as a beneficiary, and for us as researchers, how are we going to be able to tell what is effective and not effective if we don't know what's actually happening on the ground.

Other findings we had related to the coverage of services. It's Medicaid, so you're not surprised to hear that there's a wide variation in coverage among the states. There are only two states, Maine and Nevada, that we felt like we could unequivocally say they cover all the Task Force A and B-related services, not just the 24 that we looked at, but all of the A and B-related services. Other states will…

[Off microphone.]

MS. WILENSKY: Yay. Other states, some of them told us they covered all the services, but again, upon further inquiry, we found what they really meant was if they covered the service, they covered it according to the Task Force recommendations, not that they covered all the Task Force services.

Some covered all but a handful. Colorado was one of those, and they were looking into whether they wanted to cover all of them in order to get the one percent FMAP incentive. Other states hardly covered any at all, and so there's a wide variation.

We found for some of the services, there was a limitation related to family planning, meaning you only could receive those services as a family planning visit. That has more restrictions than would be intended in terms of providing general care, because everybody might not qualify for family planning

services, or even if they do, they might not think they qualify and they may not look to go to have those services.

Some of the services that we looked for were rarely covered, and there's a slide later just to give you an example of those.

We found some differences between fee-for-service and managed care in terms of coverage as well as standard of care. So, for example, you might have a different standard of care in the same state, whether it's fee-for-service or managed care, but not as many differences as I would have thought. It might be because so many beneficiaries are in managed care, especially in terms of those relevant to these preventive services.

Here's an example. We have lots and lots of numbers we could talk about, but this is just to give you an example of a few screenings that are some of the more commonly covered. And even these are not 100 percent covered. So, there is a big surprise that three states do not cover screening mammograms, all right. They'll cover mammograms diagnostically, but not as a preventive screen. Most states do cover it. And we say "likely to cover" in a handful of other states, meaning they use the age-appropriate screen language. So, we couldn't tell you for certain they cover it because there's no list that says they cover it, but I would guess, if anything's age appropriate, a screening mammogram is probably going to be in that. The same with colorectal cancer screens and cervical cancer screens. Most states cover it. A handful, we assume were likely to cover it. A few states don't.

And you can see most states offer some type of standard of care. Some Medicaid agencies develop their own. Some rely on the Task Force. Some rely on American Cancer Society. Some rely on multiple ones, even if they're not exactly the same, again, creating some confusion about exactly which claims might be covered.

In terms of the family planning limitation, this came up with both STD and HIV screens as well as

cervical cancer screens in a few states. I also put some details under the STD-HIV just to show you how complex some of our findings were. So, you could see routine STD coverage without any qualification, such as if you're pregnant or particularly high risk, those type of things. It was in 12 fee-for-service states and 19 managed care states. And family planning for STD in 12, HIV in seven. But there were also four that had age-appropriate screens, which may or may not include them. It wasn't always clear whether an HIV screen was included in an STD screen -- it wasn't specifically listed -- but it was routine in nine in fee-for-service and 15 in managed care.

So, it was just all over the place in terms of the kinds of things we were finding.

In terms of the other preventive services that are less likely to be covered, you can see less than half the states explicitly cover these various services that I put here. I didn't put blood pressure screening, which I think was about 14 states. That doesn't mean they don't cover them, and a number of these might be covered as well adult exam or in an age-appropriate screen, but again, we couldn't tell you with certainty that they are covered because that information was not available.

Speaking of well adult exams, in terms of actually accessing preventive services, so not just simply having the coverage available, we thought it was very important to look at do states cover a well adult exam, a basic check-up where you don't have a specific need. We found more states than we thought covered it, so 39 states had a well adult exam, but that still leaves a good number of states that don't.

If you take a state like Arizona, which has had Medicaid managed care forever, you would think of them as a good prevention state. They don't have a well adult exam. So when we were talking to the folks there, they were, like, will they actually access their screening mammogram? We don't know. If they have some other reason that they get there and then they get that referral, maybe they will. But if you don't have a well adult exam, that could be a significant access issue.

In the states that did have a well adult exam, 12 had a specific set of services, so they made us very

happy as researchers. We could say, this is what you cover. Twelve -- not the same 12 -- followed one or more specific guidelines, again, Task Force, ACS, or something else. But 19 states used this general age-appropriate screen language based on a generally accepted standard of care, whatever that might be. Twenty-five states charged a copay for well adult exams, and those states were most likely to charge for other preventive services, as well. And, as I mentioned before, even with managed care, a lot of not specific information available to beneficiaries.

In terms of things that you might want to think about and focus on in the future, and I think some of these things, CMS is looking at already, or is ongoing right now, are these preventive service kind of design flaws in general, just the lack of information. That is something that should be able to be clarified. The confusion about prevention and medical necessity has to be clarified in order to really get a sense of who has what coverage available to them.

When we looked at and talked to the folks about whether they were interested in the one percent FMAP increase in order to encourage them to take on all the Task Force services, most of the people that we talked to were not familiar with it. Now, other people in the agency might have been. We weren't talking to the Directors. But the people we talked to weren't familiar with it. A handful of states were, and four of those states had looked at the numbers and said it doesn't give them enough money for providing the services without cost sharing. So, that's an area to look into.

Again, the importance of well adult exams. The fact that there are limited differences between fee-for-service and managed care is good to know. And, I think there clearly needs to be improved beneficiary information if we want to help people take responsibility for their own health.

And then one thing that I didn't put on here, which I think would be really interesting, to do a similar discussion from the provider standpoint. What do they think is covered? What do they understand in terms of the flexibility they have about which standard of care they can follow? What do

they tell their patients in terms of the claims that they think are going to be paid?

So, there's lots more we can talk about, but I'm happy to answer any questions. Thank you.

VICE CHAIR SUNDWALL: Thank you very much. I'm just delighted to see this panel presenting to the Commission, because as my fellow Commissioners know, I've been talking about this for years and I'm just real pleased that we're paying some attention to it.

Your data is very interesting, but I have two questions that popped into my mind. You made a point about they're not covering adult well exams, and, in fact, the National Preventive Health Services Task Force doesn't recommend those on an annual basis. In fact, it's quite infrequent. I mean, you can have them, but the payoff of doing an annual exam is not considered worth it. There are, of course, the very specific recommendations for screening, but could you just comment on your focus on a well adult exam? Would that just be a one-time thing, or a periodic thing based on risk? I'm not quite sure why we would be interested in covering an adult physical exam for screening purposes.

MS. WILENSKY: Sure. No, and I didn't mean to imply that it was a Task Force-recommended service. Absolutely not. It's not one of their recommended services. But it's a vehicle that we thought would be important for beneficiaries to be able to access the screenings that are available.

So, again, you take somebody who should be getting a screening mammogram. When are they going to get it? If they are able to get to a doctor through the Medicaid program for an acute care need, the likelihood that their provider is going to say, oh, here's the list of screenings that you should be getting, as well, is very low, and some of the research has shown that. And the ability to take time off to go get another medical appointment to follow up on these things, and combining the fact with they just have no information, I mean, even if they wanted to say, I want to take control of my health. I want to get everything I need.

VICE CHAIR SUNDWALL: Sure.

MS. WILENSKY: This information is available to them. So, given this population, we thought it would be an important recommendation in terms of actually accessing preventive services.

VICE CHAIR SUNDWALL: I'll just close -- just my last comment is that there's a wonderful tool that ARC funded. I have an app on my smartphone that I only have to just access that, put in the age of my patient, gender, whether they smoke, and whether they're sexually active -- just those four data elements -- and up pops all of the recommended screening. Sometimes, it's just very little, depending on the age or those associated factors. But it's a great help to clinicians to know what we should be attending to. And so I think that you couple a knowledge of what is appropriate for age-specific men, women, whatever, with a coverage issue, it would be very powerful to promote screening, appropriate preventive services.

MS. WILENSKY: Mm-hmm.

CHAIR ROWLAND: And that's a great transition to our next speaker from the dental, Stephen Cha. Welcome.

* DR. CHA: Hello. Thanks so much for the invitation to be here. It's a pleasure to talk with you all, and especially about this topic. We have a ton of interest and, I think, I'm going to just take a little step back from where we've been and talk a little bit more generally about where we and Medicaid have been thinking about this.

I wanted to key off of something that Amy and Amy's introduction, which was the health of a population as measured by health status indicators, both influenced by health system and as beyond a health system. I think that's a definition which, I think, synergizes with where I'm heading for this talk, and I have the same app and use it nearly every Tuesday night when I see patients.

First of all, the Medicaid and CHIP, what is the relationship here? We are a joint state-federal program, as you know, across our partners. Almost 60 million rely on us. I think Amy was the one to point out that this stat isn't accurate now. It's 48 percent of births now, one out of every four kids, and the

largest payer of mental health services, with more low-income adults to come this year.

