Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

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National Guard Association of the United States
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10:20 a.m.

COMMISSIONERS PRESENT:
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AGENDA PAGE

P R O C E E D I N G S [10:20 a.m.]

CHAIR ROWLAND: If we could please reconvene.

Welcome to this session of the Medicaid and CHIP Payment and Access Commission. We are going to begin our discussion today by looking at improving delivery and payment to have some state perspectives on the Medical Health Homes Initiative. I am going to turn to Anna Sommers to introduce our panel.

SESSION 1

IMPROVING DELIVERY AND PAYMENT:

STATE PERSPECTIVES ON THE MEDICAID HEALTH HOMES INITIATIVE

* DR. SOMMERS: Good morning.

The Commission has previously identified improving delivery and payment systems as a priority area, so to further this work, you have requested additional information about state innovations to improve delivery and payment.

In 2011, the health home State Plan Option became available under Section 2703 of the Affordable Care Act. The State Plan Option provides states with a new tool to support care coordination and care management for Medicaid beneficiaries with complex health needs. Staff has organized this panel to provide you with state perspectives on the lessons emerging from two states, Missouri and Maine, that were early adopters of the Medicaid Health Homes Initiative.

First, you will hear from Katherine Moses, Senior Program Officer at the Center for Health Care Strategies. Ms. Moses leads CHCS's technical assistance efforts to states pursuing health homes. And then you will hear from Brent McGinty of the Missouri Coalition of Community Mental Health Centers and

Dr. Lisa Letourneau of Maine Quality Counts, who will discuss their states' implementation experience.

Panelists have been asked to address areas of interest to the Commission, including the core services required and how states have used the flexibility allowed under the provision to further their states' goals and target priority populations, performance measurement data and results, program design features considered to have the greatest impact, payment methodology, and then the sustainability of the health homes program after the 90 percent federal match expires.

So I will turn it over to Ms. Moses.

* MS. MOSES: Thank you. Great. Good morning, everyone, and thank you for having us.

Our role at the Center for Health Care Strategies, one of our roles, is to provide technical assistance to the states that are pursuing health homes through a contract with CMS, and so since 2011, we have been doing this and gathering some really interesting information on what is working, some of the challenges, and I hope to be able to share some of that with you today.

Just real quick, a couple of basics particularly focusing on the overall goal of health homes, and I will try and weave some of this throughout my portion of the presentation in terms of how it is similar or different to other scenarios such as patient-centered medical home. But the overall goal of health homes is to improve integration between physical health and behavioral health and long-term service and supports and really has a strong focus on that integration piece, and you will see that in the services and the way provider standards are developed.

One of the greatest opportunities I think of health homes is the opportunity to pay for services that previously were not able to be covered under Medicaid, difficult-to-reimburse services we have here, including the care management and care coordination functions that are so needed for the very chronically

ill populations.

It provides a great flexibility to states in how they develop their models, and I think this is one of the key -- I will highlight this again at the end. This is one of the key pieces of Medicaid health homes is that states can develop the model. They have flexibility in how they define the services, how they pay for the program and are able to tailor it to what their individual policy goals are.

Certainly, last but not least is the enhanced match. Where this has come out to play is that states have been able to build something that they wouldn't otherwise have been able to develop. Their interest had been there, but to get something launched and up off the ground maybe would not have been possible with regular match, but with limited, eight quarters of enhanced match, it really allowed them to build something thoughtful in a sustainable way that then could be affordable and sustainable after the first state quarters.

I am going to kind of breeze through this a little bit, knowing that there may be some questions. We can certainly talk more in the question-and-answer period, but medical -- health homes definitely are built out of the same concept as patient-centered medical homes. And in many states, patient-centered medical homes are foundational and are the building block for the state's health home, but generally speaking, Medicaid health homes expand on that traditional medical home model by focusing specifically on patients with chronic conditions, coordinating across the spectrum, as I mentioned earlier, of medical care, behavioral health, and long-term care, and then this very strong building of linkages to the community and social supports.

The focus for health homes includes focusing on hospital admissions, ED, and admissions to long-term care facilities, and I have a slide with a little more detail of the evaluation and quality

measurement of health homes.

So the health home services are listed here. There are six of them, and they all kind of revolve around the common theme of care coordination—as I mentioned earlier—building up and shoring up all of those additional supports that would be necessary to support individuals with chronic conditions.

It is not a menu of services. A health home must be able to provide all six of these core services, and likewise, prior to that, the state must define all six of these core services, again, with some flexibility to define it in a way that is most following their policy goals and what they are trying to accomplish, but all six must be defined, and all six must be provided by the health home.

A common misconception is that it could include direct services or medications, and it does not. It is specifically for the care coordination piece and not for any additional behavioral health, primary care, or direct care services.

One other point to make is that health home services do not need to be provided within the walls of primary care practice or of the health home, which could be an FQHC or a community mental health center. It can be virtually integrated such that the pieces come together to best serve the member, the patient, in a way that is most suiting to them. You will see that demonstrated as both Brent and Lisa talk about their specific models.

This is just a brief slide to describe who can receive services. Again, the provision is named, health homes for individuals with chronic conditions, so a very strong focus on that. The stick figure on the right could be just one, a serious mental illness as the chronic condition, and that would make them eligible for health home services. The person on the far left is two or more chronic conditions, and that is any one of the many kind of typical chronic conditions -- congestive heart failure, diabetes, behavioral health condition.

And then the middle person is representative of an individual -- and many states do leverage this potential -- is a person with one condition, let's say diabetes, and at risk for other chronic conditions. That could be because they are a smoker. So the at-risk of a second, the smoking is their at-risk condition, and then they have one and often many more chronic conditions.

I would like to take a minute to explain this map. This shows the state health home activity across the country, and I can see some of the numbers aren't showing up. But the dark blue states show states with approved state plan amendments. Hopefully, that came across in your packet. There are 15 states that have approved health home state plan amendments, totaling 22 different state plan amendments.

So a state like New York actually has three SPAs, but it is the same health home model rolled out in three geographic phases, so that's how we get from 15 states but 22 state plan amendments. Similarly, Iowa should have a 2 in that box. Missouri has 2. Washington has 2. Rhode Island has 3.

The light blue states are states that have federal funding for planning grants, specifically for health home planning, and in addition to those states, there are some that are light blue and some that are not light blue that are working with us or maybe not working with us in terms of developing a state plan amendment, starting to think about health homes and planning, so all told, more than half of the states involved and interested in or have approved health home state plan amendments.

This is another way of kind of bucketing those 15 states by the eligibility criteria, which they are leveraging for their health homes. The middle box, the gray box, focuses on individuals who either have serious mental illness, severe emotional disturbance, or substance use disorder. I would highlight Vermont, Maryland, and Rhode Island as three states that are all pursuing very specifically opioid dependency-focused health homes. There's a couple of other states that have those in the works as well.

Moving over to the chronic medical conditions focus again, these are the diabetes, congestive heart failure, the more traditional chronic medical conditions. States like Iowa and Missouri, you will see in both, both the blue box and the gray box, because they have two separate state plan amendments, one for their chronic medical conditions and one for the SMI. You will hear from Brent, a lot of times why they do that is in order to have a -- there is a different hub. The health home is centered around a different provider, the chronic medical conditions around primary care, SMI around the CMHO or behavioral health provider.

The other thing I'd point out in the far left chronic medical conditions box, is Wisconsin; they are focusing specifically on HIV/AIDS. So it could be a very narrow focus, not just a very broad focus.

Last but not least, the far right box contains a variety of things. States like New York and Washington have a very network approach model to health homes, but it could also include -- the other states are -- have a mix, so hence the word "broad," a mix of chronic medical conditions and the SMI/SED, just in one spot, so not a huge differentiation from Iowa and Missouri who have split it out, but they have put all their conditions into one state plan amendment, which is perfectly acceptable.

I won't spend a lot of time on the outcomes unless there are questions later, but there are essentially three ways that the health homes are tracking quality. One is through a core set of quality measures. The technical specifications for those actually just came out yesterday. CMS just recently released those, and those, all states, for all state plan amendments, will report on. States also have the opportunity to report on selected measures, so perhaps there is a measure that they are collecting in their managed care program that they want to also collect in their health home. So they have the opportunity to tailor that a bit to their own needs.

Then last but not least, certainly there is a third-party evaluation that will take placed in, I believe, 2015, and they will collect measures such as hospital admissions, emergency room visits, skilled nursing facility admissions. That will then kind of allow us a look at a somewhat apples-to-apples comparison across the states.

Since this is my last slide, I'd like to take a few minutes to share lessons from some of the early adopting states. We had the opportunity this past fall to pull together six states who were the first out of the gates for a meeting to talk about what they have learned, some of their perspectives on developing their health homes, what makes them sustainable, and I am sorry I was not able to share the actual -- we wrote a paper on it afterwards. It's just fresh out, so I have warm copies from Kinko's if anybody is interested in an actual copy of the report. It's on our website as well. But these next couple of bullets kind of boils those all down to a few key points that we have learned from the states.

The first is health homes have offered significant flexibility for states to define and advance their policy goals, and this ranges from states that may want to pursue, maybe a kind of raising all boats of their primary care providers and are kind of going the PCMH trial route, leveraging their patient-centered medical home structure to, of course, not only improve health for their patients with chronic medical conditions, but also to kind of move Medicaid in a direction of increased quality and provider standards.

Other states may be very narrowly focusing on particular population groups and are using health homes as a way to focus on those specifically and to improve health; in the case of Wisconsin, health for the individuals with HIV/AIDS. So the flexibility has been tremendous, and that was something we heard from the states across the board.

Second, the policy goals should drive the target population selection and program design and

payment methodology. We have seen that as the states first define their policy goal, then they were able to best define their service definitions and define how they are going to pay their providers to make that policy goal play out. So it really is a very step-wise approach once they all stepped back and thought about it, that once we understand what it is we are trying to achieve policy-wise, there are many ways to tailor that in terms of designing the program, the payment, how the members are selected.

Third, services should be defined to effectively engage with and care for people with complex needs. Again, this is a flexibility for the state, that they are able to very uniquely on their own define the services and make sure that they are meeting the needs of all individuals with chronic conditions.

Fourth, a really key thought that came out from this meeting was that this isn't going to happen on its own, and providers need support to make this transformation occur, whatever they are trying to leverage in their health home model, in terms of making a transformation. They do indeed need support, be that learning collaboratives or other ways of supporting providers. It would be outside of their health home dollars, but states are making that investment to their health home model for the purposes of helping it be sustainable and successful.

Last but not least, access to real-time data is critical for making this work. Obviously, if we are asking states to -- or providers to transition individuals out of the hospital and into their next level of care, they need to have real-time data to do that.

With that, I will end, just leaving you with a website. It is a repository of all the states' information and letters from CMS and a variety of resources.

Thank you very much. I look forward to your questions at the next session.

CHAIR ROWLAND: We will turn to you now, Brent.

* MR. McGINTY: Okay.

I have been told the green light does not work on this, but it is working. I hear myself.

Greetings from Missouri.

CHAIR ROWLAND: We can actually hear you too.

MR. McGINTY: Great, great. Greetings from Missouri, and I am not Dr. Parks. I apologize. Dr. Parks would have loved to have been here and could not make it, and instead, they sent me, so welcome. I am Brent McGinty. I am the president and CEO of the Missouri Coalition of Community Mental Health Centers, and I am here to present today on Missouri's health care home program, specifically the CMHC health care home program. Like Kathy mentioned, there were two state plans. I have some data in here on the primary care side, which is mostly FQs, but we will get to that.

A couple things. Kathy has kind of set me up here for some points that I would like to make. The first one is the incredible importance as we go through developing health care home program on cooperation from the very start among many different groups in rolling out, planning, and implementing the health care home program. In Missouri, we were blessed that we had both Medicaid at the table, the State Department of Mental Health, the FQHCs, and CMHC provider association. At the time this was being developed, I was actually on the State Department of Mental Health side, but it was a very close cooperation. We had the hospital association at the table, health foundations at the table, so it was a very cooperative kind of environment and planning environment.

Like I said, two types of health homes. The primary case side in Missouri has about 16,000 enrollees. On the CMHC side, we are about 19,000, and that is soon to grow by probably another 3,000 slots that have been added and approved, so we will be up to about 22,000.

Some of the chronic condition prevalence, you can see from the two sides there, pretty reasonable, similar similarities. Of course, the 100 percent SMI/SED for the CMHC side of things.

Very good, okay. My staff when they developed this even put in very big letters that I am supposed to say "added emphasis," so that's great, because I can see it in big letters up there. But what is important to talk about for our program on the CMHC side is we already had a community psych rehab program that was serving these individuals, so that these 19,000 people or soon to be 22,000 people were in service in our psych rehab Medicaid program, so they had a case manager. They had a community support worker that was working with them on managing their life in the community, and what has been changed, though, and really been transformative for our CMHCs is that now the community support teams have become the health care home teams and have been integrated into the health care home. That integration has been tough to get everybody on board with that, but it's actually come down to several times of saying, "No, we're literally going to move the health care home people and their desk down into the desk area of the community support teams, because we are not going to keep them on separate floors. We really physically have to move them together."

So we've learned lessons as we've gone, but really what the community support teams now have become focused on is the health and wellness, the preventative and primary care. We are concerned now about the chronic physical health conditions. Hospital admissions have become users of health technology, and we focus a lot on education and support of our providers in these areas.

Simple example. Before, a community support worker was making sure they were doing okay, they were on their meds, things are going well in their lives. They had no clue, though, that they were drinking two cases of soda a day and didn't really care if they were. That is changing. So those kind of things have

changed who we are as providers.

Reimbursement. I think this is important. Our PMPM in Missouri, what it is not is a capitation or reimbursement for individual services. I think we talked a little bit about that. We provide those services, six services that were defined there, but really what it is in Missouri is based upon when we developed it around the clinical staff capacity and also has a component for data monitoring or reporting, which is incredibly important, as was mentioned earlier, and the administration of the program.

In Missouri, anyway, what that entails is it added to the CMHCs, a health care home director, a primary care physician consultant time, so all our CMHCs consult with primary care physicians, often FQHCs, because they often serve our clients. Nurse care managers, that ratio is 1:250 on both the adult and kids side. I will get to why that might be a little bit of a problem soon. Care coordination and clerical support, data monitoring and a training component as well, and then I mentioned there is an admin portion.

So care management reports, I think Kathy mentioned the real-time data, how critical that is for good care coordination and services. In Missouri, we have three kinds of report areas that we use in our health care home. A med adherence report, so that basically are the prescriptions getting filled. We have a BPM report. This is a report that does data mining off Medicaid claims. I forgot to mention, right now this is Medicaid claims only, but we are working -- I know Dr. Parks is working very hard to try to get the Medicare claims dumped in as well, so that we can get a better picture across those payers.

So for our BPM, we use a company that has some algorithms that has best practice and will flag folks that are getting prescribed outside best practice, and both the doctors themselves get the letters that show those reports and flag their clients that are outside best practice. They get a letter every month to that effect, but also our care managers, nurse care managers get that report, so they know in their caseload

who is getting prescribed medications outside of best practice.

Disease management report. This one is used obviously quite a bit. It comes from Medicaid claims and our own metabolic screening data. For every single person in our health care home, they have to have a metabolic screening at least once a year, and that is all within our database that we keep and use. It identifies individuals that are not meeting specific HEDIS measures. We just call it they're getting flagged. So at any point, a nurse care manager can look at their disease management report and sort it by different HEDIS measures, see who is getting flagged, and it is a useful tool for them on managing how they work with their case management team on these issues.

So asthma, hypertension, diabetes, those things.