I point out these facts, which are obviously to all of you on this panel, I know, but just to highlight the fact that when you look at those factoids and you look at the population we're serving, I think you have to think -- at least, our take-home message here is that we cannot think about being successful in the Medicaid program without thinking about from a population health perspective. I would also say the converse, as well, which is that I think we've been interfacing, interdigitating with our population health partners because I think broad population health efforts probably will not be successful without really integrating and tackling the Medicaid population, as well. So, I think the point here is that this isn't an option. It is something that we feel is imperative to the nature of the population we serve.

One more step backwards, how this fits into our larger program. I think you've probably seen these slides from Cindy or me or some others a few times, but this is our efforts to be leaning forward in terms of being better partners in innovations with state plans, partners, and stakeholders. The three legs here: Our process improvements for states and providers, I think many of you are familiar with; our process and coverage improvements for consumers, which dominates the headlines these days; and a third pillar, which is delivery system reform, really trying to think about how we leverage forward the system and trying to improve this.

So, let's talk about delivery reform for a second. I think on this slide, you'll see some of the common things we often refer to when we talk about delivery reform -- health homes, integrated care models, shared savings, bundling. I think many of you are familiar with that. We've been doing a lot more work around these in the last couple years, put out a series of letters, both informational bullets and state Medicaid directors, more substantive partnerships with our states to try and elevate and promote these kinds of models.

But I want to point out that, again, these are payment changes, and we cannot be successful in these

payment reforms without really trying to think about how we are actually changing the way we actually deliver care, that payment reform has to be accompanied by delivery reform. And again, when you think about our populations, it is trying to think about how we can be successful about all of these strategies.

And so when we try to think about this -- this comes to the box in the middle of the slide -- this model of better care, better health, lower costs. I would just again remind all of us that better health has always meant improving the health of a population. It has never been about the health of the patient in front of you. It's always about how do we improve the health of the populations that we serve.

And then the seamless set of services issue is that we recognize that there are silos that exist here, and our job is not to actually remove those silos. I think sometimes, and I think as touched on in the last conversation, there are efforts, and I think we are experimenting where Medicaid takes on more responsibilities than might otherwise be suggested otherwise. But I think our focus here is really trying to think about not eliminating the silos, but really trying to connect the silos, establishing that seamless set of services across the silos, that different groups and entities have their jobs, we want to work with those different groups and entities and connect the dots so that sometimes we find gaps and sometimes we find we're both providing services.

And I would point out again that there are language barriers here, too, when we talk about translating to population health. What one world might call care coordination, another may call a caseworker, another may call primary care case coordination. There are a lot of different -- another one might call wrap-around services. There are a lot of different lingos to describe a very similar set of actions and we're trying to ensure that, in fact, the beneficiaries are getting the most efficient delivery of those systems in the best way possible.

So, the point here is that we have to have every tool in the toolbox, and part of those tools are about population health, that in pursuit of that improving population health and improving health is about a wide

variety of tools and not just the health homes, integrated care models, but things that happen underneath that. How is actually care being delivered and changed?

So, you'll see a few examples here, and this is just quick hits. Many more, I'm happy to talk about. But just in the time allotted, I just wanted to hit on a couple points very quickly.

Early elective deliveries, and again, I also want to make clear, we from CMCS are not claiming credit for any of these, but rather, I think, we're taking our job in terms of how we can promote and understand how we can best support these kinds of practices, understand from our partners what's working and not working from our perspective, and try and disseminate and share that knowledge.

So, early elective deliveries. We're seeing Ohio with a hard stop policy, decreasing their early elective deliveries from ten to seven percent in Medicaid. Interestingly, the private payers started even above ten percent and are now leveling out at that seven percent level, as well. So, you're seeing this sort of floor for where that's heading towards, and I think it's indicative of the uniform success that they're having in some of those policies.

Arkansas, again, not only a hard stop policy but payment changes, as well, an increase in 39-week deliveries and a decrease in 37- to 38-week deliveries. And, I should say, both of those were accompanied by broad sort of public and patient engagement strategies, as well, again, trying to bring to bear other resources and tackling those strategies.

Behavioral health and substance abuse. This is a SAMHSA grant program that saw in nine states community approaches that reduced suicide for kids by as much as 64 percent.

Washington's strategy decreased frequent ED utilizers, I think, and many of you are familiar with what they did last year in terms of coming out with the seven-point strategy, trying to reduce frequent ED utilization by 23 percent.

And I should also mention on this front -- actually, on both of these fronts -- we have an

informational bulletin from CMCS highlighting both the behavioral health aspect in terms of how you can promote those programs if you're in Medicaid, and just last Thursday, we released an informational bulletin on reducing inappropriate ED use on that second point, and it did mention the Washington strategy.

Tobacco programs. Clearly, this is an area of interface. Massachusetts saw a return on investment of three-to-one, I think many of you are familiar with. I also wanted to mention here in terms of -- and I will mention it again on the next slide, but this is an example where we, CMCS, sort of recognized how we can, in fact, be a better partner here, and I'll talk about that in a second.

Super-utilizer programs. I think many of you have heard and talked about these, as well, but just one quick snapshot, and we also have an informational bulletin out on this piece, as well. North Carolina Transitional Care Program, which was after our super-utilizer informational bulletin -- this is published in Health Affairs -- decreased readmissions by 20 percent.

And, finally, you just talked about the Oregon system, and again, I think I caught a little bit of that conversation in terms of the pros and cons and the CNOMs, but broad reforms utilizing community health workers. The point here with this bullet is that we need to think comprehensively about how all these tools fit together and bring to bear all the various tools in our quiver and all the tools in our toolbox.

So, what are we doing? We have seen those snapshots of success from our state partners and we're trying to be better partners from our shop, as well. So, first is leveraging resources across silos, and again, that's this idea that we're not trying to do everything, but trying to connect the dots in a more substantive fashion.

In the case of tobacco quit lines, I think we did release a state Medicaid directors' letter that said, in fact, we recognize that these are an efficient way to provide services for our beneficiaries. We recognize that they're incredibly successful in terms of helping our beneficiaries quit. So, in fact, to the degree that your tobacco quit line, which is traditionally considered a quote-unquote "public health entity" is providing

services for our Medicaid beneficiaries, we are willing to pay our fair share for that program.

The next bullet is really working across agencies, and I just want to highlight here the incredible collaborations that we've had the pleasure to be participating in with CDC, with HUD, with EPA, with all the various partners, with ARC, all the various partners across the administration in terms of bringing examples forward, trying to work collaboratively and find the best practices and find ways we can support those.

Reducing barriers to collaboration. I think the state qualified providers of preventive services, I think we received input from Nemours, from TIFA [phonetic], from a lot of our state partners, including an NGA letter that said, you have a policy that says you will not pay for services unless they're provided by a licensed practitioner and there are multiple examples of where there are strong prevention models provided by qualified providers who happen not to have a license.

And I think in recognition of this, in the July rule of this year, we released a rule. In that rule was a provision that stated that we will provide for preventive services for providers that are recommended by licensed practitioners so long as they are demonstrated to be qualified by the state. And, it's not an open game. It's not saying that we're taking all comers, but rather saying we recognize that licensure is not the one and only bar that states may use to demonstrate qualification to provide preventive services, so opening the door for states to come in with that.

And again, the integrated care model letter series, which I know many of you have heard about on past occasions. I am happy to talk about that more on questions.

We're also doing our part to facilitate learning across states. In innovators, we're standing up a Prevention Learning Network. Seven states are already participating, and I think we're trying to do our part to, again, facilitate that learning and best practices across the country.

We're facilitating adoption across our programs. I think that within the context, again, of that

broad delivery reform conversation, as many of you know, many states are coming to us with keen interest in delivering payment reforms. And I think rather than the question of how is this consistent with our regulations, I think one of the first questions we're now asking is, how is this going to improve the health of your population, and we ask this not to just try and keep states guessing at what we're trying to think. I think we put out a lot of letters that indicate this is the first question you should expect.

But, rather, it is that sometimes states come to us and say, we want a waiver, or we want this type of spa, and then when we start to dig through and see what their actual program goals are, I think we've been more creative in the past few years about trying to say, well, there might be a better tool for that, and I think it is more trying to be a better partner to our states in terms of the goals that we all share together.

And, finally, the state Innovations Model. Twenty-five states, all with a goal of 80 percent of populations within each of those states. It's an aspirational goal, and certainly not every state is there, but I think it underscores the degree to which our partnership with CMMI has really blossomed into a full-fledged partnership, trying to think about how do we connect the dots between CMMI and CMCS in these programs.

I think we also recognize we've had limited progress in the state Innovations Model so far. I'm going to be frank about that. But I think we're trying to recognize those and trying to think about how we can move forward in terms of being more productive and have a more stronger and a more fulsome partnership with our CMMI partners and our state partners.

One second on the state qualified providers, because I'm sure this will come up in questions. We did issue this final rule on July 15. We also just released an informational -- I shouldn't say "just" -- released an informational bulletin in November, highlighting the final rule. And, essentially, the purpose of the rule was to align the regulations on providers at 42 C.F.R. 440.130, which, again, stated that it was for a licensed provider with statutory provisions, particularly the ones surrounding the USPSTF A and B services.

And I think there's recognition that a lot of USPSTF A and B services are, in fact, provided by, as defined by USPSTF, by practitioners who are not licensed. So, again, now they can be recommended. But, again, the state must provide a description about how those practitioners are, in fact, qualified.

So, I'll just end with this slide, which is that we cannot do this alone and we are keen to continue our partnerships, both across the administration and with partners across the country and with you all in terms of, both, one, feedback on programs. And when I say "data," it both means specific numeric data, but also the kinds of stories and the kinds of programmatic data that we know we need to understand to be successful. I would, again, point to that provision on state qualified practitioners as an example of how we're trying to listen and be responsive.

The spread of models, that as we learn from all these models, they have to be spread, and we need to understand how we can be better partners in terms of what we need to do to eliminate those barriers or sometimes do a better job of promoting those.

And, finally, transitions. I think it would be remiss of me not to note on some sympathy with our state partners that it's an enormously unique time, I should say, for our state partners. And, I think, as we move into this year, we continue to support the efforts of our partners to try and think about negotiating the challenges of transitioning this year.

But I will also note that many of our state partners are, in fact, in the door to us, thinking about not 2014 but thinking about 2015 and trying to think about now that we're doing this expansion, or even if they're not, how do we think about the next challenge of how do we manage this population in a more efficient fashion.

And so, again, just to close, I think we definitively see these as part and parcel of our whole effort in terms of Medicaid moving forward, in terms of our whole effort in terms of the three-payment delivery reform, that this is a set of tools and a set of toolboxes that we want to be sure that we all keep open and

that involves partnerships in a new way, and I think we are committed to those partnerships and it takes more work and I think we're committed to those, and often more meetings, and we're committed to those, as well.

I appreciate this chance to talk to you all about this and happy to answer any questions.

CHAIR ROWLAND: Thank you very much.

And now I am going to turn to Alice Burton to share with us the Nemours work. Thank you.

* MS. BURTON: Great. Thank you for having me here today.

I'm honored to be here, and I'm filling in for Debbie Chang who has really led some work in bringing early education and early child health leaders together around prevention services.

And she asked me to do a paper last year, which I think picks up on the theme that Dr. Cha mentioned about working across silos.

And Debbie's group of individuals that she that she brought together -- the Community Outcomes Project -- were public health leaders, were early education leaders, non-Medicaid experts, and they really were looking for opportunities to work with Medicaid, to partner with Medicaid, recognizing that they had resources, particularly for children, for child health, that were so very important.

And this Medicaid thing was this maze that I think is fair to say was frustrating and overwhelming, and the paper that you have was an attempt to break down that maze and to break down some myths around how to work with Medicaid and to explain Medicaid, essentially, if that can be explained.

So I'm actually going to go on to explain Medicaid.

This is a slide that I have obviously borrowed from the Kaiser Foundation on Medicaid and the Uninsured. I use it when I talk to non-Medicaid audiences about Medicaid. You all are obviously a Medicaid audience, but to the non-Medicaid audience I think the top parts of this chart are understandable; its role in coverage is understandable.

I think what's less clear to non-Medicaid audiences, to non-well versed in Medicaid, is how Medicaid is used in the health delivery system, how important it is to the safety net.

And the statistic where it's 16 percent of national health expenditures -- if you look at it in certain communities or if you look at it by certain provider types, it becomes a very different kind of factor.

Also, I wonder if we're at a time now when we might be thinking about -- this group may be thinking about, essentially, adding a box here to this chart, which is, what is Medicaid's role in supporting population health? Is that a new area, a new box, that ultimately gets added to this matrix of what is Medicaid and how do you explain it to different people?

So what are some potential opportunities?

Obviously, the expansions that are happening in many states that have chosen to take up the opportunities under the Affordable Care Act have changed the shape of Medicaid in some communities, in making it even more of an insurance resource in communities. So now it may not just be children who are covered, but it's now children and their moms and their dads that are also covered by insurance.

There's a whole realm of nonmedical services. You heard the discussion of air conditioners before. And what the boundaries of what these services are and who those providers for those services are, to the regulation that was just talked about before, I think are important to think about in this context of what is Medicaid's role going to be in population health.

What's its role in education and counseling for Medicaid or a broader population?

And what are the data that support and connect Medicaid to these other data sets?

I heard earlier discussion about paired claims data.

How do we bring data and information together and share it to really achieve some population health goals?

And, ultimately, what is Medicaid's role in addressing social determinants of health? How far --

what are the boundaries of Medicaid?

I think we're in a new time and a new opportunity to address those kinds of issues.

So the paper that I did essentially was trying to explain Medicaid to a non-Medicaid audience and trying to help them to understand how you might leverage and work with Medicaid to do some of the things you say you want to do. It identified five myths and gave examples of how to do that, and I am going to go through them actually very, very quickly here.

The first was -- and this paper was written prior to this regulation that Dr. Cha spoke about being finalized. Actually, I think it was even produced before it was proposed.

The first myth was that you really -- Medicaid can't pay its nontraditional providers. There's just no opportunity to do that.

And we actually looked at a couple of places where states were doing that. They were doing it in the context of old regulatory authority. I think there's actually more opportunity to do this now.

But we explained how the state of Minnesota was working with community health workers, how they had created a state plan amendment to use community health workers under their Medicaid program. And I actually think the work that they did is a good example for other states that are looking to do this in the context of the new regulation because they tackle the same kinds of issues that other states will have to tackle.

How are you going to identify who should be a provider that you would use? If it's not licensure, what is it? What kind of certification requirements or educational requirements?

VICE CHAIR SUNDWALL: Alice, that didn't require a waiver?

MS. BURTON: They did it under a state plan.

I think the key phrase here is that they only allowed the services to be billed when they were under the supervision of a licensed provider. So they were really using an existing Medicaid authority and sort of

taking it up to the next step.

This new regulation will allow different opportunities to do that as well.

The second myth was that services can't be paid for in nontraditional settings, and the classic example of this is home visiting programs. There is lots of interest from many in home visiting programs and a sense that we want Medicaid to cover this home visiting program and a feeling like that's an overwhelming task.

And we had a couple of different examples. There are many more of them we articulated in the paper.

But I think the key to this is Medicaid does cover services outside of a clinical setting. Medicaid can cover services provided in the home.

But it's not about it being a home visiting program. It's about: What is the service? Who gets it? When?

You have to think like Medicaid and define that service in a Medicaid context. And some states have been successful in being very specific about what aspects of home visiting services are covered by Medicaid and how they should be covered.

The third myth was that Medicaid can't pay for nonmedical services, and we looked at a couple of examples where states were using Medicaid. In both of these cases, they were using waiver authority to cover environmental remediation services. For asthma, I think were both examples, or lead abatement for children in the Rhode Island example.

So they were expanding the definition of what Medicaid services and what is a medical service.

The fourth myth was that Medicaid only pays for services to enrolled individuals. And the classic example here is that a child is enrolled in the Medicaid program and their parent is not. And, how do you address issues of maternal depression or other matters when the parent is not covered?

And we looked at an example where Illinois was allowing for screening, just screening, of maternal depression to be billed under a child's Medicaid eligibility. So they were providing a service, and it could be perceived that the service is to the parent, but it really was billed under the child's Medicaid eligibility.

I think this issue will change dramatically as the expansions in Medicaid happen and more adults are enrolled in the Medicaid program.

We also provided examples of where Medicaid is using either CHIP funds or administrative dollars. To do more broad social media campaigns for teen health was the example that we included.

And the final myth that we talked about was a state can't pay for nonstatewide benefits.

I sat in on the earlier panel and listened to the discussion of Oregon and heard the word, local, local, community, community. I hear that word all the time these days.

Local community leaders often say to Medicaid, oh, it's a statewide program, and it's very daunting to try and figure out how to do a very unique local option that may be funded with local resources.

But there are examples of how states have been able to use local resources and create pilot programs in local areas to leverage and work with the Medicaid program, to provide services to Medicaid individuals.

So the paper that I did, again, was about myths. It was supposed to be educating about Medicaid. But I couldn't do the paper without talking about integrated payment models and different managed care models.

And, again, I walked in at the tail end of your prior panel and was really interested in hearing about the new -- that there's a whole new set of these very bold reforms that are happening.

I felt like there's a long history with Medicaid managed care that really could provide some lessons. Again, this was not the purpose of the paper, but it was some context that we did include in that.

Some states have very, very, very mature Medicaid managed care programs, and still, it's a challenge sometimes to fund this community-based population service. And, why? Why is that the case?