Lessons learned in Missouri: We have been at it a little over two years now, so for evaluation purposes, it's complex and difficult, and we were getting a lot of pressure to evaluate it. We started it in January, and we were wanting to get it evaluated on January 1st the following year. That's very tough to do, especially for the legislature, you know, they're wanting to know, are we saving money, are we saving money? Part of the problem is in Missouri you got to wait three months for claims run-out, so you're always kind of waiting before you can start your analysis.

Complexity of systems, this is multiple provider codes, multiple service codes, multiple beneficiary codes, and then the dreaded what's a required field in some of our systems versus optional and how that affects the data. Complexity of assumptions or cohorts and the time periods. Basically there is what we tried to say is one year is not enough. We're at year two now, so we're very -- starting to get much more comfortable with our data and feel very good about that second year starting to really analyze what has been happening.

Some of the changes that we want to make and some of the areas of focus going forward, the first one I'll mention on this list is practice coaches. We are very blessed to have a team of four practice coaches that were made up of ex-CMHC CEOs or state officials that got together as a practice coach team, who were there from the beginning, paid for by a foundation, who were assigned six or seven CMHC health care homes each, and they were able to spend time at each of them. If there was a specific problem they were having, let's say a hospital was having a HIPAA problem, they had an attorney that said, "I don't care who you are, we are not giving you the damn data," whatever it is, those kind of issues they were able to work with another CMHC that might have a really good relationship and connect hospital to hospital, or they might say, "We're not having very good integration," or, "I've got a CEO that's not supportive," whatever it is, they had the trust of the CMHC because they knew who they were, and then they were able to kind of work on those issues and smooth things out because of that trust level.

So we are very fortunate to have those practice coaches and have kept them on in a more limited capacity now, but in the development stage, they were really a wonderful resource for us.

Some PMPM adjustments that we're considering and we're thinking about, when we designed this, it was for the adult side. We are very focused on the adults. As you can imagine, you know, we kind of have the exact same system because we added the kids to it a little later in the planning process, and remarkably, they're not the same population, and they have different needs. And so we probably need to be thinking around a different caseload size for them, a lot more family -- work with families on that children and youth side.

Even the one to 250, we're finding some nurse care managers are coming back to us saying, "Man, we are really -- we could do so much better if we were one to 200 or one a little bit lower than that." So

we're finding out the one to 250 might have been a little too high.

Interventions to address weight issues, tobacco use, substance use, we're finding in our data that folks in our -- we should not be surprised by this, but we were remarkably surprised by the intensity of it, the prevalence of those issues with our population. I've got a chart I'll try to get to. Maybe I can show you before my ten minutes are up. But we need to really be focused on those issues.

Let's see. Program outcomes, just real quickly, overall all fund savings, the health care home. When we divided it up, it was important that we divided between our disease management folks, who were also in health care home, and those that are not. But 23 million across all health care homes, that's primary care and CMHC. And then for those in the CMHC disease management program, that was another 22 million in savings. That includes duals, by the way.

Some outcome measures. Like I said, we've been in two years, so we've been blessed that we've now got it -- we've been able to get a baseline, 12 months, 18 months, two years. We try to do every six months, do an update. We're very happy that this progression is out there. Some of this is better -- I need to be honest, is better measurement but also better health outcomes, and we're trying to get a report that teases the difference out between those two. But we're very happy that we're moving in this direction.

One slide here on some data we ran, year one hospitalization. I can tell you one story. When I presented this to a legislative committee, they said, "Boy, nine percent drop is wonderful. What can you do about the other 91 percent?" So we've got work to do. But at least the trend is going the other direction now, which is good.

Program sustainability, I think that was an issue that Kathy brought up that might have been something that was questioned here.

One thing Missouri did that was very, I thought, creative, and I was glad I was able to play a part in it, but we kept the program dollars in the Medicaid DMH budget at the regular state match. So when we adopted the program, the dollars were put in for the regular match, and that was done in a variety of different kind of budget ways. We moved some money around and did some things. But what that allowed us to do is when the program went from 90/10 down to the regular match, the money stayed in the DMH budget. We didn't have to go in and ask for a decision item to restore that money and make it go back to where it needed to be for the regular match.

What the state did was took the additional -- they just did an additional draw to get the additional 90 percent match and put it in the state general revenue. So what's -- you know, 5 million in a state general revenue budget of billions is hardly worth even noticing or commenting on. Five million to get for a community mental health center program is a mountain to climb. So the way we set it up there helped kind of answer that sustainability question for us. So that's the way Missouri approached that.

All right. I need to end, so I need to turn it over to Lisa. So, Lisa, thanks.

* DR. LETOURNEAU: Great. Thank you. I'm Lisa Letourneau. I'm the Executive Director of Maine Quality Counts, and I appreciate the opportunity to tell you a little bit about our Health Homes Initiative.

I should start out by saying I represent a regional health improvement collaborative, Maine Quality Counts. We're one of several conveners of the medical home and health home efforts in Maine, along with the Dirigo Health Agency's Maine Quality Forum; MaineCare, which is our Medicaid program; and the Maine Health Management Coalition, which is our employer coalition. So just to make the distinction, I am not a state employee, but we are one of the conveners of this effort.

Another point worth making up front is that our Medicaid program thought it was important to use the health homes opportunity to align with efforts that were already well underway in Maine to promote and strengthen primary care really as a foundational step to widen our system delivery and payment reform efforts, which had begun in the form of a multipayer medical home pilot. So when Section 2703 became available, we were already several years into a multipayer medical home pilot that included Medicaid as a payer as well as Medicare, because we were one of eight states selected for the CMS Multipayer Advanced Primary Care Practice, the MAPCP demonstration.

So it was really an opportunity to align and expand efforts in Maine, and I think the state has done a great job at doing that. It was also seen as an opportunity to align with the current policy priorities of this administration, which were to promote a locally delivered, value-based purchasing type of strategy, building on the community capacity of primary care and the health systems in the state.

So to that end, we were very pleased to see the expectations for the Federal Health Homes Initiative be very much in alignment with our existing expectations for medical home. So they went a little beyond in terms of what was currently expected from our medical home practices, but for the most part were hugely in alignment.

We also saw it as an opportunity to expand engagement of primary care practices in the state. So while we had 75 primary care practices in Maine already participating in the multipayer pilot, this was an opportunity to open this up to any interested and eligible practice, but we essentially kept the eligibility criteria and the expectations pretty much the same for both.

We do have both Stage A and Stage B Health Homes Initiatives underway in Maine. As we referenced, the Stage B for our behavioral health homes is the SPA is still under consideration by CMS, but

the program was officially launched on April 1st. So Stage A went first. That was the one most in alignment with our current multipayer medical home pilot and includes the focus on individuals both with two or more chronic conditions and one chronic condition and being at risk for a second. And, actually, we made the argument that virtually every one of the chronic conditions that both CMS required and the state identify automatically puts you at risk for a second one almost, you know, for all.

So that was put in place in, I think it was, 2012, and while planning began for Stage B, the behavioral health homes program specifically for adults with serious mental illness and children with serious emotional disturbance, and really looking for the opportunity to integrate. So with both of these programs, primary care is the base for chronic disease management with supplemental help from in the case of Stage A what we call a community care team to provide extra care management for the top 3 to 5 percent of individuals with the most high cost, high needs in that practice in Stage B. The primary locus of control is a community mental health center expected to work in close alignment with a health homes practice, a primary care practice, to improve that integration of physical and behavioral health. And we are, again, just starting the Stage B.

The pay model, again, because we were aligning this with the multipayer pilot, right now the practices in the multipayer pilot are paid by the participating private payers in the state as well as Medicaid and Medicare. I mentioned the MAPCP demo. The practices that are participating but only in the Health Homes Initiative are paid only by Medicaid, and you can see the payment amounts, the model is sort of a typical medical home model of the per member per month prospective medical home payments or care management payments at approximately $7 per member per month for Medicare under that Medicare demo, which is slated to go through the end of this year, $12 per member per month for Medicaid, but that

is only for eligible patients. So both for commercial and Medicare, they're paid across the whole population. For Medicare, health homes, because of the way the federal program was set up, they're only paid, so they're paid a higher amount on fewer patients, just on those with two or more or one and at risk.

They continue to get their ongoing fee-for-service payments, which still do comprise the majority of their payment, and then both Medicaid and several of the commercial plans had existing pay-for-performance programs in place, so the argument was if you do well and perform in accordance with the expectations, then you are well positioned to take advantage of those. We actually would have liked to set up a shared savings program, but because of a whole set of technical issues and the fact that most of our health plans are large commercial plans and Maine is a small blip on their radar, we weren't really able to do that.

We do feel strongly, as Missouri does, that both these primary care practices and soon-to-be community mental health centers need assistance for this change. This is not something that they instinctively know how to do. They all think they're giving good care, and to truly make that transformation to a team-based, patient-centered, proactive approach, we similarly feel and have observed that they need considerable assistance with that. That has largely come in Maine through foundation funding and taking advantage of various and sundry opportunities, but has not, to a large extent to date, been a state investment. That is an ongoing discussion, and that has taken the form of both quality improvement coaches, facilitators, as was discussed in Missouri, technical assistance experts in various arenas, and feedback reports, particularly using claims data.

With both the multipayer pilot and the health homes, we have been able to engage over 160 practices in the State of Maine, you can see throughout the region. There are approximately, we think,

about 500 practices in the state in total, so it's not everyone, but it's a good start. You can see another depiction of that here, about 540. Over 160 now are engaged in one or more of these pilots. You can see the 25 that -- the 75 in our multipayer pilot, it was initially 25, then expanded. And then a much wider set in the Health Homes Initiative, which really is a complicated way of depicting that it is a growing initiative. We like to call it "Maine's medical home movement," with considerable attention and buy-in by the provider community I think reflecting the fact that they see this as the way the system change is needed, again, really as the foundation of wider efforts such as ACOs and other payment and delivery system changes.

The collective practices serving the patients now serve about half of the Maine population, which includes just over 123,000 Medicaid members, and of those, 35 percent, or about 43,000, are eligible, so meaning the practices are getting paid those extra health home services on that smaller number, the 43,000.

We don't have results to date because our program is still relatively young. We have a formal evaluation being conducted by the University of Maine underway for the medical home pilot and the Health Homes Initiative, but, again, because we're relatively early in the Health Homes Initiative, results are still pending.

We do hear some great reports from the individual practices who track their own changes and things like emergency department use and hospitalizations, so we have those individual self-reports to date.

We also are a participant in the Robert Wood Johnson Foundation-funded Aligning Forces for Quality Initiative and through that have had the opportunity to have our employer coalition take a look at commercial claims, and they did in the first two years of analysis find evidence of decreased hospitalization and emergency department visits, although because in that market unit costs have continued to go up, the overall costs were not showing a decrease. But what the practices were able to impact in terms of

utilization showed very favorably results. And I think it's important to note that other medical home pilots around the country, notably recently Vermont, Michigan -- and one other one that I'm blanking out on -- have just recently -- Minnesota, excuse me -- have recently published their own results from their first few years, and all are showing important positive results, particularly in terms of those types of decreased utilization and hospitalization and emergency department use.

In terms of lessons learned, I think we're very similar to Missouri in many ways, but I would additionally add that, particularly on the primary care side, we recognize and others have recently observed that movement to this kind of model really requires true transformation on the part of the practice. It is not a matter of checking boxes. There are national recognition programs for this kind of work, such as the National Committee on Quality Assurance, and we are very quick to say that while that is very helpful, it is not sufficient. NCQA does not a medical home make. With all due respect to my colleagues at NCQA, it is a good starter, but it does not necessarily mean the practice has transformed. And I think it's very risky in evaluating results to look at a bar simply of achieving NCQA recognition as a hallmark or a marker of medical home transformation, because it is not the same. Transformation requires time, it requires culture change, it requires substantial resources and support to practices to help make these changes. And the financial support and incentives we feel have to continue to be aligned and have to be meaningful. The initiatives such as Medicaid and Medicare being involved have got to be aligned with multipayer efforts if it's going to be significant to the practices. And I would respectfully suggest that simply adding on medical home payments is not enough to sustain this work a long time. We have simply got to move away from our very broken fee-for-service system. Adding on little nibbles around the edges, as this does, is good. It's a good start. It's get the early adopters. But it is not enough. We have got to change both the

payment to providers and then provider compensation within that system.

We have some pretty crazy examples in Maine of provider groups trying to change their overall payment system, and yet providers still being paid on an RVU-based system, on a volume-based system. So there are very misaligned incentives and messages there, so we have got to really escalate the pace of change for that payment and the provider compensation within that.

I mentioned already the absolute necessity for transformation support, and that while changing the payment for primary care is essential, we think this is a critical component, just focusing on primary care clearly is not enough. If we don't change the incentives for specialists and hospitals, the wider medical neighborhood, again, we are going to be swimming upstream and looking to primary care once again to do the impossible, which they cannot be expected to do this on their own.

So that is my contact information, and again, I am pleased to be here and happy to answer questions.

CHAIR ROWLAND: Well, thank you all very much.

I'd like to start by obviously recognizing that there is a 90 percent federal match in this program, but how much of this program could be done without any other changes in legislation? Are there bars in the current Medicaid program that prevent you from implementing health homes -- and if so, what are they -- that were changed by the legislation?

MS. MOSES: Well, a couple of things that come to mind is that health homes allow states to very narrowly target individuals with chronic conditions, so it does not require statewide-ness in terms of anybody who is in Medicaid is eligible for health homes. It's anyone who meets the eligibility criteria of that state. And so, again, Wisconsin, very narrowly focusing on HIV/AIDS, other states saying, you know,

a long list of chronic conditions. But, regardless, if you're not on that list, however big or small the list, you're not able to receive health home services.

And I would also say another big difference in my mind -- and I'll certainly turn to my colleagues -- is the absolutely to, similarly related, kind of roll this out geographically, so the ability to -- though many states have made this a statewide initiative, you could certainly say, you know, chronic condition or serious mental illness in this urban center or this particularly medical center. You know, it could be very limited.

I think states have been kind of hungry for the opportunity to take some things like this to scale, and so they're all -- many of them are doing it statewide. But it's a great opportunity for rolling it out. As we've seen in states like Iowa and New York, they're rolling out the same model, but over the course of maybe 12 to 18 months, and that is a flexibility allowed by health homes.

I don't know if you'd add anything else, Lisa or Brent.

DR. LETOURNEAU: Well, I would just say that that is a very good point about it being narrowly defined, relatively narrowly defined to certain populations, which in some ways is antithetical to the overall notion of primary care medical home, which is really intended to be a population-based approach.

So while I can understand the desire on the part of policymakers and payers to focus on those in greatest need, the reality is those who might have one condition, for example, say in a state that just defines diabetes as one and not at risk for another, which we say that automatically puts you in two, but that person may not qualify for health home services in other states, and it is absolutely going to cost our society and that state dollars down the road.

We also ask practices as part of the medical home model to do things like manage1 your whole population, be aware of your whole population, track outcomes on your whole population. So to say only

certain patients are eligible for health home services again is just -- it sort of flies in the face of what we really need practices to do, which is to look at and manage their whole population proactively and not just wait for people to get sick.

The other issue, I would just repeat my earlier comment about it is still largely a fee-for-service model, and that is just not the most helpful thing to deliver these kinds of services. Practitioners are bound to the in-person visit when in reality they need to be spending time looking at their population, managing their population, nurses doing phone calls, and while, again, their health homes payment is great to support some of that, we need to fundamentally change this broken fee-for-service system.

CHAIR ROWLAND: Except that states have the capacity to do that, do they not?