Well, part of it, I think, is that the cost of new prevention services are often not built into capitation rates. It's a very fundamental decision and often a question that every MCO executive asks -- is it in my capitation rate? Then I'll pay for it.

And that relates very much to the length of time that's necessary for them to recognize savings from it, if they're not paid for something.

How long is somebody enrolled in a managed care program, and how long will it be before they really can recognize the savings that would accrue from community-based population health prevention programs?

Other more subtle ones that I think are important are some health plans have very proprietary approaches. So, when you talk about we want to do this local community in this, you know, you use the local community multiple times and you say you're doing something across the providers and coordinators. It's hard because they have a model of disease management or care coordination that they want to use, and to make that highly localized is challenging.

And it also can be challenging to use a different set of public providers who have maybe not partnered with managed care programs before. I think this has changed a lot in the last 15 to 20 years, but there are certainly still providers that don't know how to bill the Medicaid program, or it's a daunting task to work with the Medicaid program.

So, to the extent that we think there is a whole network of providers that haven't worked with Medicare and that are available, there's work to have them understand contracting with managed care plans, to have them understand the billing structures and all that goes with that.

When we looked at all the different examples in how states overcame myths, one of the keys was there was some organization, some individual -- we called it an integrator -- that was essential to bridging the gap between the dialogue of Medicaid and public health and prevention, and that integrator provided a

sustained leadership and was able to bridge the gap across the system. It is really an essential role in local communities, to driving and connecting the dots on change.

So Nemours is continuing to do work in this area, in the effort to cut across silos. They convened their early education and child health leaders and Medicaid leaders to develop pilot Medicaid reimbursement initiatives. They have talked about a number of different ideas and mostly are focused on trying to identify opportunities where community health workers could be used across the different programs.

You know, there are still challenges that remain to that. One is the Medicaid complexity and working through that. The billing issue that I talked about with billing providers, the issues around return on investment, and figuring out how to develop the principles around training and certification for these new types of providers I think will be challenging, and also having to navigate the boundaries in the relationship with the existing medical community and how that works.

So the conclusions we had for this paper were really that states have been successful. They've used many different approaches to secure Medicaid financing for community-based prevention. They've been very different in different states, and they've used different opportunities and different leverage -- different existing policy leverage -- to do that.

Obviously, we've all said that the goals of Medicaid and public health leaders are increasingly aligned and that the Medicaid could -- I would say should -- evolve as it moves forward to address population health.

I believe these integrated payments, both the managed care models as well as the new models that you heard in your prior panel, hold great potential and great promise.

I do think there's a challenge in how we evaluate them and the expectations for them and the aggressive savings targets may lead us to look to the low-hanging fruit of super utilizers and things like that versus longer-term prevention strategies around children and other things. So I think there are both.

And, ultimately, I think the success in bridging the gap between public health and Medicaid and truly creating a population health program really requires developing, particularly on the public health side, significant programmatic detail and understanding of what they're trying to do with the Medicaid. It requires sustained leadership and partnership between those types of organizations to succeed.

Thank you for having for me.

CHAIR ROWLAND: Well, thank you, thank all three of you, for your comments and for beginning our discussion on where to go with population health.

Certainly, the fact that there's wide variation across the states is reemphasized once again in your comments, but I think it also shows where there are models that could be learned from and complexity that could be reduced.

And, with that, I'll take questions.

Denise, do you want to start?

COMMISSIONER HENNING: I think this would probably be best to Ms. Wilensky.

So, in reading your paper, the ACA -- I didn't get that. I didn't realize that the expansion population would actually have access to things like vaccines and the existing Medicaid population would not. To me, that seems really strange.

MS. WILENSKY: It is strange, yet true.

[Laughter.]

MS. WILENSKY: But, yes, for the expansion population, they're eligible for essential health benefits which includes the preventive services requirement, but that's not true of the existing program.

So what they did for the existing Medicaid program was offer a 1 percent for preventive services increase in your FMAP if you agree to add all the preventive services, but again, it doesn't seem to be financially a win. It may be just there to bring your attention to the attention.

COMMISSIONER HENNING: I know in the state of Florida I'm dealing with pregnant women, and the flu vaccine -- they just decided to cover that for pregnant women, which is like woo-hoo. You know.

However, they don't cover pertussis. You know. Go figure that one.

And that's for pregnant women only. So I still can't get people that are not yet pregnant the flu vaccine or pertussis…

MS. WILENSKY: Right.

COMMISSIONER HENNING: …without going through or jumping through a bunch of hoops to get it through the vaccine manufacturers.

MS. WILENSKY: And others here may know why better. My guess is they didn't want to put another mandate on states in the whole ideological discussion of what should the federal government do and what should the state government do.

But, yes, it does seem to be quite a gap that most others are going to be covered this way.

COMMISSIONER WALDREN: Yeah, that brought up one of the points I was going to say.

I like your idea of talking to the physicians. I would also add kind of the billing manager piece into that, to get that looked at, because all the data we have gotten thus far have been kind of at the mouth. The documentation -- I mean the head of the river. This gets towards the mouth of it.

And it also brings up this issue, too -- that as a doc, how would I know if they're an expansion Medicaid patient versus another Medicaid patient? And, if I've been denied in the past, why would I try to do it and then get caught for the costs and submit a bill again?

So I think you'd find out that maybe some things that are covered, but are changes, that people are not doing.

The other thing that would be interesting -- I don't know if we could look at it -- is how many claims

processes are out there for Medicaid, and could you look at denial rates and actually readmittance rates to see that these are actually being utilized and paid for, or was there actually denial so that you actually know that won't be paid for?

That would be interesting, but I like the idea of the survey.

MS. WILENSKY: Yeah, it would be interesting to see where the end result is because when I talk to the folks in the Medicaid office and they tell me, well, it depends on what the provider says, then I say, well, does it depend on which standard they use? Well, it's up to the provider.

And so it would be interesting -- who is making these final decisions and how consistent are they.

COMMISSIONER ROSENBAUM: Sorry I had to step out for a minute, so I don't know if my question got asked.

But, in light of Sara's research, how -- do you, Steve, see any need for some additional clarification for states around the preventive benefit expansion option?

One of the things that struck me -- and you point this out, of course, in the article and in your remarks -- is, in fact, a lot of confusion on the part of states themselves as to what it means to have a preventive benefit covered. It means without a medical indication.

We had back -- I can remember 30 years ago a directive or guidance going out on EPSDT that a screen could not be subjected to medical necessity because it was by -- in and of itself, medically necessary.

And I'm just wondering, given what you found, whether there might be -- it might be wise to do an additional explanation of what it would mean actually to add these procedures, you know, because I think a lot of states believes that they don't need to take the option because they're already covering preventive benefits when, in fact, from this most excellent, you know, real drill-down on the issue of coverage, we discovered that actually they probably, in some cases, are not.

DR. CHA: No, I think that there's a lot of confusion out there, and I think that -- I will say one

thing, which is I want to concur that I think the provider look would be really helpful, and I think it would be really good to see underneath the hood, what's actually going on.

MS. WILENSKY: We accept grant funding.

DR. CHA: We are not a grant-making organization, as many of you know.

[Laughter.]

DR. CHA: But I will say that I think we put out guidances on the preventive services implementation. I think we just put out another one.

That one in November also contained information in terms of, just as an example -- we don't plan to do this every time, but just as an example, in this transition year, pointed out that HIV had just become an A&B recommendation and sort of explained what that meant in terms of implications for payment programs.

Again, we don't plan to do that every time the EPSDT updates, but we recognize this is a transition time, and we're trying to help our partners understand what's going on.

You know, some of our state partners will tell me when I ask them, after the study -- and I think you saw some of this in the press -- some very reliable state Medicaid directors who said, I don't think this is a problem.

COMMISSIONER ROSENBAUM: Right.

DR. CHA: And so, you know, I'm not sure what to make of that. You know. And I don't mean that positively or negatively.

Some of these people I really know quite well and trust a lot. So I honestly don't know what to think of that.

I think, ideally, we have clear coverage and it's uniform across the country.

I think in this transition point I think we've done what we can to provide clarity about what our

policy is and what the law is.

And I think as we get more information -- and I think that's part of the point of the Prevention Learning Network -- is to get a better sense of:

What are your real hurdles going on?

Why aren't you, for instance, taking up the 1 percent? Is about the juice isn't worth the squeeze, or is it something else going on there?

And I think we're eager to learn from these interactions in terms of what would be most helpful from our partners' perspective and the providers' perspective and especially the benes' perspective, to actually make this delivery a reality.

I'm not 100 percent what that next step is, but I think we're open, absolutely.

COMMISSIONER ROSENBAUM: Can I just ask one follow-up question -- which is, of course, your study focuses on procedure code by procedure code, whether the procedure is covered as a basic Medicaid state plan item.

Do we know, going back to the managed care discussion we had before, the extent to which managed care organizations on their own, especially as they're now moving toward alternative benefit plan design for the newly eligibles, you know, along with the traditional eligibles, where there will be coverage for all of the U.S. Preventive Services Task Force?