DR. LETOURNEAU: Well, the health homes service is overlaid for the most part on top of a fee-for-service payment. It doesn't change the underlying fee-for-service payment. In fact, as we've been going through the SPA process, we've even got pushback sometimes about having to -- some of the earliest SPAs that went through, they wanted documentation of visits, some -- the very first ones they required an in-person visit to document a health home service. So it is trying to change a very traditional fee-based system.

CHAIR ROWLAND: Okay.

COMMISSIONER HENNING: I guess this is for Mr. McGinty, but any of you could chime in if you want. I was just looking at these different health homes, and I'm wondering how dental fits in with all of this, because I don't see it anywhere.

MR. McGINTY: All right. Dental that's a very timely question, actually. In Missouri, Donna and I were just talking before the meeting, dental had been pulled out for adults for Medicaid coverage, and

there was a small dental piece and a waiver for DD individuals. But kids were covered, but not adults. That is probably going to change this year, which is wonderful, because our health care home directors and nurse care managers were going bonkers trying to get folks served and find resources to get their dental care met, because we were having horrible anecdotal stories that I have of people going to the ERs. We ran a report. I think for us it was we had 600 unique visitors to ERs from our health care home last year. You know, and often those were coordinated, you need to go to the ER to get your teeth fixed, and that's what we had to do. We couldn't wait any longer or whatever.

So we're very fortunate that we will get dental added and hope that we can then coordinate that better. And it's an extremely timely question, and we're hopeful that we can move forward a little bit on dental and get it added to the service array and get these folks better care.

DR. LETOURNEAU: Well, similarly in Maine, it is not, unfortunately, because it is not -- general preventive dentistry is not a covered issue. It's the same issue, huge utilization in the emergency department, and it is very problematic and probably would benefit from policy considerations.

MR. McGINTY: Yeah, and not only that, we had a health care home director in Columbia and Springfield, Missouri, testify that they were running into -- this is probably not news, but, you know, testify to the fact that how many of their patients were getting hooked on the pain meds and starting down a path of abuse on those as well after their dental care in the ER. So, I mean, it was really becoming a problem for us.

COMMISSIONER ROSENBAUM: I'd like to follow up actually on the question that Diane posed, because I think this whole very good presentation raises sort of bigger questions for us.

The health homes provisions in the law I think could be viewed as the introduction of a new service

delivery arrangement, although I think that would actually be inaccurate, because, frankly, I don't see anything in the legislation that authorizes activities that were not already under one provision or another authorized.

What I think the legislation does do is provide a very powerful financial incentive to move states in the direction of imbuing their primary care systems with certain characteristics, which we now know as the health home characteristics. If I think back 30 years ago, it was the characteristics of primary care case management, you know, its own class of managed care. But now we're more sophisticated, and I think we understand a lot better.

So going forward, I'm focused on the same question that I think Diane was focused on, which is, Should we think about the health homes amendments as a new service delivery arrangement or as a series of characteristics that ought to be part and parcel of service delivery to Medicaid beneficiaries -- and to other people, too -- so that, for example, any state that prefers to use its general managed care authority would be expected to imbue its managed care arrangements with health home characteristics?

That sort of kicks it up a notch, and the reason I'm thinking of it that way is because -- and this is sort of my question, particularly in the Missouri example where you've got sort of two different kinds of health homes. So what happens -- how do you deal in the health home for people whose primary diagnosis I assume is mental illness, how do you deal with somebody whose under your care but who has, say, cancer? You know, how does that happen? How do you have the vertical integration in a delivery system that would let that person get appropriate oncology treatment while you're dealing with obviously the other diagnoses?

MR. McGINTY: Yeah. The broader legal question, I might defer to Kathy and others, but one

thing I might mention on that, though, is what -- we felt like health care home, whether it's structured as part of an overall law or kept separate in a health care home section or provision or however you want to approach it, in Missouri, anyway, what this has meant for community mental health centers and those with serious mental illness is that focus on that population that has been ignored, I think, their health care and people focusing on that, for a long time, at least in our state. And so it's been transformative, and whatever it took to get there, we're obviously grateful for on a go-forward basis. You know, I don't know if it gets rolled in, if we somehow get left behind or not with parity and other things. I hope not. But, we certainly have been blessed, how it's treated our populations in Missouri, because it was kind of incentivized and held out differently.

COMMISSIONER ROSENBAUM: So, what does it do, though, when you have a patient whose primary -- whose portal, entry portal, is mental illness, and so has a customized primary care entry point that really is customized to somebody with mental illness, which is great. But, so how do you manage things like a heart condition or a cancer or other conditions that obviously require that you call on other parts of the delivery system besides you?

MR. McGINTY: Right. One of the things we can do is if at any point they are better served in a primary care setting, we have -- or in the other health care home, we do hand-offs quite a bit between providers, so, our FQHC partners on the primary care side. So, we do that, also.

But in many cases, the care management, we're not providing, obviously, any of the primary care services directly. We're just the coordinator of that care. And so we often, whether it's for the most basic primary care or if it gets into that specialized care, we're just there to make sure they're making their appointments. We're going in, sometimes, with them to the doctors to make sure that we're listening, as

well, so that we know what the next appointment is and what that next stage. We're working with the families to make sure, if we can, obviously, to have them there to educate them, but in many cases, that's not possible or they're disconnected and alone. So, we're just there for them to be that person to try to educate them and to make them meet -- get that next appointment, et cetera.

But we have also on staff, remember, the primary care physician consult and they are reviewing difficult cases with the nurse care managers to try to coordinate and make sure that we're doing what we can to coordinate that care. So, that's a component of it, too.

COMMISSIONER RILEY: I wonder -- it's a follow-up. I wonder if we could just think a little bit more about plan of care, because it strikes me -- I think, Lisa, your point about changing payment is essential, but not enough. So, when you think about a health home or a stronger primary care, I'm trying to think about a plan of care for an individual, which obviously cuts across behavioral health, it cuts across specialties, how would you do the restructuring of the system to build on the health home experience to meet your goal of a program that could really cover the total costs? Who authorizes care? Who becomes that payment reform vehicle? How do you build on the health home? Should it be hospitals? What's the structure of that kind of payment reform?

MS. LETOURNEAU: I'm not sure I'm totally following your question. I guess I'm thinking the structure is each -- given the multiplicity of payers, it's we have to set an expectation and examples for each payer to follow to move to something other than fee-for-service, whether that's ultimately a global budget, global capitation, whether that's primary care capitation within that, whether that's models like Arkansas has used for transitional models, episode-based payments, including for primary care. But, I feel like I'm not getting it here.

COMMISSIONER RILEY: Who do you hold accountable? It strikes me; do you hold the health home accountable? Do you hold -- who's accountable to make sure that we're not -- I worry about what we learned from the PCCM model, where it was just an add-on in payments and it really didn't necessarily change care. This is like PCCM on steroids. But, if you're trying to do a plan of care that cuts across primary care, specialty care, behavioral health, who's accountable?

MS. LETOURNEAU: Well, I think it is the primary care, or the primary health home for that individual, be it primary care for, in our case, Stage A, or the behavioral health home in our Stage B, and whatever larger organization they are a part of, if they are, and most of our primary care practices in Maine, and I think many other states now, are part of larger either organized provider groups, primary care groups, and/or health systems. And I think it is completely reasonable and a very good idea to have some level of accountability.

It is interesting, there was recently a meeting of the eight states in the Medicare MAPCP demo, which really does not include a provision of accountability for those. It's very much like the early pilots. You just give them the money and hope they do good things and measure it later. Plus, the seven regions and states in the Medicare Comprehensive Primary Care Initiative, which was started a little bit later and does have a strong component of accountability, both in terms of practices required to demonstrate their success in meeting a certain set of milestones -- there are nine milestones -- as well as a shared savings component, which may or may not be the best other payment model. But there is a very different level of accountability there and it could be an interesting one to learn more about.

VICE CHAIR SUNDWALL: Thank you for your presentations, and I'm sorry I missed Kathy's. I don't know if yours was the best, but these two were great.

What I want to just weigh in on is that I am a primary care doctor that sees patients two days a week in a safety net clinic and the importance of this mental health integration cannot be overstated. We have had the benefit of some grants, one from Intermountain Health Care, one from NAMI, the National Alliance of the Mentally Ill, so now we have in our clinic a nurse practitioner who has prescribing ability and is expert in the psychotropic medications, which I confess, as a family doctor, overwhelm me when they start layering them and they have multiple drugs. We have another psychologist who can do counseling.

The quality of care for our patients who have concurrent mental illness, which is at least half of them, of one degree or another, is enormous, and I am worried. When you talked about sustainability, it really caught my attention, because whatever the Commission might do to facilitate some policy that would make this the model that we need to have, to have mental health integrated in these primary care settings, especially for this population we serve, is just very, very important.

And it's my impression, and I'm sure it -- I think it's nationwide -- but our mental health system, Valley Mental Health -- I think it was the recipient of a former federal grant -- their budgets were cut so much, they divested themselves of a lot of their patients into the primary care setting. And us primary care docs would love to help them, but we don't have that expertise. So, this integration couldn't be more important and I commend you for your efforts. I hope we can get some lessons learned that we can maybe translate into policies that will help you sustain these very worthwhile efforts.

MR. McGINTY: Can I -- I might -- I was just going to follow up briefly. Missouri did incentivize, even at a state level, with some grants that we fought for to co-locate among CMHCs and FQHCs those resources just like you talked about with the grant dollars. So, and then I have seven members who are both FQs and CMHCs. So, it is starting down that path a little bit because people are

identifying that need and this health care home initiative, why it was important we both -- I mean, when we worked together, I met the FQs and the CMHCs. We meet all the time together to coordinate that and try to provide those resources to each other. Yeah.

COMMISSIONER CHECKETT: Well, I would just add, as a Missourian, I can't be quiet any longer here, but --

[Laughter.]

COMMISSIONER CHECKETT: -- I do think Brent is making an important point. The dynamics are different in every state, but in Missouri, especially in recent years, and I think it's leadership-driven, the CMHCs and the FQHCs have really been together, and together, this is a really powerful force as opposed to, I think, historically, and in other states, sometimes you see that, where there's a little bit of tussling. So, I think it's really helped to create a very coordinated effort, so --

MS. MOSES: Just to add on to that for one second, I would add that we've seen, and I'm thinking back to the slide that just kind of bucketed the health homes in three groups. In that middle section, states that are pursuing serious mental illness, though it looked pretty even across the board, I would say that serious mental illness health homes were the ones that states were most -- like, the first few out the door had that focus, and the states we're working with now in terms of just starting to plan and coming in the door and starting to develop their models are all very interested in SMI.

And so it may be kind of misrepresented according to that chart, but there is definitely what I see as pent-up demand for this type of an engine, a tool to help do that integration of physical health and -- behavioral health and physical health. I think it's a great resource.

COMMISSIONER SMITH: I couldn't agree with you more. My experience as a foster parent

and adoptive parent has been with -- we see a high incidence of parents who have both mental illness and/or substance abuse issues, primarily, alcohol is what I've had experience with. And I was wondering if you coordinate with the foster care system, the protective services, you know, family and child services, and if so, is any of that -- do you have any studies or anything that show the impact that it has on that in a positive way, because I know that substance abuse, in particular, can affect both the developing fetus, but then also the dysfunctional life just exacerbates and you end up with a child with serious emotional disturbances. So, I was just wondering if that's something that is brought into your findings and do you actually coordinate with those services.

MR. McGINTY: Yeah. And not only is it in our findings, but -- oh, I'm sorry.

COMMISSIONER SMITH: Before I get cut off, also, I was wondering what, along those lines, what do you do with what is considered noncompliance, because I know there must be a high rate of that. To me, it's the reality of somebody's life, but how do you handle the noncompliance issue?

MR. McGINTY: On the foster care question, I should -- it's remarkable you ask, because one of the things that's in the budget this year is a pilot focused on a health care home model around foster care. So, Missouri is going to be rolling that out very soon and that is underway because of the issues you brought up, that they're being recognized there, and how to address the issues you were talking about.

COMMISSIONER SMITH: My son was in one. That's why I was --

MR. McGINTY: Yeah. Yeah. So, that's where -- that's kind of where we're heading next, is that population, and we'll see what we can do there and what results we get.

The noncompliance, I think you're talking about the individual client noncompliance, so they don't make an appointment, they don't go to treatment, those kind of things, I think, is what you're referring to,

and we're trying to change that concept and that stigma around what's failure, especially in substance use treatment. You know, that has been the accusation, that you failed treatment and, therefore, we should stop or it's not worth, and we find that that is -- we're finding more and more it's trauma-based and you start getting close to issues that are very painful and hurtful to people and they run away from that treatment.

It doesn't mean you stop. You reengage them. You keep asking them, do you want to come back? Are you ready now? And we don't lose track of those folks. We keep engaged with them, and hopefully, they come back and that's not a failure. We've got to kind of change how we think about that. But, we still run into that, that people view that as a failure.

MS. MOSES: And, I would add, one of the things that behavioral health homes, many of them have on their team, their health home team, is up here a support staff member, so, you know, either a peer for the kids, peer for the parent, peer for the adult, if it's the adult in the health home, and I would say that's -- you know, I would hold that out as almost a best practice of the behavioral health home, is that there really -- their selectability to define your team, and folks are realizing that's an important piece, is having someone that can serve as that liaison, can serve as the relationship builder with either the child or the adult, whoever is in the health home, or the child with the child's parent. And so that's a key piece.

And to go back to Trish's question just for a little bit, because it kind of relates to this, what we're seeing in several health homes is -- I just wanted to clarify -- it could be one specific entity, a primary care practice, an FQHC, a CMHO, that is the health home. But, in many cases, it's a network, a group of providers melding together to provide the health home services, and that is a differences from that and patient-centered medical homes who, as their box, are getting certified as meeting certain qualifications. This is saying, we want this set of services to be met and do it however you need to. If you have most of

the skill set within your CMHO but you need to pull in a peer support specialist and a primary care physician consultant, then that's your health home and they provide the services.

And so I think it kind of gets to both Robin's question and Trish's in terms of how needs can be better met, and it's by virtually assembling this team, if states so decide to do it that way, to meet the needs of the eligible members.

MS. LETOURNEAU: And if I could just chime in on the issue of noncompliance, it's a great point. In Maine, I think one of our providers said early on, or maybe it was a patient, that noncompliance is defined as a patient and provider who have two different goals. And so we have worked hard to try to get rid of that word, but it is a very commonly held attitude and sort of approach, and, I think, for me, underscores the need for this transformation support. The average primary care doctor probably still uses that term right now in Maine and it just -- we need to teach providers about the science of behavioral change and what it really means to be patient-centered and what it really means to engage patients in trauma-informed care, but that doesn't -- you know, they didn't come out of medical school with that, at least not in the last ten to 20 years. So, a huge need for education and training and support for very well-intentioned providers who grew up in a different culture.

COMMISSIONER MOORE: Thank you. I would be curious if you all would comment on the need for continuing the 90/10 match, the extent to which you will learn enough to show the value of this that it would continue in the absence of that.

MS. LETOURNEAU: Well, I'll jump in before Brent says you don't need it, because their state was so forward-thinking that they just banked it --

[Laughter.]

MS. LETOURNEAU: -- and say, ours was not quite that forward thinking and I think it is a real challenge. Two years is not very long in this work. If you look at most of the states that have been doing this work, I would say it's safe to say most do not show positive results until the third year, and sometimes longer. So, I am very fearful that states that are expecting -- and that is, you know, that is our sustainability plan and we hope to demonstrate the results that will then create the savings to be able to continue that level of funding just from the state. But, I am very concerned that two years is not enough.

MS. MOSES: We have heard that from other states. In the sustainability meeting that we had this past fall, there were a couple of states that said the same thing as what Lisa is saying, is that we have all intentions of building this into the fiber of our program, but we can't -- it's based upon demonstrating savings, and so not saying that forever it's necessary, but a little bit longer, we just have a couple of states say that that would be very beneficial to them.

CHAIR ROWLAND: Is the only way to sustain it to demonstrate savings, or to demonstrate that it provides better quality care and is a better way to deliver services to a vulnerable population?

MS. LETOURNEAU: States have very tight budgets.

MS. MOSES: Yeah. I think states sell it to their legislature as -- you know, the several states that first initially took it on said this will be a cost savings mechanism for us at a time of very tight budgets, you know, two, three, four years ago, three years ago --

CHAIR ROWLAND: So, what does that have to do with the 90 percent match, the 90 percent match?

MS. LETOURNEAU: The match would allow the state to get into it, but with the hope that by the end of the two years, you'd be able to demonstrate the savings and give back your difference, right,

between the 90 and our current, say, 66 match.

I was just going to add one more thing in terms of the time. I was fortunate to be at a meeting up in the Bangor area of Maine this past week. Bangor was the recipient of a Beacon grant, award, several years even before our health homes initiative, and I was just completely struck by how much the community had changed. The meeting was about care transitions and reducing avoidable readmissions and everyone who was -- it was a collection of primary care practices and hospitals and long-term care facilities, skilled nursing facilities. They were all talking about these wonderful things they were doing about calling patients at home and doing meta reconciliation and just having tremendous outreach, and it just struck me that how different this was from three to four years ago. But, it took three to four years and they definitely got an extra boost because of that. So, it is no small task. It is not fast. And it is definitely worth it in the end when you see results like that.

CHAIR ROWLAND: Judy, are you finished? Andy, and then we'll get to you, Donna.

COMMISSIONER COHEN: Actually, I have a follow-up that is a variant of Judy's question, but just with a slightly different lens, and I'll try and make it really quick, and your answers can be quick, too.

It's one question to say, should it be extended. I'm kind of interested in the whole concept of a two-year enhanced match policy and your reactions to whether that is a good way to jump-start an important transformation or a not good way, you know, we left -- actually, I'm making an assumption that may not be true, Kathy, but that some states decided not to do it because of the short time frame. I'm just sort of curious about whether this is a, you know, with limited resources, is this a good way to jump-start transformation, or maybe you can give us a little pro and con on that.

MS. MOSES: Oh, go ahead, Lisa.

MS. LETOURNEAU: Well, I think the notion of an enhanced match is a good way to get states in the game that otherwise, under constrained resources, would say, we just don't have the ability to do that. I think two years -- I would never have done it two years to start, particularly knowing what we are doing now. You know, more like three to five, four, something like that would, I think, get others. But, I don't think we would have had the opportunity to expand to the degree to engage the number of practices that we have in Maine without that, without the enhanced match.

MR. McGINTY: And, I might add, I come from a state that won't take a 100 percent match.

[Laughter.]

MR. McGINTY: But, anyway, but I do -- yeah, I mean, just another example that, for us, anyway, is the Excellence in Mental Health Act that just passed where it has a 90/10 enhanced match rate in it to kind of incentivize states to adopt a PPS system versus a fee-for-service.

So, I mean, the problem with it is, while we're going to pursue it, absolutely -- we want to be one of the eight -- is you've got to design your system for the next step after. And so it is troubling and you've got to really think through, okay, at the end, it goes away. Where are we financially? Where are we system-wise? Do we have to revert back to things? I mean, it can be something you just have to prepare for very carefully.

MS. MOSES: And, Andy, I would say, we heard loud and clear from states that it -- and I think it's one of the quotes in this paper, even -- that without the match -- if this is something we wanted to do, but without us only having to put in ten percent, we wouldn't have pursued it at this time. We wouldn't have pursued it. We would have not -- we would have just stayed status quo, even though we knew it was something we needed to do to move our program forward.

So, again, I would say -- I don't know if I said it during my presentation, I meant to -- that I don't think anyone jumped into health homes with their blindfolds on. They all realized that, we're going to have to demonstrate something after eight quarters, and that is a little scary, and that they, you know, especially those states that are building it off of savings, you know, pursuant to state savings.

COMMISSIONER GABOW: Thank you. I have two quick questions. The first is sort of a follow-up to Lisa's, it's time to get rid of fee-for-service. Given that we know that the Medicaid population has a high incidence of behavioral illness and that patients with behavioral illness have a high incidence of medical illness, is it time to get rid of the concept of two separate delivery systems in Medicaid and think about a unified, integrated model of care for all patients? That's the first question.

The second is that given that the data on PCMH has been variable in terms of saving money, and I know we don't have money in health homes, I would like to ask you to sort of peel the onion on your $22 million of savings. How did you demonstrate that over its components? Thank you.

MR. McGINTY: Yeah. We obviously are moving in whatever system we planned for and the Excellence Act has kind of thrown a loop into that. But, in Missouri just specifically, there are certain funding streams that we always want to make sure that we protect because they might be advantageous to us and there are all those issues where you look to make sure the policy makers know if they make a move toward full integration, for instance, and I assume by that you might mean one payer or a system of paying that is the same for all providers, I don't know for sure, but --

COMMISSIONER GABOW: Actually, delivery model was what I was talking about.

MR. McGINTY: Delivery model. Okay. I'm sorry. Delivery model. You know, there are differences, a little bit, between our two health care homes and our state plans, but we work together in a

very integrated way. So, I'd have to think about that a little bit.

And on your other question, on the peeling the onion of the $22 million, right, so, we have three groups that make that up. We do a dual analysis and we do a three standard deviation group to take out outliers on both sides, and then we do a disease management analysis of people that come into the program through our disease management outreach tool. And then we break it down even further by what service delivery -- where the savings are coming from the claims and all the different service codes. And so a lot of hospitalization, some pharmacy savings, too, but the majority is in hospital and ER and we can provide that breakout to this group. That might be helpful to get into the detail a little bit. It's not in here very deep, so I apologize for that, but we can get that to Anna or somebody.

CHAIR ROWLAND: That would be very helpful, if you could get that to us.

MR. McGINTY: Yeah.

CHAIR ROWLAND: Burt. Well, Burt was in line a long time ago. Is he passing?

[Off microphone conversation.]

CHAIR ROWLAND: Then it's Donna.

COMMISSIONER CHECKETT: Okay. So I'm going to go from the sublime to the mundane, and this is really a mundane question, but my little mind is kind of whirling here about how does this all really work, and so I'm wondering, both Lisa and Brent, in the actual practice sites, what information and data do your care managers see beyond what they can see from the clinical records at the actual practice site? So, whichever one of you wants to go first.

MS. LETOURNEAU: I'll jump in, and the reality is they have some great data now and data that they didn't used to have and it is still far from ideal in terms of being coordinated. So, what is new under

this initiative is that through the Medicaid Health Homes Initiative, they now have a Medicaid provider portal that they -- someone in the practice, not usually the doctor, but the population health manager or the practice administrator goes on and there's information, nearly real-time information there on their Medicaid members organized by care gaps and high need. So, they can see patients -- show me all the patients who have had three or more hospitalizations, three or more ED visits, haven't had a hemoglobin A1C test in X months, have 11 or more medications. So, it is their responsibility to go in and look for care gaps, be they utilization -- over-utilization, avoidable utilization, or gaps in tests and services.

Because we are participants in the Medicare demo, they have a Medicare portal that they can go to, and there, it's organized a little differently, but it's a similar idea, population management using Medicare claims data.

We also are a state that's fortunate to have an active, functioning health information exchange, HealthInfoNet, and through that, they can sign up to get active alerts of admission discharge and transfer, so they will be able to get pinged when any of their patients, if they sign them all up, are admitted to the hospital ED or discharged. And, if they go into HealthInfoNet, they could find information if the patient has been to another hospital.

To the extent they participate in private payer ACO or other sort of care management arrangements, they may have an Aetna portal and a Cigna portal and an Anthem portal. So, it is sort of water, water everywhere, and not particularly -- it is good. It is all good and in the right direction, but what we really need is a coordinated, timely system of data.

COMMISSIONER CHECKETT: Yeah.

MS. LETOURNEAU: In addition, actually -- one other thing -- we also, because we have an

all-paid claims database through the main health data organization and are -- we're a SIMS state, a SIMS testing state, they also -- now, every primary care practice in the state, including these, get a report every two -- excuse me, twice a year, every six months, that uses all of the commercial claims, and soon to be Medicaid and Medicare, to show them how they are doing overall in terms of utilization and cost as a practice, which is also huge and brand new, though that data is time lagged, by definition, and not patient identifiable.

COMMISSIONER CHECKETT: Great. Thank you.

MS. LETOURNEAU: Lots of good, disparate data.

COMMISSIONER CHECKETT: Brent?

MR. McGINTY: Yes to what she said, but our system in Missouri is called CyberAccess and they can access the claims data through that and then get a good feel for those gaps, and then the hospitalization they are actually sent by e-mail in Missouri, anyway, if one of their clients -- they run a DCN report against it and they're notified by e-mail every day if they have a health care home client that's pinged against an admission, and they're working with the plans, I think, to get that data, as well. So, hopefully, it'll all be functional, soon.

COMMISSIONER CHECKETT: Right.

MR. McGINTY: But, that's been very useful, too, because one of the measures is, have you coordinated within 72 hours for discharge planning purposes and care after that. So, that --

COMMISSIONER CHECKETT: Brent --

MR. McGINTY: Yes?

COMMISSIONER CHECKETT: -- because I understand what Lisa said, but in Missouri, and I don't know this, so, when you get all that data, is it being organized, like there is some software system that's

running it, so that when your nurses -- they're not just looking at data. It's telling them kind of, here are the things, and pointing out whether it's gaps in care or whatever, so -- because, you know, that's my worry, is that we have access to an extraordinary amount of data now, but how do we make sure all that data becomes actionable information?

MR. McGINTY: You do have a data tool that --

COMMISSIONER CHECKETT: Okay.

MR. McGINTY: -- runs that on both the primary care side, they have a tool, and then we have it, although they're starting to use our tool now, I think. But, yes, we do have a data aggregate tool that you can sort by your different -- all different ways and cut that data and look at it that helps that nurse care manager not just have a massive database they have to go proactively use, but they can do some population management, individual care management, individual health plans, and all that in a data system.

COMMISSIONER CHECKETT: Right.

MR. McGINTY: So, it is there now.

COMMISSIONER CHECKETT: Yeah, and also beyond the practice itself, which I think is really key to where we are going with delivery system reform and payment reform, is that it's great to talk about doing all these things, but when you're just looking at what's happening in your own health care practice, it's very limited. So, great answers and great to hear this program.

MR. McGINTY: And I know we're looking at --

CHAIR ROWLAND: It would also be great if you could provide some of those indicators that you're using, the things that are the keys to kind of being able to manage, so that as we look at what kind of data requirements should be there for systems, you could give us some guidance as to what are some of the

most useful indicators that you use to really identify where actions need to be taken.

COMMISSIONER CHECKETT: Thank you.

CHAIR ROWLAND: Okay. I have Steve and I have Trish. You can battle it out. You're going? Okay.

COMMISSIONER WALDREN: She wasn't looking. That's the only way I could do that.

[Laughter.]

COMMISSIONER RILEY: That's right.

COMMISSIONER WALDREN: So, I wonder, if I ran across -- so, I'm in Kansas, just a couple miles. So, if I drove over to Missouri and looked around, I just wonder, would I be able to say, oh, look, I see a medical home, or I see a health home. I think, as we think about the analysis of it, we need to go a little bit beyond just the name of these things. Lisa, your comment about NCQA doesn't equal medical home. I think a spa doesn't necessarily mean a medical home, either, although it would be nice to have a spa in a medical home.

[Laughter.]

COMMISSIONER WALDREN: I think as we get into our analytics, that we need to get down into what are the services and capabilities that are provided. So, is it the integration of behavioral health? Is it the population? Is it the care management fee? Is it the care coordination? Because I think we'll get into the same problem with our analytics that people have done with their medical home or with EHRs, is that it's an aggregate concept and there's many different implementations. It's like saying, transportation is good and fast, and then we say, I just did a study on walking and it's not fast. So, transportation is not fast. So, let us get a little bit farther beyond just the name of patient medical home or health home.

Thanks for your comments. I appreciate them.

MS. LETOURNEAU: And I would just echo, again, you know, I think CPCI is one attempt to get a little further down that road in terms of what do we really mean, are they really doing what we think they're doing, and having some accountability around that, so -- the comprehensive primary care initiative of CMS. Sorry.

CHAIR ROWLAND: Robin.

COMMISSIONER SMITH: Just a quick comment, kind of to bring it all back home, is I know we have to look at the budget for the medical part, but I just think that we would be remiss if the states didn't also look at, perhaps you're not saving in the medical part, but you could be saving in all the other areas, you know, where fees might be required, payments might be required, that you no longer have. Foster care would be an example. If you have an intact family, you don't need that anymore. Or, perhaps somebody that can now go back to work because their chronic illness is under control can now, you know, not need public assistance, or --

VICE CHAIR SUNDWALL: [Off microphone.] Or not go to jail.

COMMISSIONER SMITH: Or not go to jail, or a lot of things. So, I just think that this cost savings may not just lie with the medical part.

COMMISSIONER MARTINEZ ROGERS: And just quickly, to follow up with Robin, I'm a psychiatric mental health nurse, clinical nurse specialist. Following up with if mental health issues become somewhat more controlled, most likely, the medical part of the patient will also be somewhat more controlled because they get a more balanced life. One affects the other. It's kind of like a domino effect. So, either, it'll be a win-win situation.

MS. LETOURNEAU: It is. I would just make one slight comment to that, though, and Brent and I were talking ahead of time. You know, one of the unintended consequences to what could be very appropriate treatment in this day and age is the use of atypical antipsychotics and a ballooning of rates of obesity and diabetes. So, all the more cause for an integrated physical and behavioral health approach.

CHAIR ROWLAND: Well, thank you. I mean, I think we are very interested in this model. We're interested in how to make an effective part of the way we deliver services to very vulnerable populations. We know that those with mental health diagnoses are often among our highest cost, highest need population.

So, you've given us a lot to think about. We hope you'll feed back to us some of the information on the indicators you're using, as well as kind of your success and your ability to document savings. But, this has been a very helpful start at what I know is going to be an ongoing conversation. So, thank you very much for being here.

And now we are going to turn to our report on our Managed Care Payment Roundtable.

We are at Tab 3 in your notebook, and we are going to turn to the Managed Care Payment Roundtable and ask Mr. Park to both walk us through some of the key issues that came up at that roundtable and to begin our discussion of where to go next on managed care payment.

SESSION 2:

REPORT ON MANAGED CARE PAYMENT ROUNDTABLE

* MR. PARK: Thank you, Diane.

On March 13th, MACPAC convened an expert roundtable on Medicaid managed care rate setting. Attendees included representatives from actuarial firms, state Medicaid officials, managed care plans, CMS,

and beneficiary advocacy groups. The purpose of the roundtable --

CHAIR ROWLAND: And our own Mark Hoyt, I believe.

MR. PARK: Yes. Commissioner Hoyt was present.

The purpose of the roundtable was to gain a better understanding of the important issues in the rate-setting process from various perspectives and to identify potential areas of work that the Commission may want to consider as part of its future analytic agenda on managed care.

Today's session provides a summary of the main issues and themes that arose from the roundtable discussion. The staff would appreciate the Commissioners' feedback on issues and themes raised during the roundtable and if there are particular ones that you would want more analysis on or to prioritize for future MACPAC work.