Are they just going to align the coverage up to that standard on their own?

Will this be -- will there literally be one preventive benefit for the newly eligibles and one for the traditional eligibles, literally, in the same product?

Do we have any sense at all of how that…

COMMISSIONER CHECKETT: I would say that we will do whatever the state puts in the contract.

I am sitting here, just wondering, you know, myself if the states are even focused on it, and I'm not sure I want to ask the question.

But, no, it's a fascinating and terrifying thought.

DR. CHA: I would just point out that there's the other potential. And not to be Pollyanna here, but just the other potential here is that the plans -- because the entire world is going a certain -- certainly, for the plan. I don't know fee-for-service, and it's not a ball of wax.

But for the plans, the entire plan is going another way. The world is going another way.

And it may be -- again, I don't want to speculate too far. It may be the simplest thing to do is just wrap it all up into one uniform coverage.

Now that's our hope. Obviously, we're not sort of confident that that's the world, but I would just sort of put that in the discussion as one of the potentials that's going to happen here.

I don't know. Again, I'm not -- that's speculation, purely.

MS. WILENSKY: We actually tried to look at that a little bit, just knowing that some plans are already going above and beyond whatever the requirements are, but it got way too quickly too big because even in one state you had to look at all the different plans.

So we don't know.

VICE CHAIR SUNDWALL: Let me make a comment that's hard for me to make because of my enthusiasm for this. I have wanted very much to have uniform coverage, not only for the Preventive Health Services Task Force but for all immunizations recommended by the ACIP. It just makes sense to me as a public health official and a physician.

However, Diane and others have reminded me that the Commission, in whatever recommendations we make, we have to do what essentially is a budget analysis. You know, a cost estimate of what it would cost.

And, again, I share your interest in this and in improving population health, but you know, Steve, I thought of this. Remember -- you may recall I made a comment at the TIFA and Nemours meeting that we had on Halloween, on October 31st.

But I thought, gosh, doesn't this seem kind of counter to what -- as we expand Medicaid and states are going to be struggling with how do they keep up with things, and yet now you're talking about new kinds of providers, new kinds of services and alternative settings.

Isn't this yet more, more, more Medicaid spending that -- notwithstanding the noble goal of population health it seems like it's -- now I'm wearing the hat of someone who used to be responsible for a Medicaid program and worrying about, how can I keep up with all this?

DR. CHA: I appreciate that you raised the point.

I think that this shouldn't be the way we divide the world, but I think within the bucket of this world there are probably, on that point, two ways to define this.

One is services that are value-added that may cost more, and I think this is part of what Alice was raising in her talks -- is she hoped to go beyond just the low-hanging fruit.

I would also point out that there's another bucket where I do think that there is a genuine -- and this isn't Pollyanna. I think there's a genuine history of having some potential for cost reduction through improvements and integration of care and population health strategies.

And, again, super utilizers, tobacco being the first -- and behavioral health being the first three that come to mind as there are some data that shows that we can actually, by integrating resources across sectors and across silos and integrating a population health strategy, in fact, see some actual change in cost inflection for those.

And probably asthma is probably on that list, too, although less solid studies than the first three I mentioned.

I think there is -- but I do not want to shy away from this idea that we are all too happy to pay for a CABG that may or may not be necessary. But we still have a major bulk in terms of thinking about preventive services that may, in fact, be value-added but, in fact, cost money.

And that's not to say that we need to jump all on board at one time, but rather, I think this would be my -- and I have been -- as you know, I think I raised the TIFA and the Nemours meeting. I've been talking to our friends at ARC.

Particularly with the state-qualified preventive providers provision, I think that there's real potential for fantastic stuff. I think it's a wide gate, and I think it would help if there were other validators and other entities who are helping provide some direction for the community in terms of directions to go -- the best directions to go.

I think we are bound by our regs, but I think that the communities and advocates can do a lot of work to help ensure that the first things coming in through the door are, in fact, high value propositions.

But I think to your point, back to your point, I think both are out there. I think we're open to both conversations, but we also understand at this point in the game, for a lot of our state partners, we may be more focused on one than another.

CHAIR ROWLAND: But since David raised the cost estimating problem, I mean, the real problem here is that the cost for the preventive services is incurred now; the savings are harder to document and longer down the road. And so if ARC and others can really gather any evidence of the savings associated, we all know how that helps with CBO cost estimates.

We've had some anecdotes today. I mean, years ago, when I worked in the Department, we proposed giving flu vaccines and pneumococcal vaccines to the elderly, and we naively calculated the cost of just the administration of the vaccine and the doctor's visit. And the actuaries came back with this huge cost for it because we were keeping people alive longer and the longer we kept them alive the more services

they would use on Medicare. So it had a bigger hit.

So I think we need to accumulate as much evidence on the value of these things for individuals and not always get so focused on the cost. But the cost is an issue.

VICE CHAIR SUNDWALL: The longer they live the longer they pay taxes, don't they?

I don't know. Maybe?

CHAIR ROWLAND: With the elderly, now it's the more they use their Social Security benefits and their health care services.

VICE CHAIR SUNDWALL: That's true.

CHAIR ROWLAND: Other comments to the panel?

[Pause.]

CHAIR ROWLAND: Well, on that sorry note, I think that this is an area where we really do want to continue, Sara. I think finding out that when people say they cover preventive services that they don't always cover them and looking at the difference between the new eligibles and the existing Medicaid population has got be something that remains on this Commission's agenda.

And we thank you all for coming to enlighten us today and look forward to continuing to work with you as we continue, especially with David's emphasis on this, to probe how to really improve the availability of these services to this very vulnerable population where the preventive services and population health can make such a great difference.

Thank you.

[Pause.]

CHAIR ROWLAND: We are going to turn away right now from all of our discussion of payment and delivery systems to look at the other side of the coin, the enrollment of individuals post-implementation of the Affordable Care Act, and so I'm going to turn it over to Moira Forbes to introduce Michael Perry,

but welcome, Michael. Good to see you.

Session 7: Early Insights into ACA Enrollment: Focus Group Highlights

* MS. FORBES: Thanks, Diane. Hello again.

As mentioned at the December meeting, MACPAC is convening a series of focus groups with newly enrolled Medicaid beneficiaries -- I'm sorry, enrollees -- to gain insights into various implementation issues, including understanding of and experience with the application process, coverage, and how to access care.

So we began this effort last fall as part of our broader ACA implementation monitoring portfolio. Other organizations are also monitoring the ACA. I'm sure everyone has been seeing all kinds of things in the news, but we were concerned that information from other sources would either not be immediately available, would be limited to what they choose to release, or would focus on the exchange-eligible population and not the Medicaid expansion population.

And so we decided to conduct our own series of focus groups to provide the Commission with a near-real-time insight into the issues Medicaid enrollees are experiencing, including: Do enrollees understand what services and providers are covered? What unexpected policy or operational issues are emerging? Are there acute access issues among certain provider types or services? And are there affordability issues that may be affecting enrollment or access?

So we're conducting two series of focus groups. We just completed one, which focused on issues relating to eligibility and enrollment, and we will do another set in the spring that will focus on access and affordability.

We're also considering conducting a series of focus groups with providers to learn more about their perspectives on Medicaid and expansion implementation.

We're conducting the focus groups in different locations around the country, and we have been doing multiple sessions at each site to get a variety of perspectives. The first series was held in December

in Baltimore, Reno, and L.A. We chose these states because they all chose to expand Medicaid to adults with incomes up to 138 percent of the federal poverty level. We wanted to hear from persons who were newly eligible for Medicaid. Of course, all states have made changes because of the ACA that have resulted in some people, you know, newly becoming eligible. But we wanted to look at states that were implementing the full expansion.

Maryland, Nevada, and California are also all states that are operating their own health insurance exchanges, which wasn't the only reason we chose those states but it was an additional factor.

We engaged an experienced focus group facilitator, Perry Undem, to coordinate and moderate the focus groups, and Commission staff, Veronica and I, observed all of the focus groups in person. Actually many of us attended the first set in Maryland.

So Mike Perry, one of the partners of Perry Undem, facilitated most of the first series of focus groups and will present on our findings.

* MR. PERRY: Great, and thank you for inviting me here today.

So this presentation is going to be different than I think a lot of the ones you heard throughout the day. This is public opinion research. This is focus group qualitative research. The reason we did qualitative research is it's open enrollment, everything's in flux right now, and it would be impossible to try and do a representative survey of this population. So we held these focus groups really to get into people's lives, to get into their thinking around enrollment, what do they know, what they don't know, what barriers are they facing, what messages are moving them towards enrollment, what barriers are stopping them towards enrollment. Fascinating insights from the research.

I went through this, but we wanted to know -- start the conversation about the ACA, what they knew about that, what information had been breaking through around the Affordable Care Act, and if there were any new obligations, responsibilities, opportunities for them.