As a reminder, your meeting materials include a background paper on some of these issues and a list of the attendees. As mentioned before, Mark Hoyt participated in the roundtable, so I invite him to add his thoughts on what the important takeaways were from the discussion.

The roundtable was organized around a few broad themes, which I will discuss in greater detail.

The discussion about rate setting from the Medicaid expansion group focused primarily on how the lack of claims experience for the low-income on childless adults creates a challenge in developing the baseline costs and utilization, trend, and savings assumptions used to calculate the capitation rates. Many of the participating actuaries seemed to have the most uncertainty regarding assumptions on pent-up demand and the mix of individuals that would ultimately enroll in the program.

Pent-up demand may not become apparent immediately upon enrollment, and early experience may not reflect a true baseline, so it may take a few years of experience to get a true sense of what the steady

state of the population may be.

It is also difficult to base assumptions on other states' experience with low-income adults, as the eligibility rules and benefit designs are different across states.

The managed LTSS discussion focused on how the developed capitation rates incentivize health plans to provide care in the most cost-effective setting, while still mitigating the plan's financial risk. Participants discussed whether having a blended rate based on a targeted nursing facility and community-based services mix created stronger incentives to provide community-based care than separate nursing facility and community-based rate cells, with some incentives for transitions.

Some states use different LTSS rebalancing and savings assumptions by region to account for provider availability or make different assumptions by plan to take into account the plan's actual enrollment mix. Plans felt this better reflected their abilities to achieve the targets.

The use of functional assessment data can be valuable to the rate-setting process to better predict LTSS cost. There was some support among participants for the development of common functional assessment tools, such as the core set of measures, as long as states still had some flexibility to add other components.

Recently, CMS has encouraged the development of standard assessment tools within a state.

Throughout the roundtable, there was a lot of discussion about risk sharing and risk mitigation strategies. CMS has encouraged states to use two-sided risk corridors for the expansion population due to some of the uncertainties with the population. Plans also support risk corridors but had some concerns due to the timing of cash flows, particularly if a plan had to ensure a large up-front loss with the risk payment coming several months later.

Some states have also built risk corridors around specific assumptions. For example, Arizona built risk corridors around the targeted nursing facility community-based services mix in their MLTSS rates. Even with risk corridors or risk adjustment, high-risk pools can be a useful tool for programs that cover special high-cost populations, such as individuals who are dependent on a ventilator. A high-risk pool provides additional coverage beyond risk sharing or risk mitigation, should these extremely high-cost individuals disproportionately enroll in one managed care plan.

The discussion on pay-for-performance and value focused on the ability of risk-based managed care plans to deliver value to the state and how the capitation rates may be designed to promote value through increased quality and lower cost. Plans were generally supportive of quality-based incentives, as long as the measures were consistent across plans, transparent in the definition, and attainable based on reasonable assumptions and actual experience in a marketplace.

Some participants believe that states should use operational quality measures in the early years of a new program and then introduce the clinical measures later once actual experience was known.

Participants also discussed withholds, in which a state keeps a certain percentage of the capitation rate that the plan may earn back by meeting certain quality and outcome measures.

There has not been clear guidance as to whether the withhold amount should be considered in determining the actuarially sound rate range. CMS has started to require that states certify that the rate minus the withhold is actuarially sound and a draft of a new actuarial standard or practice for Medicaid rate setting has a similar standard.

There was some discussion on medical loss ratios and if there should be a national standard for Medicaid. Most participants were against a national standard for Medicaid due to the difference in the

populations and benefits included in managed care in each state. Because there is not a standard population or a benefits package, a reasonable medical loss ratio in one state may not be reasonable in another.

Because MLRs can be volatile from year to year, some participants suggested that states should calculate the MLR using a rolling average over a few years or allow a plan to carry over a certain amount of losses to account for the year-to-year variability.

There was some mention that MLRs do not necessarily measure quality or value. Plans believe they should have the ability to put more resources into non-medical cost if these investments can improve outcomes or drive value.

A small number of states instead use a profit-sharing model where the state will share in any profits above a certain threshold. One benefit to a model of this kind is that it does not require a clear delineation between medical and administrative cost, which allows plans more flexibility in how they deliver services.

Some states have introduced other service delivery models, such as accountable care organizations, in conjunction with risk-based managed care. There are challenges in measuring savings and performance for these other delivery models, and states need to determine how to evaluate savings and how to factor the achieved savings in future arrangements.

In cases where the managed care plans are expected to contract with the accountable care organizations or these other delivery models, the plans wanted the state to clarify their expectations of how profits and losses should be allocated between the plans and these other entities.

In terms of federal oversight, CMS has been working on improving the review process by updating review tools and protocols, strengthening the capacity to provide systematic reviews, and clarifying policies

across regional offices. Actuaries and plans would like more guidance from CMS on certain complicated issues. One example would be for CMS to provide guidance on the options available to build the health insurer fee created by the ACA into the capitation rate.

Both CMS and state representatives share that administrative capacity and staff turnover contribute to complications in the rate review process, and that there is a need for structured training on managed care issues.

Throughout the discussion, participants had a few suggestions for future work that could help the rate-setting process. Most of these were related to collecting data and conducting research to improve the assumptions and adjustments used in the rate-setting process and improving the rate-setting infrastructure by providing more guidance and technical assistance and also increased training for staff. Examples of these suggestions included better data on the Medicaid expansion population, such as quantifying the magnitude of pent-up demand and identifying the key drivers, such as selection issues that drive enrollment and spending patterns.

A study on MLTSS to identify if certain incentive structures are better than others in promoting a shift to more cost-effective care and improved outcomes, guidance or technical assistance on how to structure quality incentives and other arrangements between plans and providers to drive value and actually change provider behavior.

Identify essential core domains of functional assessments that could help develop standard LTSS risk adjustment tools, and also, more training and education for staff on managed care oversight and rate setting. And all participants thought this could be beneficial across CMS, states, and the health plans.

Our contractor, Mathematica Policy Research, has prepared a summary report of the roundtable,

which includes more detail than this presentation that we are reviewing now and will be provided to the Commission later in the spring.

As I mentioned earlier, we would appreciate feedback on any next steps or priorities for the Commission based on the issues raised during the roundtable.

CHAIR ROWLAND: And that document is in your briefing books.

MR. PARK: Yes.

CHAIR ROWLAND: I am going to turn first to Mark, since he was a participant in the roundtable, and then we will start the questions around the table with Patty, Sarah.

Okay, Mark.

COMMISSIONER HOYT: A couple other comments or thoughts on what is going on in the background that is putting even more energy into this from an actuarial point of view, the actuaries have operated under what is called a "practice note" in the past, issued by a society of actuaries. The committee met and provided general guidance. This is specific to Medicaid managed care rate setting that they are supposed to adhere to. That is being upgraded to a standard of practice now, which is more of a "thou shalt" than, you know, suggested guidelines.

Other just general trends that you're aware of, more and more people being enrolled in managed care plans or contracts, more and more money being spent.

The other thing that might not be completely clear from reading through this or thinking about things, like the primary care bump, actuaries could go on -- and some of them do -- for hours on the health insurance fee and health insurer fee and how to treat that in the rates and to track that. That is just one little small item of rate setting.

Also, remember this is supposed to be prospective rate setting, so one of the things that would drive any managed care company crazy is when states don't do that or they are just unable to do that, to provide what the rates will be. It ought to be 30 to 60 days in advance of when the contract starts, and that is extremely challenging. I know you have this kind of elevation of the process that an actuary is supposed to follow. It is just making things pretty complicated, and several of these items in here are just real hard to deal with.

The discussion on long-term care was pretty lengthy, too, that Chris could only touch on right here but a whole lot of concerns there. Some of those, we've talked about as well.

One other comment real quick maybe on the risk corridors or other things you could do there, which I think are good ideas when you have expansion or things that are brand-new, at least in terms of covering risk as fairly as possible, is the accounting around that or the data sources that are sometimes complicated there, so now you are doing something retroactively. I think whether you are publicly held or privately held, it kind of drives the accountants nuts when you don't really know what the payment is going to be really for this year that's now ended and you are trying to do accrual accounting. It could take 6 to 12, 15 months or more to fully reconcile a reinsurance premium or a risk corridor and decide what actually happened, so that creates its own level of stress as well. It is just making all the financial transactions incredibly complicated, and that is while you are trying to expand Medicaid and do all these other things.

This was a great discussion. You guys can just be jealous you missed seeing 20 actuaries in the same room for 8 hours. I couldn't sleep for nights after that.

[Laughter.]

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: If we were in that room, we would all need to be in the behavioral health medical home.

[Laughter.]

COMMISSIONER GABOW: I have three quick questions. The first is, given that UPL is part of the fee-for-service payment and is excluded from managed care, was there any discussion about how or if the whole issue of UPL needs to be woven some way into rates?

The second question is, given that there doesn't seem to be good movement between commercial Medicare and Medicaid, but you would think they might be, given the delivery models, how do actuaries look, or should they look, at what's happening in those other markets as you set these rates?

And the final is, given this population, should there be risk adjustments for the social determinants of health, like homelessness or a level of education or the structure of the family unit? I mean, a single mother of four may be different than an adult. How do we think about those social determinants of health in terms of how we are going to set rates to maximize care?

Those are my three questions. Thank you.

MR. PARK: Sure. There was a little bit of discussion on the UPL, but it was more in general terms of how certain wrap-around payments are discouraged in managed care rates, which would include UPLs, and in other cases, one of the participants had brought up maybe a desire to have a wrap-around payment to the accountable care organization. CMS had stated the reasons that these were prohibited in terms of wanting the payments to be tied to actual services. So nothing was really said in terms of how to better take these into account.

I think CMS's preference would be for the arrangements to become more based on actual services,

so to pay like hospitals based on the actual services incurred versus having a UPL payment when that interacts with managed care.

Particularly with other markets, I think much of that discussion was around the expansion population, and if individuals are churning between the exchange and Medicaid, how can you take this into account in the rate-setting process if they are only maybe in Medicaid for 6 months versus a year and whether certain services would be provided in Medicaid versus the exchange and while they are churning.

There was a similar discussion about not necessarily social determinants of health but other factors that might be important to consider on the exchange population, like income, are individuals below 100 percent of the federal poverty level different than individuals above, between 100 and 138 percent, and whether there are any data out there that could help actuaries determine if that should be a factor in creating the rates and if separate rates should be paid for different income levels.

COMMISSIONER ROSENBAUM: So I have, I guess, a somewhat different question. I don't even -- it has become so difficult in Medicaid to grapple with this question of service delivery. It is sort of a continuum from the last discussion.

We have got this proliferation of delivery types, and this discussion, of course, today, the discussion you had, this really interesting roundtable discussion was about delivery types that are risk-sharing delivery types, and there are several different models of risk-sharing delivery types. The thing that the risk-sharing delivery types, I think, tend to have in common is more vertical integration.

I am sure there are primary care case management models that use risk capitation, but given what we know about quality in the private sector -- so we point to things like the Cleveland Clinic or Marshfield or Denver Health -- it is not clear to me why there is -- and I realize in some states, it is rural and smaller

populations, but I am increasingly interested in why we can't move the Medicaid delivery system more toward a more comprehensive vertical integration model.

It is like we have all these payment arrangements, but I feel like we are sort of not going anywhere with them, other than trying to figure out who is carrying risk at any given time, without dealing with the underlying question of why are we doing this.

I would like to see us sort of think about the roundtable discussion in the context of not just how do you set your rates, but how do you accomplish something that would be good to accomplish in the program. It goes back to the last panel where this question -- I am still not sure of the answer -- if I have someone with a mental illness diagnosis who is getting primary care from a provider that is sort of specialized to deal with primary care, what happens to this person who has cancer?

I am concerned that we are sort of wandering around in delivery systems and payment mechanisms and not sort of getting underneath it all to say what would you have to do to structure a payment system to get us to a place where we see more comprehensive and vertical integration of care along the models that we know get all the kudos in health services research.

This is a long way of saying I am wondering in your discussion, when you think about these models, whether the scope, the size, the depth of coverage, all that sort of changes the way you think about distribution of risk.

MR. PARK: Sure. And certainly, the discussion did not go into the depths that you would have preferred, but some of the discussion about how where in states where there is managed care and these other delivery models, such as shared savings models or accountable care organizations, there was some discussion, and there was no clear conclusion about how should savings be appropriately distributed

between like the managed care plan and the ACO and providers, where you have all these different incentive arrangements, and how can a managed care plan actually change the behavior of the provider, where currently a lot of the arrangements with managed care organizations and the provider are still fee-for-service-based.

So if you put these quality incentives on the managed care plan, what are the things they can do to actually change the provider behavior and kind of become these more vertically integrated systems.

There wasn't a whole lot of clarity as to what the best practices might be, but there was some interest in doing more research to develop how states and managed care organizations could kind of achieve some of those goals.

COMMISSIONER HOYT: Yeah. I was going to say I think what you are talking about, Sara, is sort of where program design and the financing structure of Medicaid collides, and the simplest answer I can come up with to your question is start over --

[Laughter.]

COMMISSIONER HOYT: -- because you've got different financing schemes that we have written chapters on or talked about that have been around or layered in. I am thinking even of comments in the long-term care chapter later where it is kind of like what you are seeing is just sort of now an aggregation of all these different things that have happened over time, but there was no overall strategy to it or that somebody put all the elements on the table at the same time and said, "I think this would make sense. This is how we want to do this. So as the delivery of care or the ways to manage risk have evolved over time, I don't think the payments kept pace.

And even related to Patty's comment about -- I think she was asking about commercial and

Medicare payment rates or financing, how that would compare to Medicaid, it is so hard to do without pulling the veil back on Medicaid. Other things we have written about, about supplemental payments and UPLs and these other things, all these little streams of revenue that providers get or that states have used to try and supplement their share, there is no counterpart to that in the commercial space or Medicare, so it makes it really hard to look at that and go, "Oh, yeah. Let's do some A-B comparisons." You can't do it. So until you change some of that financing, you are going to be blocked. It's a significant barrier to doing some of these other things.

COMMISSIONER CHAMBERS: Chris, thanks for a great report. The detail that was in the write-up about the session was really helpful, and it really appeared to cover a lot of key areas.

Mark, appreciate that you participated in that since, like you said, got so excited being in a room with all those actuaries. I am glad that there is somebody who enjoys that, since I can't share the same thrill.

[Laughter.]

COMMISSIONER CHAMBERS: But certainly, I also enjoyed your comment about getting rates before a rate year starts. That would be a revolutionary idea for those of us who have to try to do budgets and rates are done afterwards, but just the history of getting things right and why this is so important is getting it wrong is very detrimental to the delivery system.

California's example is when ABD or seniors and persons with disability population was mandatory starting in 2011, as the state really miscalculated the rates initially, and it took several years for it to be corrected, but it put some plans at really financial risk of actually being able to continue to participate, and so it is so important. And then that really translates into the discussion about the expansion rates and how plans went into it so fearful of what was going to be the impact, what was really going to be a pent-up

demand, what was this population like.

At least our experience in California was we were very collaborative with the state and with CMS's, really, guidance on trying to be able to establish rates that would protect everyone, as the federal government didn't have an incentive to overpay when they were footing 100 percent of the bill, but the same time as the state needed to be prudent with taxpayer dollars, and the plans wanted to make sure as protection. So I think as putting risk corridors and looking back later at what the result was is sort of the shared savings concept on steroids, and I think it was a really good process.

The other piece is a concentration on the LTSS. For those of us who are just embarking on that, a lot of work has gone on. In our experience in California, the duals demo started April 1st in four counties or in three of the four countries, and it is still a great unknown as to what the results of that will be.

So I think continuing to make sure the right incentives are in place, particularly on the balancing issues, as we are going to talk later in the LTSS discussion, to make sure that happens.

Just in general is the whole actuarial soundness issue of rates in general. So it sounds like it was a great discussion, and I am glad we embarked on that and look forward to working on those issues as we go forward.

Thanks.

COMMISSIONER HOYT: This isn't in response to anything Richard said. It is just one other thing that I thought of. It wasn't front and center on the agenda, but it was something that was discussed there, and it is part of this standard of practice that is about to come out.

If you are not aware of this, there is no requirement that CHIP rates be actuarially sound. Actuaries for a long time kind of scratched their head and said why would you not want that to be true, and

that is early on in this standard of practice that CHIP rates should be actuarially sound, and that would be a future requirement.

Also, you are probably aware that CMS has a checklist they sort of go through in their office to see, at least according to them, that the rate filing and the rates themselves are, I guess, you'd say actuarially sound to them or meet their criteria. That is in the process of being kind of rethought as well.

CHAIR ROWLAND: Well, I certainly think that this is an excellent beginning, and the background paper had a lot of great content in it, and then your discussion obviously and your summary add to that. So I think we really have a really insightful paper that we can put out or begin to put out on these issues and figure out the follow-up work from there, so good work on the part of the Commission staff. Mark, thank you for the guidance you obviously gave them in helping to put this together, and we look forward to continuing this part of the discussion.

At this point, we will adjourn for our lunch break and reconvene at 1:15. This is a working lunch for the Commission members, so please return to the table as soon as possible.

Thank you, and thank you, Chris.

* [Whereupon, at 12:18 p.m., the meeting was recessed, to reconvene at 1:15 p.m. this same day.]

AFTERNOON SESSION [1:24 p.m.]

CHAIR ROWLAND: Thank you, and we'll reconvene now with the major topic that the Commission is working through as part of our upcoming June report, and that's to continue our examination of the Children's Health Insurance Program and the options for its future. And so I'm going to turn to Chris to really begin the walk -- I know we're going down a number of quick turnarounds on this one -- through the content of this chapter as we struggle to decide where we're going with our recommendations. So, Chris?

SESSION 3:

REVIEW OF DRAFT JUNE REPORT ON THE FUTURE OF CHIP

* MR. PETERSON: Thank you, Diane.

In our March report, the chapter on CHIP described the short-term and long-term issues facing CHIP. The March chapter then focused on the short-term issues, including your two recommendations to eliminate CHIP waiting periods and premiums for children below 150 percent of the federal poverty level.

In that chapter, we said that the June report would focus on the longer-term issues, which we discussed at earlier meetings and culminating in the February meeting. In the February meeting, we provided you with separate papers on eligibility, affordability, covered benefits, and network adequacy. And based on your feedback, we have put together a draft chapter for the June report that you have in your materials. It reflects your comments from our last meeting as well as technical comments we have already received from some of our external reviewers. And so what we are going to talk about today in this session is first, summarize the draft chapter very quickly, since it is much of the same material you saw last time; and so you can have ample time to discuss the potential recommendation that you seemed to coalesce

around at our last meeting; and then we will turn to that discussion of the draft recommendation.

So the chapter begins with a brief overview of the history of CHIP: that it was enacted in the Balanced Budget Act of 1997 as something separate from Medicaid, to be different from Medicaid in terms of giving states greater flexibility and enhanced matching; and it also provided capped funding through fiscal year 2007.

CHIPRA came along, and it did a number of things related to CHIP, including requiring dental benefits, mental health parity. It did things beyond CHIP, for example, the child quality measures, which are not in the CHIP statute but are in other parts and deal with Medicaid and CHIP both. But CHIPRA extended CHIP allotments through 2013, and then the ACA extended CHIP allotments, the financing, through 2015.

In terms of the impact of CHIP, since CHIP's creation, the percentage of uninsured children has been cut in half. And another important aspect of CHIP is that it has encouraged enrollment of eligible but uninsured children. So enrolling not only CHIP-eligible kids but also Medicaid-eligible kids has been one of its impacts.

As we talk about eligibility, as was discussed in our last meeting, the ACA's maintenance of effort, the MOE, for children applies through fiscal year 2019 so that if CHIP funding is exhausted, under current law there are two scenarios that our reading of current law is that Medicaid expansion programs, subject to that MOE, must continue to offer Medicaid coverage even once the CHIP money runs out, even though they will be getting the lower Medicaid matching rate. And for separate CHIP programs, they are required to transition enrollees to exchange plans that are comparable if those plans are available.

And I want to make one slight clarification. We had some feedback from CMS on this point, and I

just want to say what their interpretation of that provision is. You remember we talked about it last time. And CMS says that as the CHIP money ends, separate CHIP programs, those states must transition those kids to certified exchange plans. If there are not certified exchange plans, the state is not required to transition those kids and those families. But the families may, on their own, obtain exchange coverage if it's available to them. So I just wanted to point that out. It's a slight adjustment from what's in the chapter I think that you have.

So as we look at where kids are currently, 30 percent are in Medicaid expansion CHIP programs, and then 300,000 unborn children, as we talked about last time, and then two-thirds are in separate CHIP programs who are 0 to 18 years old.

CHAIR ROWLAND: Just for clarification, currently the children that are in Medicaid expansion programs are getting the higher enhanced CHIP match even though they're in Medicaid.

MR. PETERSON: That's right. That's right. So in 1997 states had the option, once CHIP came along, we can expand Medicaid and just put more kids in our Medicaid program. The difference is we're going to get the CHIP matching rate from CHIP funds. So those kids are Medicaid kids, but they're just receiving the CHIP matching rate, CHIP dollars.

If CHIP ended, exchange subsidies may not be available as an alternative, as we talked about last time. Many former separate CHIP children would be ineligible for exchange subsidies because they are eligible for a parent's employer-sponsored coverage. In some cases, the parents are already enrolled in that coverage; in some cases they are not.

We have not estimated the impact on how many more kids would be uninsured, but this number, 2 million, comes from an analysis by the Urban Institute that was published in 2011 that, with this scenario, 2

million more children could be uninsured if CHIP ends under current law.

But we did look at, among the separate CHIP kids, where their eligibility would be, and there may be kind of a default assumption that all of these kids would be eligible for subsidized exchange coverage. In fact, we found that only 44 percent are; the others are eligible for employer-sponsored coverage. And, of course, the issue is: Would those kids be enrolled in that coverage in the absence of CHIP?

So that covers the eligibility issues, and now I'll turn it over to Lindsay to talk about affordability.

* MS. HEBERT: Okay. Great. Thanks, Chris.

So as we reviewed at the February meeting and as Chris just reviewed, if CHIP funding runs out, separate CHIP programs are required to transition enrollees to exchange plans if they have been certified by the HHS Secretary as at least comparable to CHIP in terms of benefits and cost sharing. I will review our analysis of cost-sharing comparability before turning it over to Ben to discuss the benefits.

In our analysis of affordability, we estimated actuarial values of five states' CHIP plans. We then compared these actuarial values to the prescribed actuarial values for exchange plans for individuals qualifying for cost-sharing reductions as outlined in the ACA.

In Table 1, we show the actuarial values of these five separate CHIP plans. As you can see, they are all between 97 and 100 percent, with the exception of the highest income group in Utah's separate CHIP plan, which has an actuarial value of 90 percent.

Table 2 shows the prescribed actuarial values of exchange plans for individuals qualifying for cost-sharing reductions, and these would apply to individuals with incomes below 250 percent of the federal poverty level.

As you can see, in comparing the actuarial values in these two tables, subsidized exchange plans do

not appear comparable to separate CHIP plans in terms of cost sharing.

Now I'll turn it over to Ben.

* MR. FINDER: Thank you, Lindsay.

The draft chapter includes a comparison of covered benefits available in separate CHIP programs and exchange plans. But because exchange plans are so new, there's very little information available on these differences. Some existing research points to three areas where some differences may exist.

A GAO comparison of separate CHIP programs and EHB benchmarks found that covered benefits were mostly consistent between the two programs. The two exceptions were habilitative benefits and pediatric hearing benefits.

The same study found that separate CHIP programs tend to have fewer benefit limits relative to EHB benchmark plans.

And another difference between separate CHIP programs and exchange plans is their approach to offering dental coverage. Dental coverage is a mandatory benefit of separate CHIP programs. Exchange plans are not required to cover pediatric oral benefits if stand-alone dental plans are available in an exchange.

Individuals and families are not required to purchase pediatric coverage when offered separately, except for three states -- Kentucky, Nevada, and Washington -- where it's required by state law. So it's possible for someone to enroll in an exchange plan and not have access to pediatric oral health benefits. And the section concludes by highlighting these issues for consideration in our discussion of the future of CHIP.

And now I'll turn it over to Veronica.

* MS. DAHER: Thank you.

So in the network adequacy section, we discussed the assumption that CHIP networks are more comprehensive than QHP networks, and note that we have found limited evidence to either support or refute this position.

A comparison of Medicaid, CHIP, and QHP network adequacy standards found them to be similar, though QHP networks are only beginning to be tested.

Another important issue is the monitoring and enforcement of network adequacy standards at a federal and state level. In future reports, MACPAC will examine network adequacy monitoring and enforcement to provide further context to these comparisons, as well as work to develop additional information to shed light on CHIP and QHP network adequacy.

MR. PETERSON: So under current law, federal CHIP funds will begin to run out shortly after fiscal year 2015, and that's going to vary by state. But beginning in about a year and a half, under current law the money will start to run out in various states. The ACA's 23 percentage point increase in the CHIP matching rate that applies for fiscal year 2016 through 2019 will accelerate the exhausting of those funds. And then as we have talked about, states with Medicaid expansion programs would have to -- our understanding is that they would have to continue that coverage so states would face higher expenditures for those children as they move to the regular match, while states with separate CHIP coverage, after the money runs out, would no longer be required to finance any coverage whatsoever.

So the issues that were talked about in the previous meetings we've kind of highlighted here, that as a result of this scenario, under current law uninsurance among children would increase significantly; that cost sharing for affected children's health care services would increase significantly for many families; that

during the MOE there would be kind of an inequity between states that are Medicaid expansion versus separate CHIP; that it's unclear whether or not exchange plans are ready to serve as an appropriate alternative; and that CHIP funding should be temporarily extended while these issues are considered and addressed.

And so based on most of the comments that happened at the last meeting, we started -- we crafted this potential recommendation as kind of a starting point for your conversation here today: that the Congress should extend the federal CHIP allotments through fiscal year 2019, and the idea was, as was talked about last time, consistent with the maintenance of effort.

CHAIR ROWLAND: So what we need to focus our discussion on today is what range of options should be considered for CHIP's future, how to structure those options in our discussion, and whether we want to make a short-term extension recommendation while things settle out, if so, what the extent of that recommendation would be. And we are, of course, hampered by the fact that each of the recommendations we might make are likely to have significant differences in terms of their cost, and we don't actually have formal cost estimates on any of the range of options. So we really need to think through the substance of the recommendations or the substance of the options right now and then try and work through to see what the cost estimates may be down the road.

So I told Patty that we would open the discussion with her. You'll wait? Okay. Then, David.

VICE CHAIR SUNDWALL: I like this idea of having options, and I think that one obvious one is that we could do nothing. As a Commission, we could recommend that we let the law play out and see what happens, because I think there are those who expect that there will be children that will be in the exchanges. We know some states, of course, will be able to cover them with Medicaid, and that as the law

states, is one option that we have before us as a Commission.

COMMISSIONER ROSENBAUM: I concur that there is the option of simply letting the program lapse, letting program funding lapse. And, of course, even the states that run separate programs could make the decision to do what the Medicaid expansion states have done and cover the children as a Medicaid eligibility -- without the enhanced funding, of course, because that would go away.

I think there are probably a couple of other options we want to consider beyond this one that would began to think about last time, and we can think about sort of laying them out as a series of options that are somewhat overlapping, somewhat complementary to one another. So in addition to the option David identified, I would put two more on the table. One is to think about essentially a transitional funding period for CHIP, but one that is shorter than the full four years. And the argument in favor of a shorter period is that there are, as the chapter very accurately points out, decided shortcomings in the Affordable Care Act itself, in the premium subsidy system and in the operation of exchange plans for children. The actuarial value of the plans in pediatrics is much greater in CHIP. There, of course, are complications with the dental benefit under the Affordable Care Act, and there is, of course, the so-called family glitch problem.

These are very specific problems, and I am concerned that by extending the transition period through the 2019 date we are sending -- we are letting everybody essentially to allow those problems to continue to go on as opposed to taking the steps that might, in fact, be desirable to actually make the Affordable Care Act work more appropriately for children.

I think the original act envisioned that more would have happened already to bring pediatric policy into alignment with the Affordable Care Act. It hasn't happened because, of course, implementation has been so complex. But I think we need to think very carefully about how long a transition period we want

to recommend.

So one option would be a two-year transition period with the expectation that two years is enough time to begin to do the additional work of aligning national health reform with pediatric policy. The two really should be able to live together.

So I would flag that both a hard -- I see those options are related, that is, if we went with a shorter time period, we would also be recommending a series of steps toward the alignment of child health policy, better alignment into the Affordable Care Act, to sort of set a faster pace for ourselves with a bridge time. So I would add those.

VICE CHAIR SUNDWALL: Sara, just a clarification. So I understand it, your recommendation for the shorter transition would be just one additional year of funding beyond what we have now?

COMMISSIONER ROSENBAUM: Probably, given the fact that we are almost at 2015, I would recommend continuing, and I think 2016 will be a complex year because it's an election year, so not a lot may happen. So I would recommend into 2017, but with a clear timeline and instructions about the kinds of analytic work that will be needed between now and then to determine whether in 2017 we should, in fact, have ready to go changes in the underlying Affordable Care Act to eliminate the kinds of problems that have become all too evident.

CHAIR ROWLAND: Well, Sara, actually wouldn't those changes have to be enacted during this transition period? So actually the two-year extension would provide time for legislation to address the next steps.

COMMISSIONER ROSENBAUM: Yes.

COMMISSIONER EDELSTEIN: My question is of Sara. I want to understand better your

thinking about how a shorter period would leverage our interest in addressing those specific problems in the Affordable Care Act for kids?

COMMISSIONER ROSENBAUM: Yes, I think that a signal that the Commission is ready to extend CHIP all the way -- its funding structure and, therefore, its separateness as a program really -- all the way through 2019 suggests that we have -- there's sort of an implicit implication from that, which is that we have not a lot of faith, that several very specific problems with the Affordable Care Act can be identified, addressed in legislation, and rectified. And I think that, despite the complexities of the Affordable Care Act, the notion that we should as a country be able to structure something that we're calling national health insurance to be as responsive to pediatrics as it needs to be to adults is not something I'm ready to give up on. I think the longer the glide path, the easier it is to put off. Also, I should note, we don't know the cost estimates at this point. The cost estimates could be significant. And without cost estimates, I am very concerned about obligating -- about recommending that Congress obligate itself to four years of funding.

CHAIR ROWLAND: I think it's also clear that this chapter that we have before us really does lay out a lot of the issues between CHIP and the Affordable Care Act so that the areas that need to be addressed are clearly there in the chapter.

COMMISSIONER CARTE: As we look at an array of options from the doing nothing to a bridge or a glide path and to perhaps a full four years, as was previously discussed, I'd just like to have clarity that in the chapter we talk about two million children at risk of losing coverage just due to eligibility reasons in the separate CHIP programs, but the additional two million that could lose coverage just for affordability issues. And one of the things that I think argues for having at least two years out is I think I heard from a

study that, you know, most households or families make their decision on going into the exchange what plans they choose just based on premiums, and I've seen firsthand from CHIP focus groups that sometimes families will choose a plan based on a low, what to them is an affordable premium, only to find out they have other out-of-pocket costs, and then they subsequently drop coverage.