The second thing we wanted to know about is feelings about Medicaid, whether they had prior experience with Medicaid, and we had a number of former beneficiaries in the focus groups; or if they have never, ever had Medicaid in their life, we wanted to know what they thought about the program, but they knew what they didn't know. We wanted motivations and barriers towards enrollment. We wanted to find out about the enrollment process, heard a lot of good insights about people who had gone through the process or midway through, got through all the way successfully, and what was that like.

And then, lastly, we had them look forward. How are they going to use this insurance? What's their first step? What's the first service they really want? Are they going to change where they get care? Are they going to change their provider? So those were the topics.

Here are the breakouts of these focus groups. We held two focus groups with Latinos who had recently applied for Medicaid. One of those groups was conducted in Spanish. We held two focus groups with young adults 18 to 34. We know they're a very interesting audience, had people we're looking at. We wanted to know how that audience connected with Medicaid. We had one group with parents. We know from prior work that parents also approach this issue slightly different, so we wanted to hear from parents. We wanted to talk to childless adults. We did one group with them. And then, lastly, we talked to two groups of people who are eligible but not yet enrolled, so they -- some have tinkered with the website and looked at it, but most of them have not gotten very far in the enrollment process. We wanted to know what kept those individuals from even taking that first step.

I'm going to highlight some of the big findings here.

The first one, it's always important to keep in mind these folks were on the whole spectrum of enrollment, like I've said, some who've done nothing yet, no first enrollment step, all the way to those who are successfully enrolled in the program and have a card, an insurance card, they're ready to go. No matter where they were on the spectrum, they really value health insurance. Life is hard without having insurance.

A number of them had medical debt. A number of them had ongoing health conditions that they hadn't been able to treat.

They had looked for health insurance, a number of them, before. It's just out of reach, not affordable. A number of them had applied for Medicaid before. interestingly, in a state like Nevada, we had childless adults who just knew they could never get Medicaid before the childless adults, so they had experienced being turned away from Medicaid before. But the key is they wanted insurance. They really want insurance. Every hand went up. If you could find affordable insurance, would you pay? Yes, yes, yes. So every hand goes up. That is the first point.

The second point is if you knew Medicaid had expanded. Let me just give you the context of this finding so you can get the feeling that we got in doing these focus groups.

So there's a lot of confusion around the Affordable Care Act. Right now there's a lot of confusion around open enrollment. There's some things they know, and there are some things they don't know. The things that they know is: The awareness of HealthCare.gov has gone way up because that has been in the media. Their impressions were not positive, generally. They knew about glitches. They knew things like the woman's face on the HealthCare.gov website had changed. They knew that. But yet they didn't know some very important things around enrollment.

For example, they didn't know that there was financial help available through the marketplaces. They didn't know Medicaid limits had changed, rules had changed, they may now be eligible. They didn't know about navigators. They didn't know -- even though some of the folks in our group ended up working with navigators, they didn't know about them in advance. And they were confused around enrollment deadlines, because remember we were doing this in the final days of December, and deadlines were shifting, and they didn't know how that affected them.

So there was a list of things they didn't know about that really do matter about enrollment, and then

a list of things they did know about that really were confusing them, not really helping them move toward enrollment.

So the issue here around Medicaid is that very few of these individuals -- I'd say one or two at most in each focus group -- knew that they could now be eligible for Medicaid. It's just missing -- it just was missing from their knowledge. They were all pleasantly surprised when they found it, but it's a surprise. It's a surprise that they qualify for Medicaid.

Why this matters -- and I'll leave this point, but this is an important point. Why this matters is there's really two barriers facing the Medicaid-eligible population to enroll:

One is they've never felt -- this group, many of this group felt they could never qualify for Medicaid. They've never been eligible, so that hasn't changed. If they don't know rules have changed, they still think they may not be eligible.

The second barrier is affordability. That in large -- that is the large barrier facing all of the uninsured right now, the perception that, "I've never been able to afford insurance. I'm not going to be able to afford it now," and that's because they don't know there's financial help available through the marketplace.

So there's two barriers with this population in particular that they're facing to enrollment.

Next is that they had many motivations for wanting Medicaid, for wanting to get health coverage: protection from bills. Sort of a financial mind-set around the benefits of health insurance really were the most prevalent motivation for this group because so many have had medical debt. So the financial protection was a key reason.

Another is that a number of ongoing health concerns, had ongoing health concerns they really wanted to address, and this was their chance to do that.

We had some parents who had children in CHIP and Medicaid who felt that as part of family

obligation being there for their children, they needed health insurance.

And, lastly, the mandate came up. One or two people per focus group, when I asked them, "Well, why did you end up applying for Medicaid?" And they'd look at me, and they'd say, "Well, Mike, because I have to. I'm supposed to do this." You know? So something about the mandate is making people think and driving them towards coverage.

The fourth point here is many are unfamiliar with Medicaid. I think we really -- again, I can't underestimate how important that point is. They don't know the basics. So even though during the enrollment process many of them learn that there would be no premium with Medicaid, they still questioned cost. They said, "Well, is there a deductible? Are there co-pays when I get services? I want to know about the costs of Medicaid."

There were questions about physicians. "Can I see any physician I want? Are there limits? Will some turn me away? What's the issue with physicians?"

They don't know about the services covered. Many have heard that it's generous, the services are fairly comprehensive, but they have no idea. So a Medicaid 101 kind of education seems to be particularly needed now with these new enrollees coming in. They don't know the basics at all about Medicaid. So even though many had successfully come through the enrollment process, they didn't know what they had, and they didn't know what they were going to be encountering as they went forward.

Most wanted in-person help to enroll, so the pathway to enrollment was sort of chaotic for a lot of these folks. Some were outside a supermarket, someone approached them. You know, someone was outside a CVS or a supermarket who was a navigator approached them. They ended up enrolling there. Some were connected to some system of care or to a community-based organization or a mental health care organization in one case where someone reached out to them from that organization to tell them they may be eligible. Some people just went to HealthCare.gov and found -- or in this case the state marketplace

and found their way into Medicaid that way. So they had many different pathways.

Many used a combination of enrollment methods, started online, got confused, got on the phone, ended up in person. So we had a lot of multiple use of enrollment methods here.

But the key here is that a lot of them, I'd say the majority, wanted help. They wanted to talk to an informed person about what Medicaid was and to answer some of their questions about coverage and costs and those kinds of things. So they wanted help.

COMMISSIONER ROSENBAUM: Can I ask you one clarifying question?

MR. PERRY: Sure.

COMMISSIONER ROSENBAUM: When you say enroll, are we talking about the threshold question of whether you're financially eligible for Medicaid or the enrollment into a plan? Because they're really two things here. And I assume you mean both.

MR. PERRY: I mean all of the above, yes. I mean that we had a number of people who made it through, chose a plan, enrolled into a plan. And then we had a number of people who were sort of stuck right before that process.

But wanting help was key, and, again, that's where the information about not knowing about navigators would really make a difference, would really make a difference if they knew that they could get some help, and a lot of them didn't know that. They thought on their own, and if they weren't lucky enough to encounter a navigator, that was a challenge.

Lastly, it's not that they want to go through the old Medicaid enrollment process. It's not like they are saying, "I want to go to a county office and go through that process." They want help, but they want help not that way, if that makes sense. They want sort of an informed person helping them go through the process.

Lastly, auto-enrollment help. So we went to Baltimore, and we went to Los Angeles. Both of

them had prior coverage programs there. Both of those -- we had people in both of those focus groups who were being auto-enrolled into Medicaid because they had participated in those programs. They were incredibly thankful that auto-enrollment was there because, without it, they would have -- they have a lot of confusion around the Affordable Care Act. They may have missed this opportunity to enroll.

The challenge around that is that they weren't sure what their own responsibility was in the enrollment process. So we had a number of them who were communicated with that they were being auto-enrolled in Medicaid who still went and applied, who still filled out an application, because they wanted it so badly. They didn't want to chance it, that some automatic system was going to get them into Medicaid. So there was some confusion around -- whatever the communication has been around auto-enrollment, there still were some question marks with these consumers: "Do I need to still do anything?"

An interesting finding up there. Medicaid equals health coverage. I think the phenomenon -- and I'm someone who has worked on a lot of public opinion studies on Medicaid for a long, long time, and I think the difference here -- and I don't know what it means for the long term of this program, but the difference here is that people who applied for Medicaid in our study wanted health insurance. Straightforward, "I wanted health insurance." We asked them about other benefits. We asked them about SNAP. Was this part of your effort to try and get other kinds of support? In every single case it was not. It was health insurance was what they wanted. So in their head, the new enrollees wanted health insurance and they got enrolled, you know, through Medicaid into a plan. It's health insurance. You know, interesting idea here about what that means for the future of program. It's related to the next point, which is about the stigma attached to Medicaid.