So the point there is we would not see for two years out after 2016 what would be the real effect of some of these issues.

COMMISSIONER HENNING: One thing I wanted to point out too about the CHIP program is that -- and we all know this, but certain states use the CHIP program to cover undocumented pregnant women, and yes, they're not here legally, but those babies are going to be U.S. citizens. And we have a responsibility to make sure that those babies are born healthy. And it's going to cost us a lot more money if they're born unhealthy.

And even though 300,000 doesn't sound like a big number, it's about 8 percent of the pregnant population that delivers each year. So we really need to keep in mind that that's another group that loses coverage completely if CHIP goes away.

MR. PETERSON: And I just want to -- just technically, the unborn child is covered, so CHIP cannot cover undocumented women.

COMMISSIONER HENNING: Right, but it is a way for them to get their prenatal care.

CHAIR ROWLAND: For the unborn child to get the prenatal care.

COMMISSIONER COHEN: Thanks, and great job with a tough and incredibly important topic. I guess I want to make a couple of points.

First of all, I agree with the suggestion that we lay out options, agree with the suggestion that one of

the options be a two-year extension. I think we all recognize that, you know, two years in the life of changing a Medicaid program is a short -- sorry, Medicaid or CHIP or, you know, any state program where it's going to take a very large number of states to make changes is a short period of time. But I agree with two points.

First of all, without information about the cost, it is really difficult to imagine right now, with the information that we have now, making a recommendation that goes further out than that. And, secondly, and as importantly to me, I think it sends a strong signal that the work and the action and the thinking and the legislative work and the policy work has to be done quickly, and now, and that this is not kicking the can down the road for, you know, ten years' worth of extensions and things like that. So that's one point that I want to make on the substance.

I think we also, though, have to recognize that because we don't have full information about the ACA and its implementation, we don't have the research base that we are going to be sort of laying out the components of it in the chapter, and now we also know that we don't know the cost of extending CHIP, this may very well have to end up being a multistep process in sort of figuring this out. And I think none of us would prefer it that way, but it really has to be, and it may be more than two steps. It may have to be three.

So, personally, I would sort of lean toward a short extension for now, considering how much we don't know, but we will learn more about, say, for example, the cost estimate before we learn the answer to many of the substantive questions that you are posing.

So I think we sort of have to acknowledge that we may do something short -- and I would lean towards doing something fairly short term and seeing where that takes us.

I guess the last point -- oh, sorry.

CHAIR ROWLAND: We should be clear about what the issue is with the cost estimate, and that's that we don't know how to net out the interaction with the Affordable Care Act and with the subsidies in the exchange. So that, in fact, one of the reasons that we are unable to make a longer-term recommendation is that we need that information about how the exchange subsidies are interacting with CHIP coverage and how to net that out to get at that federal cost. So we know what it would be to straight-line extend CHIP, but that's not in the same world as we now have the Affordable Care Act and have to take that into account in figuring out what the federal cost would be.

Go ahead and finish your point.

COMMISSIONER COHEN: I'm done. Thank you.

COMMISSIONER MOORE: While I think it might be a little bit repetitive, I think that if we can actually write out the four options that have been discussed with some description that comes out of the chapter as you've already written it, it will make it much clearer for all of us. And then hopefully we will get some cost estimates on each of those. I don't have any idea what the timing will be, and then we'll be able to explain our reasoning and our thought processes and the options separate from all of the basic information, which is very, very good and has been very well written in the chapter. So I would just like to urge that we put this together in maybe a slightly different way than we have done for other chapters.

And since we're talking about this as something for the June report, the question I have for the staff is: If we put this together as an optional paper, we have some sense of where we're all leaning if we can -- in the absence of a cost estimate, and then when we get a cost estimate, before our May meeting, can we change our minds? Or can we use that to further explicate the materials and the recommendation?

CHAIR ROWLAND: Well, we can also always put out the June report but then actually issue a firmer recommendation with cost estimates in September. I mean, we have no limitation on when we can make recommendations. It's only when they get published in a June or a March report. And I think that as we go forward, the more information we get, we may well have a lot more information in September where we want to take an additional step. Just as we did some recommendations in the March report, now we're considering a next step. But I think this is an evolving process and we shouldn't see it as we must make the final recommendation. In fact, I doubt we can make a final recommendation on CHIP until we've considered a lot more options.

VICE CHAIR SUNDWALL: Just a point of clarification for our guests. We're spending all this time worrying about this because the statute requires any recommendation we made to have a cost estimate. It's just like when I worked on the Hill and we do bills, you have to get that budget impact statement, and so do we.

CHAIR ROWLAND: Okay. And Patty was next, I think.

COMMISSIONER GABOW: I think that having a glide path which is short and sending a message that we don't see this as a need to go on for life as we know it really fits with one of the principles on the Commission, which is simplification of our health system, and to the extent that we can do that, I think we should. In that regard, I think an option that has to be there is the option that exists now that states could move these children to Medicaid, and I think we should say that. It isn't just that they could move to subsidized premium for those states that have a separate CHIP, but states could make a decision.

So I think let's take all the options, but I think having clarity that we don't -- one of our other principles is we believe insurance coverage creates access and quality care, that we don't want to see 2- to 4

million children uninsured, and we don't want to step back from the tremendous progress we've made in improving the health and well-being of children. They are our future in this country, and we should invest in our future.

So I think that all those, that principle and the principle of simplification, I think, lead us to having a glide path to another alternative.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: I would just reinforce the importance of talking about the bridge, that we want to learn the lessons from CHIP and address the issues we've raised to get to health reform with a good pediatric benefit. I would hate to see this viewed as kicking, kicking the issue down the road.

I would also caution us, though, to speak a little bit about the cost to the states as we think about the cost in the state budgeting process, because I think there is a considerable disconnect and lack of understanding about the complexity here. On the one hand, the law says we shall -- we are going to have a 23 percent bump in match and continue maintenance of effort to 2019, but the funding is only available to 2015. I think that is not widely understood in a broad public and needs to be, so we are quite clear about this. This isn't the federal government changing its mind or taking back money that it had promised in the ACA.

And that we talk about -- as we talk about the options, we talk about the implications to states. While it is true that states could pick up these children on Medicaid, that would be at a regular match rate, and I think that is a state obligation. So I think the 2 years also gives the states time to plan for this, but we also, I think, do need to address this issue of the 23 percent bump.

CHAIR ROWLAND: Well, we also should recognize that even if states are covering these

children now under the Medicaid expansion, they are getting an enhanced match rate for those children, and so if the funding ends, they lose that enhanced match too. So there are implications for the states, regardless of which of the two policy options they pursue.

COMMISSIONER CARTE: Well, I would just like to remind folks, too, that states may have the option at looking at a basic health plan that they are only just now seeing the federal regulations for.

VICE CHAIR SUNDWALL: I just want to make one more point. I keep hearing states haven't had time to prepare. Well, the law was passed in 2010. I think they have had time. I mean, they have been anticipating this, and I think some states have. So I understand and am supportive of this transition period. I think it makes sense of the complexity of unrolling the ACA, but it is not like they haven't known that this was in the law.

CHAIR ROWLAND: Well, some states may, even if there is a 2-year extension, decide not to pursue it. I mean, those are always state decisions.

COMMISSIONER CARTE: You have to admit, though, it was a bit of an unknown known, Dave.

VICE CHAIR SUNDWALL: A bit of a what?

COMMISSIONER CARTE: An unknown known.

[Laughter.]

CHAIR ROWLAND: I also think that the groundwork that's been laid here at looking at what the disconnects are between CHIP and the Affordable Care Act really need to be looked at in terms of the difference between the Medicaid CHIP programs and the separate CHIP programs.

Clearly, we know that the income eligibility levels for CHIP are very high in some places, and so

children in those income groups going into the exchange would face a very different cost-sharing structure than some that are below 250 percent of poverty.

So as we look at some of the future options, we may want to have some differentiation by the income of the children versus where the states had ended up with CHIP today. So I think there is a lot more work going forward in addition to where we can include today for our June report with any recommendations or any options.

But I think we have set out for you some options that we want to consider. I think we should take those up again in our discussion tomorrow to come to a final decision on how we handle this particular chapter. I think the meat of the chapter is terrific. I think it really sets out these issues, and now it's really how we pull it together for both our short-term recommendation and our next phase of really looking at this issue to be able to advise Congress on some of the choices and some of the opportunities and some of the challenges of the different options going forward.

Andy.

COMMISSIONER COHEN: Is it okay if I just raise one more point that I don't think has come up? And maybe it wasn't addressed so much in the chapter. I just think we should be very clear in our discussion in comparing what exists in CHIP today to what is available under the ACA today and the exchanges among QHPs. Mostly in that analysis, we are talking about what the law requires, because we are talking about subsidy levels, but where we are talking about networks and things, I think we just have to be really clear about what is a requirement under the law or regulation and what is just an empirical fact about how it's been implemented at this moment, particularly with CHIP.

There is a big difference between kind of like what the sort of statutory minimums in terms of

benefits and networks and other things, what they are and what they could be, and I just think we need to be clear about that and lay that out, because again we're talking about a world with lots of change happening and potentially some very different incentives for states too. We just want to keep our eye not only on what is but what could be under existing law.

CHAIR ROWLAND: I also think as we go looking forward as the future of CHIP, we also have to be cognizant of the fact that CHIP is not an entitlement program, and that the other ways in which people are going to be able to get insurance coverage through either Medicaid or through the exchange and in fact even though some of the employer offerings are more requirements now than in the CHIP program, and so how do we really fit the structure of CHIP with the structure of an environment in which insurance is now a mandatory provision.

Okay. Well, that has started us on a good discussion, as always, and we will turn to our next issue for our June report, which is administrative capacity. We are very pleased with the discussion so far and will look forward to continuing it tomorrow, and we will hope that tomorrow for our discussion, you will be able to lay out a little more clearly for us some of the options we can consider, even in the absence of a cost estimate.

And now we are going to turn to Tab 5, Building Capacity to Administer Medicaid and CHIP.

SESSION 4:

REVIEW OF DRAFT JUNE REPORT CHAPTER ON ADMINISTRATIVE CAPACITY

* MS. FORBES: Thanks, Diane.

Yes. We are going to talk about the draft chapter for the June report on building state capacity to administer Medicaid and CHIP.

As you will recall at least year's retreat --

Sorry. Am I not on?

CHAIR ROWLAND: Slower. Slower.

MS. FORBES: I have hardly hit any of this yet. I'm a Yankee. The mic is on. Do you want me to move it closer? Is that better? All right. I got to wake you up. It is that two o'clock time frame when everyone falls asleep. I got to get you jazzed up. It's administration, exactly.

So we talked last summer at the retreat how you identified program administration and accountability as one of MACPAC's priority areas, and at our January meeting, we had a presentation from Eileen Griffin at the Muskie School as well as the Maryland and Tennessee state Medicaid directors who talked about the demands and challenges of running a high-performing Medicaid program.

After that session and in our follow-up session in February, you raised a number of issues you would like to see in a foundational chapter on state administrative capacity, which we have incorporated into the draft that you should all have in your binders.

This chapter incorporates information from the January session as well as additional research by staff. It describes the administrative requirements for state Medicaid programs, obstacles states and the federal government face in administering Medicaid effectively, and describe some models and strategies that have been implemented to strengthen administrative capacity. The draft chapter does not include any recommendations to the Congress.

So, as we know, we've been talking all day about how large the Medicaid and CHIP programs are and how significant -- together they account for 15 percent of national health care spending, and they covered an estimated 70 million people in Medicaid and 8 million in CHIP, and that was prior to the

implementation of the Medicaid expansion and the MAGI simplifications.

So as these programs increase in size and scope and as states seek to increase value and accountability through more sophisticated purchasing strategies, the importance of effective program administration certainly grows. However, Medicaid experts have noted that administrative capacity constraints hinders a state's ability to meet program requirements, to implement proactive strategies, to improve quality outcomes and value, and to integrate Medicaid and CHIP into broader delivery system and financing reforms.

As governmental health insurance programs, state Medicaid programs must manage all of the operational functions of a large health insurer as well as a host of additional responsibilities related to public health, social insurance, and public financing. Federal statute and regulations spell out minimum requirements and expectations for state program administration but also give states flexibility as long as these requirements are met. As a result of this flexibility, there is significant variation in how states organize staff and operate their Medicaid programs.

Additional administrative demands and variation stem from state efforts to go beyond basic program expectations and leverage Medicaid's purchasing power to contain cost growth, drive value, and improve population health.

In sum, the demands on state Medicaid agencies are extensive and diverse. An abbreviated list of these responsibilities is included in the draft chapter.

It takes significant capacity to meet these broad demands, and at our January meeting, state Medicaid directors and policy experts identified a variety of barriers to developing and maintaining Medicaid administrative capacity. So the chapter summarizes some of the major challenges.

There are increasing system demands and complexity, as Congress has significantly expanded the options available to states -- we spent some time this morning talking about just one small option. While this creates opportunities that are desirable to states, new options and requirements almost always mean additional responsibilities for state staff that are usually absorbed into existing workloads.

Second, the role of state Medicaid staff is changing. As state programs and systems become more sophisticated, Medicaid staff must take on additional responsibility for contract oversight, data analytics, IT systems development, and implementation of delivery system reform efforts. So the state Medicaid agencies need high-level analytic, financial, and clinical expertise to implement and oversee these systems but struggle to attract and retain staff with the necessary qualifications.

Finally, there is a lack of administrative performance standards or measures that could be used to determine the appropriate level of investment in program administration or where it would do the most good. In addition, the structure of the federal match for program administration exerts downward pressure on Medicaid administrative resources, particularly in the large number of states where the federal medical assistance percentage, the FMAP for health care services, is greater than the matching rate for administration.

While the chapter focuses on state administrative capacity, we included some discussion of federal administrative resources and needs. As the federal agency responsible for developing policy, assuring state compliance with federal program requirements, and for making over $260 billion in federal Medicaid payments, effective administration at the federal level is important.

Many of the same capacity issues that affect states also affect CMS. Primary federal responsibility for administration of Medicaid and CHIP rests with the Center for Medicaid and CHIP services within

CMS, but similar to state Medicaid agencies that have to coordinate with sister agencies and with counties, CMCS also needs to share oversight between the Central Office, 10 CMS regional offices and other agencies, the OIG and the GAO. CMS administrative capacity is similarly challenged by a combination of budget constraints, retirements, and the changing nature of health program oversight.

So CMS, states, and private organizations have developed a variety of strategies to strengthen Medicaid administrative capacity. These include methods to increase the effectiveness of existing resources, mechanisms to supplement state resources, and ways to share costs with other states or other state agencies, and the chapter provides several examples of each of these.

So MACPAC's future work in this area will focus on learning more to inform two key questions: How should administrative performance be measures, and what strategies are most effective in helping states develop adequate capacity? Activities that will inform these questions may include a survey of the range of organizational models used by state Medicaid programs; a review of the performance metrics used by states, federal agencies, and private sector payers; and an assessment of the methods to assess the return on capacity-building investments.

Moving forward, the Commission will continue to focus on how to improve and modernize Medicaid at the state and federal levels, including reviews of administrative capacity, performance measures, and accountability.

CHAIR ROWLAND: Okay. I thought that when we were doing some of the initial comments on the draft, we wanted the chapter to be labeled "Administrative Capacity," so that it didn't seem like we were only focusing on states.

MS. FORBES: I am happy to make that change. It does focus primarily on states.