So the question I have in my head: The more it becomes health insurance, does more of the stigma start to go away? The stigma, you know, it's a nuanced issue, because the stigma seems to be

coming from the enrollment process. The old enrollment process for Medicaid seems to be where a lot of the negativity is coming from. The storytelling around the focus group, it was coming from a caseworker who was this way or, you know, the long waits and the way they felt degraded in an old enrollment system. And, you know, that's changing obviously. And so that's where a lot of the stigma was coming from.

There were probably one to two people per group who had an experience with a provider or someone at a front desk of an office who made them wait longer or who didn't treat them as well. That person -- the rest of the group believed that person when they told that story. Although they didn't have personal experience with that, they believed that could possibly happen to them. So there's the issue of stigma still there. Is it evolving or changing? It seems to be. But it's going to be interesting to track.

VICE CHAIR SUNDWALL: Michael, is this new attitude only among the category of the newly eligible, those up to 138 percent of poverty, not the traditional…

MR. PERRY: We had them mixed together, so we had around the table people who had had Medicaid not so long in the distant past. They had -- some had lost the coverage over a year ago, let's say. We wanted there to be a gap of time when we recruited individuals, so we didn't have someone who was just churning who was now in our focus group. So we wanted to make sure they had had a time out of the program. But we did have people who had a lot of experience with Medicaid, and it was mostly them where the storytelling of that experience was coming from.

The new enrollees had sort of a clean slate about the program, and they were thankful that they were getting the coverage.

Another finding we thought was interesting -- I'm not sure what to do with this one -- was the issue of dental care. It was not that it was on the list of things I was planning to ask them about, but it came up. And it came up in every single focus group, and it came up as the reason why a lot of them wanted Medicaid. It was a motivation to enroll.

CHAIR ROWLAND: [off microphone] in your focus groups kind of hovering around.

MR. PERRY: All right. Then you can understand. You can understand. It's an important service.

COMMISSIONER EDELSTEIN: Anytime that a focus group or a population has asked for help about health care services and dental is included, dental is always the first service that they're looking for.

MR. PERRY: Yeah. So that's a motivator to get it. You know, whether they're in a state where it's covered or not covered or offered or an extra benefit, you know, it's unclear what the impact of that's going to be. But it's driving them to look for Medicaid. Vision care was also there, but it was mostly the dental care that was driving it.

Another point is we talked to them about their future uses of Medicaid, and two things popped for us. One is wanting their own doctor. Some have their own doctor. They want to keep that doctor. But many of them want to form that relationship with a doctor, with a provider. So that was an important thing that they were going to get from Medicaid. Another thing is that they want a checkup. They have not -- the thing that goes when you're uninsured is preventive care. It just goes. The thing they want is preventive care. So it comes up as an important factor here.

Two findings here about the eligible but not enrolled, how are they different from the folks who actually have gotten through the process or are in the process? The way that they were different is they knew less. They knew less than even the Medicaid folks who had sort of stumbled into Medicaid. They knew less about Medicaid, number one. They knew less about financial help. To this group of individuals, affordability is the main barrier. The idea is, you know, you don't shop for shoes if you can't afford shoes. So you don't shop for insurance if you can't afford insurance. And so that's the big barrier for that group. They don't know that Medicaid is available to them. It's not on their radar at all, and they just feel they can't afford it. So they're holding back. They're holding back because they just can't believe

they'd find affordable insurance.

The next finding, which is definitely related to this, is that if they knew that Medicaid -- you know, free or low-cost coverage was available to them, it would make a difference. You know, we asked them that question, the focus group. It would make a difference. Affordable coverage is what they want. If they knew they could get affordable coverage, a lot of them would sign up. At least that's what they told us in the focus group. So getting that information out there would be key.

We know Latinos are key for enrollment. They make up a lot of the uninsured, and so we really tried to hear their voice in the focus groups. We noticed a difference that is worth exploring between the Spanish-dominant participants and the English-speaking Latinos, and the difference was that the Spanish language participants knew less, had seen less ads for Covered California, for example, who knew -- were least familiar that Covered California even exists, who knew the least about Medi-Cal, who had more questions, were more hesitant about enrollment. So we think that's worth exploring. It may be -- their language is certainly a part of it. Some of these materials haven't been in Spanish in the ads and were slow to maybe start in some of those states, and maybe that's why they were missing it. But they seemed to be missing more vital information than the English-proficient Latinos in our group. So we noticed a divide there. In polling, you often notice a divide there, too, so it's worth exploring.

And then the next finding is that the difference also in both of those two focus groups with the other focus groups is the positive nature of the conversation. The others were positive, too, but there was mixed feelings as well. In the Latino groups, stigma was not an issue. Negative feeling around Medicaid was not an issue. Wanting health coverage was prevalent, and being open to enrolling in Medicaid, just very strong positive feelings and an eagerness to enroll. So there was a tonal difference that I think was interesting as well.

Let me wrap up. One of the biggest challenges for the folks in our focus group -- you know, near

the end of December was when we were talking with them -- is that they felt that there had really been no follow-up, and they weren't sure where they stood. So many had gotten through the enrollment process successfully, got a confirmation e-mail, but then had heard nothing else. So January 1st was approaching soon. They didn't have an insurance card. They didn't know if they could use their Medicaid. They had no follow-up person to call. They had been putting phone calls in and had long waits, haven't been able to get to somebody, someone hasn't been able to look at their case. So the follow-up they thought was a problem.

They didn't think about that. I mean, they only wanted to sort of get through the enrollment process, but now here they were, they got through it, and they didn't know what was coming next, and so that was a challenge.

And then, lastly, we did do a lot of conversations around how can we improve this process, and there's three sort of categories of improvement ideas. One is about pre-enrollment kind of ideas, and that is, explain more that Medicaid rules have changed and I may now be eligible; provide more information about what Medicaid is, what it covers, just some basic information about Medicaid; tell me more about the Affordable Care Act and if I have to pay a fine if I don't sign up for Medicaid, when I can enroll. So there was more education around the key things that they care about with enrollment. That was one improvement idea.

In the actual enrollment process, I have to say these folks were determined. A number of them did encounter problems and glitches and computers freezing and accounts -- creating multiple accounts. They had those problems, but they were determined to get through them, and many of them had gotten through them. So the glitches were not keeping them away from fully enrolling. But they did want someone to talk to. So if they got stuck online, they wanted someone to talk to. Many did get through to, you know, the customer service line, but it took a lot of effort and long waits, and so they want sort of more -- 24

hours is what they came up with, but more available individuals to talk with. They want to know about navigators as well. Meeting in person is something that's appealing to them.

And then, lastly, the post-enrollment, the main information they want there is follow-up. What do I do next? When are the things coming? Who can I call? Is there a designated person who is managing my case that I can follow up with? So those were the improvement ideas.

So just to end up, where are we now? We are reading through the transcripts and writing a report. We wanted to hear your feedback and questions today. We'll incorporate that into our report. Within two to three weeks we'll have a report ready that really digs at this issue in more detail.

With that, that's where we are.

CHAIR ROWLAND: Thank you very much.

Richard.

COMMISSIONER CHAMBERS: Thanks for the information. It's totally relevant to me because we're one of the plans in Covered California and have been really frustrated with a lot of the things that your focus group told you.

One thing I didn't hear you reference that seems to be anecdotal information is that back when CHIP came on in the late 1990s, there was the issue about -- particularly in Latino communities -- was the whole immigration issue and fear of Immigration Services, and folks are wondering whether that's carried over. Did that come up at all in your focus groups?

MR. PERRY: It's still a concern. I mean, it's still an issue. It's not enough of a concern to keep them from making that first step, because I think we got the sense that wanting health insurance -- we found those focus groups to be very eager to enroll. So, it was a concern. It did come up, but not enough to stop someone from taking a first step. So the question is, if they make a first step, should we have information there right away on a landing page that talks about immigration status and enrollment and

-- because they're not clear on that. But, I think that they're willing to go that first step and see that information. But, it's still a fear. It's still there.

COMMISSIONER CHAMBERS: Great. And just as California has seen with the enrollment is 1.2 million of -- it's 50 percent of the eligible enrollees. A small percentage of the 650,000 enrolled so far are Latino, and I give credit to Peter Lee and the California exchange, at least, of identifying the challenges and really trying to up the game exactly along the lines that you're saying, so thanks for the information.

MR. PERRY: Sure. Great.

CHAIR ROWLAND: You know, in some survey work that was done in California, there's a lot of immigrants who are not eligible for coverage who believe that the ACA will help them, so I think that that works on both sides of the aisle. But I think some of the individuals who think they'll benefit the most in the Hispanic community are actually excluded in the law.

Andy, and then Trish.

COMMISSIONER COHEN: You probably are going to do this in your part -- by the way, great presentation. Thank you so much -- but, I'm sort of curious. Obviously, I mean, it seems like a pretty significant communication failure that so many people did not know that there had been a change in eligibility that was relevant to them, and so I'm just curious -- and I know you are in three different markets, you don't need to go into all of it, but I'm sure it will be in your report -- what were the sort of background strategies in those markets? We should know, at least, what's failing, you know, like, how much -- was it just sort of national outreach? What had the state done that was unique? What kind of strategies had been used in those markets that at least weren't working by December?

VICE CHAIR SUNDWALL: [Off microphone.] Could you tell us what the three markets were?

MR. PERRY: Sure. So, we were Baltimore. We were in Reno, Nevada. And we were in Los Angeles.

I can answer your question drawing on work I've done with Kaiser Family Foundation, actually, where we did sort of talk to marketplace staff, for example, what outreach strategies were, and we did talk to -- my sense is that explicit messaging around Medicaid has not been part of any state's outreach and enrollment. I think even using the language, "free or low-cost coverage" has not been -- you know, just as a subtle clue that "this could be you" -- has not been and been resisted in state marketing plans.

I think my impression of what they're doing is that they are really marketing to the subsidy population, but then they're using in their choice of navigator grants, and they're using them, they're picking partners on the ground who have relationships or a long history of working with a lower-income population to do it on the ground. So, an on-the-ground effort to get Medicaid, but in the airwaves not. It seems that's my impression.

VICE CHAIR SUNDWALL: Good.

MR. PERRY: I don't know. Others around the table probably know more than I do about that, but my observation of states is that I've never seen -- I haven't seen any explicit message that "you could now qualify for Medicaid" anywhere, only in the verbal communications of navigators, who've done a great job, I think, of enrolling this population, but I think it's been on them to do it. That's my impression.

COMMISSIONER RILEY: Wonderful, as always. It's intriguing, though, that it may be that very strategy that's the reason why people see it as insurance. You know, it might be that there's a flip side to that, that when they're not marketing Medicaid, they're marketing insurance and people are getting that message, and maybe that's a good thing.

MR. PERRY: Sure.

COMMISSIONER RILEY: I know you only did one focus group with 18 to 34s so that you can't really generalize, but were there any differences among the young invincibles that you noted?

MR. PERRY: Yes, and I can again draw on other work. Just so you know, we've been doing a lot

of work with the uninsured for the Robert Wood Johnson Foundation for Kaiser, for Enroll America, for others, so we've been paying attention to this young, invincible audience. They were present. They were very -- the groups we did for this project were very consistent with what we've been learning in others.

I break out the young women from the young men. I think we lump them together as if they're sort of in one mindset, and the young women seem more motivated and engaged and more connected to health care generally than the young men in that cohort. So, I'm just saying, if you're around the table and there are five young women and five young men, you're going to get more engagement and experience with health care and a wanting to pursue it. So, we've noticed this has been borne out in polling, as well. There's a differential in interest in enrolling.

So, one thing is, so the young women are different from young men. And what's going on with them, I think, their whole issue is financial. It's so the -- a financial -- it's a financial calculation and decision strictly for the young men about -- around affordability. So, that's what's going to either get them to enroll, a sense that this actually could be affordable, or not. So, getting this audience a message around Medicaid, I think, would be a great thing to do, just because it's free or low cost and the cost is foremost in their heads.

COMMISSIONER RILEY: Do the young men share the idea that it's a value, that they want insurance?

MR. PERRY: Yes, they do. I mean, I remember in one of these focus groups having a 24-year-old guy who is nervous about playing pick-up basketball games with his friends, because if he gets injured, it's -- so, it's about the ER bill. It's about what happens when the accidents. It's -- and I know this is known for all of you who work on this issue, but it's more about -- it's not so much the prevention, but it's more about the cost of not having it. And so Medicaid can certainly fit that bill because it can provide that protection from bills.

VICE CHAIR SUNDWALL: Just a comment. I was intrigued by your impression that there's a whole new attitude about this, because you're selling it as insurance, not Medicaid. I'm going to just suppose that if that survey, or this focus group were in Utah, a conservative state, there would still be this reluctance or this stigma, or, I guess, how it's talked about. But, I think that -- I'm not sure you can extrapolate your impression generally. I think there's still some reluctance because of concern about government or stigma or what have you.

MR. PERRY: I agree. I think that's why Nevada was an interesting state to include in this. So, Nevada hadn't had a history with expanding Medicaid at all. If you were a childless, non-pregnant adult, you couldn't get coverage. So, in a way, not that different from Utah in terms of the experience of the public there with the Medicaid program. And so in that way similar, you certainly heard anti-government. I mean, all the things you're talking about were there.

But the idea that this is health insurance, you know, for those people who successfully made it through, that was there in Nevada, that, "I got health insurance." They won't give it up. I mean, there was no one who was saying, when I found out -- so, they would go in to enroll. They may not have known they were ever going to get Medicaid. They end up in Medicaid. Not one of them would have made another decision. We asked this in the focus group. They were glad they got it in the end.

So, I think that's where they ultimately -- it's not a good thing to be uninsured. If you can choose being uninsured or Medicaid, you're always going to pick Medicaid, so…

CHAIR ROWLAND: Well, Michael, thank you very much.

MR. PERRY: Sure.

CHAIR ROWLAND: You always are able to bring the voices of the people to us as well as the statistics.

I really think that one of the things that we might want to explore in the future is not just what

people are experiencing in the expansion states, but where I think there's going to be even greater confusion is in some of the non-expansion states, and so maybe in the next round of focus groups, we ought to think about doing one or two focus groups in a non-expansion state. So, maybe we could go to Utah.

COMMISSIONER CHECKETT: Diane, you know, to add to that, I was having a similar thought, and in particular, if we went to, like, in Kentucky, where they've got -- or Tennessee, where they've got a border, these really closely shared borders with urban areas that go over the two states, I think it would be most elucidating.

I would say that, to me, this was really the best -- I guess we've saved the best for last today. It was a wonderful presentation, and thank you so much.

CHAIR ROWLAND: Thank you.

And now, before we adjourn, if there is anyone in our audience who would like to come up and offer any comments or suggestions to the Commission, please take the mic. And I see someone coming forward.

Public Comment

* MR. BUSHMAN: Good afternoon. My name is Jesse Bushman and I represent the American College of Nurse Midwives.

I just wanted to thank the Commission for some recent focus that they put on the complexity around the coverage for pregnant women. It's something that we've been trying to puzzle through ourselves and talk to our members about, and it's fairly difficult to do. And so we appreciate the time that the Commission has taken and the staff work to look at what's involved in that and to try to think through what could be done to help ameliorate that for the women who will be making those choices.

There's another topic that I wanted to touch on just related to some things that you've talked about today and that's related to payment reform. As you know, we lead a coalition of organizations interested in

maternity care and we sent a letter to the Commission with some ideas about what to focus on. One of those was about payment reform, because we do a relatively poor job of promoting normal physiological birth in the United States, and some of that is driven by financial incentives to do interventions that are not always necessary for every woman.

As you look at payment reform, when you think about the things like Accountable Care Organizations and those sorts of models, as a payer who is covering half of the births in the country, I think it's important to consider that it's not just looking at trying to do something like reduce the rate of Caesarian, because there are a lot of interlocking interventions that lead to each other, like inductions, that lead to further use of epidural, that then leads to further Caesarian rates, and that all of these interventions in and of themselves are not independent, and that payment as a single episode-based approach could try to address that by reducing the overall use of these interventions themselves.

So, I do want to encourage the Commission to -- as you're looking at these payment models, consider maternity care as something to be included as an episode, but also look at the providers and try to identify providers that are really focusing on normal physiological birth and are able to promote that and to reduce the, not only the cost, but the use of the interventions themselves, and then make the states aware of that.

Thank you.

CHAIR ROWLAND: Thank you very much.

Any other comments? If not, it has been a full day – oops…

MS. PSMYTHE: One more. Hi. Thank you so much. It's been fascinating to be here. My name is Amelia Psmythe and I'm the Deputy Director of United States Breastfeeding Committee, and we have been honored to very recently join the Coalition for Quality Maternity Care that recently sent a letter to MACPAC making recommendations about the additions of quality measures for birth, and we're very

delighted that exclusive breastmilk feeding was at the top of the recommendations.

Because we are brand new on the Coalition, we missed the opportunity to sign onto that letter, so I'm here in part just to formally endorse those recommendations and to say how pleased we are to see that as something that you could all be looking for.

We also wanted to say that we're very pleased by the July rule that opens the door to cover preventive services that are recommended by licensed providers to qualified non-licensed providers and the way that this opens possibilities to increase access to lactation care. So, thank you very much for that development, as well.

CHAIR ROWLAND: Well, thank you, and I'm glad that you made it to the mic.

Anyone else?

[No response.]

CHAIR ROWLAND: Okay. Then we will stand adjourned until our February meeting, and we thank everyone for a very full and productive day. Thank you.

[Whereupon, at 4:45 p.m., the meeting was adjourned.]