CHAIR ROWLAND: I think it can focus primarily on states --

MS. FORBES: That's fine.

CHAIR ROWLAND: -- but I think we want to make a statement that we are interested in looking at improving the ability to administer a high-performing Medicaid program at both the federal and state level, and that this particular chapter focuses initially on some of the state issues.

Comments. Judy and then Trish and the Donna.

COMMISSIONER MOORE: Moira, a good overview paper. I agree with Diane that we have really -- actually, we have commented before, made recommendations before on federal administrative issues related to program integrity, and so if we focus more on state capacity in this particular chapter, I think that makes for fine sense.

In terms of the chapter itself, I would like to sharpen our approach to the next steps part at the end a little bit, with a little more specific targeting priority. Well, in other words, to say that the Commission would put priority into some particular areas.

For my view of that, I would certainly agree that the standards for assessment of efficiency, value, and performance would be high on the list.

I think that in the subject area of best practices, which is kind of more generally described here, one of the things that I think would be very valuable is to catalog and learn more about some of the recent activities whereby states are joining together to do joint RFPs or contracting, to use each other's already-developed policies and operational tools, and just so that those get shared.

I think for me, the 50-year history of the Medicaid program is just replete with examples of states reinventing the wheel over and over and over, not because they really wanted to but because there wasn't,

there weren't, there aren't adequate sharing mechanism, and as we move into a much more automated world, it's considerably easier. But it is expensive. It's resource-intensive. States don't necessarily have enough people to learn from the other people in other states, and I think that's one thing that maybe we could help shed some light on.

So I guess in the next-steps part of the chapter at the very end, I'd just like to see the language sharpened a little bit, so that we put ourselves on record as listing some specific priority areas that we'd want to get into more detail on in the coming years.

VICE CHAIR SUNDWALL: Just to follow up on that, it seems particularly relevant to MMIS systems. When you talk about sharing resources, that is something that I am not sure we address in the chapter. I would have to look through it, but did we address anything about the Medicaid information management systems?

MS. FORBES: A little bit. But I think to Judy's point, CMS has put explicit rules around the 90/10 funding for enhanced eligibility systems that required them to be -- I'm sorry. It encouraged states to work with other states, so I think there's specific examples in the IT field that we can absolutely include more in our effort, if we can work --

VICE CHAIR SUNDWALL: If we could emphasize that, because we -- meaning having been responsible for a state Medicaid program -- you feel like you have been taken to the cleaners time and again with these exorbitant costs of these things and understanding other states are duplicating effort.

I have just a question. Your comment raised a question with me, Diane. Is it the sense that there is an insufficient administrative capacity at the federal level as there is at the states? I mean, I can attest to it at the state level, but when I had to run that or be responsible for that program, we always had the

regional office to deal with. It was over in Denver and in Baltimore, and it felt like there were a whole lot of cooks in the kitchen. But I don't know the sense that you all have about the administrative capacity at the federal level. I certainly know from firsthand experience, it is very thin at the state level.

CHAIR ROWLAND: Well, I think one of the things that we raise in this chapter, which I consider a federal-level issue, is a training institute or what are the pieces of federal administration that could help make the Medicaid program smoother across the country, and I don't know about the staffing. I mean, I don't know, with all the new responsibilities, what the staffing levels and the skill mix for the federal government workforce is either. I think that is something that we could do much more work on.

Trish and Donna are on my list and then Andy.

COMMISSIONER RILEY: Well, I think it's a great chapter and very, very well done.

Around the CMS issues, I think Judy raises good points, as does David, because all of us have struggled what a regional office is and must be. Especially in an era of such mass communication, their roles may be redundant. Who knows? I mean, I think those are the kinds of issues we could look at.

I thought one of the important points -- so for CMS, I think there is also a role about some kind of preemptive capacity to think about the implications of new congressional mandates, new CMS mandates on CMS and the states, what are the administrative implications, so that there is some kind of thoughtful analysis before new things happen about what the implications are for administrative capacity. Some kind of a measure or report on that, it seems to me, would be highly, highly useful.

I note the point about the OIG. Here is CMS saying to the states, we're going to put PERM on the shelf for a while as you play out ACA, but the OIG is going to look at this. That kind of interagency cooperation at the federal level is terribly important on administrative capacity.

To Judy's point, I would add data analytics as a key issue for the states where they very much need capacity.

Finally, I just urge us not -- the accreditation piece, I think is a little too short shrift. I am not sure everybody is ready for some kind of accreditation. Clearly, you need the standards first, but I would encourage us to add to the paper a little bit more around bonus payments, incentives. Once we have standards about what administrative capacity should look like, rather than go to a full-bore accreditation process, why not an incentive kind of system, higher matching rates, whatever that would sort of incentive states to get there. Accreditation processes to me need a lot more thought, because they can be very expensive and time consuming. But I thought it was a really fine paper.

COMMISSIONER CHECKETT: I was very pleased with the paper overall.

A couple thoughts. I first want to really concur with the point Judy made, though. I think it is important enough that I want to make sure that we maximize everything we can with this paper, and I would like to see more specific and stronger recommendations about what states should have, what tools certainly the federal government should have as they administer these really complicated programs.

One idea -- and I think we talked about this when we talked about this concept before -- that I want to throw out again for the Commission's consideration is do we include recommendations about what type of staff a state Medicaid agency should have, not that it has to be a specific staff person but a subject-matter expert. Whether or not that is contracted out with a sister agency or through a school of medicine, I think we should lay those out, but there are states that don't have full-time pharmacists. They don't have full-time psychiatrists or part-time psychiatrists. I just think that we are going to do a lot of people a disservice and a missed opportunity if we don't lie out what some of those kinds of core things are.

I think when the Medicaid directors were here and Darin Gordon brought up what is the biggest insurance company in the state -- and I am from an insurance company, and I have been a state Medicaid director, so I have been in this business a long time. Yes, a point really well made. If you had a million people in an insurance company, you would be staffed significantly stronger in the operation of the program.

I think we talked about that. We kind of danced around it, and I think I might have even said let's don't go down that road, and now I am thinking that was not a good idea, because I think that is what is missing from this paper. And I would really like us to consider that.

Anyway, overall, I like it. I really want to think about how can we be stronger about what we recommend.

I would like legislators, advocacy groups, provider associations, and state agencies to be able to take this chapter and say this is what we need to run our program better, so that would be my goal for this.

Thank you.

CHAIR ROWLAND: And I certainly think adding in the next steps for MACPAC to really develop more of that kind of information and background is important.

Andy. I have Mark and Denise.

COMMISSIONER COHEN: It's on with no light.

Great job, Moira.

I raised this in another context before, but I think I can structure this as something that I think would be good for a next step. I was looking at the references, and it is all references about Medicaid. I do think that sometimes we can learn the most and think about new ideas by looking outside of the

program that we are examining, and so I would encourage -- I mean, there is a whole literature about government and civil service and capacity that is outside of Medicaid specifically, and I just would really encourage to look at maybe what are some other areas of like highly technical government regulation or other kinds of agencies and whether or not there are any others that have developed some solutions to some of these problems.

Many of these problems go across different kinds of government functions. Medicaid, for its money, I mean, Medicaid really is unique, but education systems have similar issues as well. So I just would really encourage a look outside the program for looking for both ideas and any sort of developing of a new kind of insight about the issues, so that is one area for a next step that I think could be really valuable.

COMMISSIONER HOYT: So I am not sure whether you want to use this or how you want to use it, but I can tell you it is definitely factual.

So state staff, I think one of the problems they have is the inertia. They just can't change things very fast, and the nature of health care, Medicaid, and managed care in particular, change is constant. We used to make jokes about that is the only constant we have is change.

So states are really slow. They are kind of strapped. They can't fire people or move people around fast enough to keep up. I could bore you with stories of examples like this, and they can't staff up fast enough to keep up with new areas that start to grow.

The consulting firm I used to work for -- and there's plenty of RFPs out there -- we would look at them to see if they were looking for what we would call "staff extenders." It is like a literal term, and it ends up costing taxpayers double, triple, quadruple what it would cost to just hire the staff outright. But the states can't, because there is a hiring freeze, so they can't pay properly.

I have had plenty of clients tell me, "It is way easier to hire you or bring you guys in than it is to hire somebody to do this," and it would usually mean having somebody -- and it would say this in the RFP: You must be here in the state capital 4 days a week minimum. They set up office space for you, and this is true in a whole bunch of different areas.

We didn't like that type of contract, because it was hard on staff, and it is not what we wanted to do, but there is a ton of business out there for different firms doing that, and all you are doing is doing work that, you know, the state could hire somebody to do instead of paying consulting fees to do it. And then they are paying travel and everything else on top of it.

CHAIR ROWLAND: You know, to follow up on Mark's point, one of the things I think is missing from this chapter was the comment that Medicaid often trains people to go out and then work in all these other areas and are there ways that we could encourage that, just like a business school or a school of public health trains people to be hospital administrators and to be insurance executives or whatever, but we're not really training people in our schools to help run a Medicare or Medicaid program.

And so I think we -- we talk here about a training institute, but that's for people who are already in the system. What do we do to kind of develop a better group of people that states and others can recruit from? And so I think that needs to be reflected somewhat, and I preempted Denise.

COMMISSIONER HENNING: Good point, actually. So, go into the colleges and develop a program to recruit some students to do internships or whatever.

But, anyway, what I was thinking as we're doing this discussion is what would it take to build in administrative capacity to also kind of keep track of access to care and make sure that big chunks of the population aren't falling through the cracks. So, things like if the CHIP does go away, if pregnant women

all of a sudden are forced to choose between exchanges and Medicaid and will they have affordable coverage offered to them, you know, what would it take to make sure that that's part of your ideal administrative capacity.

CHAIR ROWLAND: So, I think, clearly, that this is a great foundational piece. I think we want to really expand on the next steps and other things that should be looked at, because what -- you know, the program can get -- it has low administrative costs, but some of that, as Mark notes, is because some of those costs are pushed off in other kind of contracting. So, what does it really take to run this program that is so complex and that takes care of such vulnerable populations in a way that it has the right staffing tools and the right capacity to not end up on the other side of the equation you work on, which is the program integrity side. So, let's really focus here on we should be investing in making the program run as smoothly and as competently as possible and at the best cost possible. Thank you.

And now, we're going to turn to Amy Bernstein and to the topic near and dear to all of our hearts, especially to my Vice Chair, Medicaid and Population Health, and that will be at Tab 6 of your briefing books.

SESSION 5:

REVIEW OF DRAFT JUNE REPORT CHAPTER ON MEDICAID AND POPULATION HEALTH

* MS. BERNSTEIN: Thank you, Diane.

Just as a reminder, this chapter is a foundational chapter. It contains no recommendations. You heard from Mary Selecky in February of 2014 [sic]. You talked about the integration of population health and public health in Washington State. And then you heard January of this year from a panel with various

aspects of population health presented. And then in February, you had a discussion about issues related to population health.

And also as a reminder, population health is an ideology more than anything else. It's a way of thinking about how to improve the health of a defined population. So, it's not -- it's a very broad and, let's say, foundational issue.

The overview of the chapter, which was crafted based on your direction at the last meeting, it has three major sections. The first one describes current population health, Medicaid population health initiatives and programs and what programs are doing now, how they partner with others to improve population health. And the last section is on monitoring population health with a focus on data that are needed and how they are used.

Again as a reminder, and just for the record, we will put a definition in. This is the Institute of Medicine definition, which is quoted from the National Research Council, which is why it doesn't say IOM, which is the health of a population is measured by health status indicators and is influenced by social, economic, and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services. So, many things affect the health of the population other than medical care, and specifically, other than acute medical care.

So, why do we care about population health? And I'm sure we'll talk about more of that later, but, really, medical care is really only one factor in improving the health of the population. As you all know and as you heard this morning with the health homes discussions, Medicaid beneficiaries are disproportionately affected by many of these social determinants of health. They are poorer and sicker and have many barriers to care that wealthier and non-Medicaid people do not have.

Providing non-acute medical care and other population health initiatives can improve health outcomes and may help control costs, and certainly improve health, which is what they're designed to do. This chapter is sort of our first foray into thinking about and looking at how Medicaid programs consider these population health perspectives and initiatives within the context of their programs.

The chapter starts with, as I said, the current mechanisms that Medicaid is providing. The EPSDT program is probably the first major population health initiative that Medicaid undertook, noticing that military recruits, for the most part -- is, I think, where the focus began -- they were getting people who were applying who were very unhealthy from conditions that could have been prevented if there had been earlier intervention. And to this day, EPSDT is an incredibly generous program which provides many non-medical services to children.

Medicaid programs provide preventive benefits. They can provide non-medical care through waiver and demonstration benefits. Again, the health homes demonstration that you heard this morning is one example. There are ACOs and CCOs which provide incentives to beneficiaries and providers to have good health outcomes.

You heard from Dr. Cha in January about the use of administrative funds for Medicaid to do things like fund tobacco quit lines. You heard about the enhanced pregnancy benefits that are provided to pregnant women through most Medicaid programs that have things like targeted case management and nutrition counseling and transportation. Managed care plans can provide benefits over and above what are in state plans. And you also heard in January on how non-licensed or non-traditional providers can now, through the ACA, increasingly be used to provide non-medical benefits.

In addition, the Affordable Care Act has many provisions that also are designed to improve the

health of the population. You talked a little bit this morning about the community assessments for nonprofit hospitals, where they have to demonstrate benefit to the community and generally show that they are in some way increasing the health of the people that they serve, or provide other benefits, I guess. The ACA provides that all health -- that qualified health plans must provide preventive benefits in the new adult group. It does not, as Dr. Sara Wilensky presented, mandate these benefits for current Medicaid enrollees. However, most Medicaid programs do provide a lot of preventive benefits anyhow. Also, in the ACA, there are public awareness campaigns to improve health and reduce chronic disease and incentives for preventing chronic diseases, and also increased match rates and funding for immunization programs.

The chapter then describes many partnerships. Medicaid programs are increasingly, and again, you heard about this this morning in the presentation, partnering with others to develop initiatives to improve the health of their populations. CMS, for example, is partnering with HRSA and the Administration on Children and Families in the Strong Start program. CMS works with health plans and providers in various other partnerships that are described in the chapter, and obviously within states. As Mary Selecky and others have presented, state Medicaid programs partner with public health agencies and other state agencies in order to exchange information, as they are doing in Wyoming, which has an electronic health record where they are sort of exchanging information with each other, the public health departments and the Medicaid departments. And there are, then, multi-sector partnerships, again, like Strong Start for mothers and children, where CMS is partnering with other agencies to reduce early elective pre-term births.

There are some challenges to these partnerships, and once again, some of these were noted this morning. Different financing mechanisms can impede some of these partnerships. For example, if you have an ACO or a CCO, if you have a Federally Qualified Health Center that is paid on a cost basis or a

fee-for-service basis, it's harder for them sometimes to get the benefits of some sort of shared savings, so those regs, I think, are still being worked on.

There are different time frames for evaluating the effectiveness of health status, and as we all know, for preventive care, sometimes the time frame is longer than some organizations are willing to tolerate. So, you know, and even things like the health homes, they were saying that two years is not enough in order to see the savings for that. But, some of these, especially things that have to do with determinants of health or things that are individual behaviors, like obesity or nutrition or smoking, it takes longer for those gains to be realized.

There are incompatible data systems. I think you have all heard about them from various ways. I mean, there are hospitals that cannot exchange information with the hospital across the street from them, much less with anyone else. So, that can be a problem if you're trying to share data, let's say, between a public health department and a Medicaid system.

There's general differences in organizational culture or goals. You know, a managed care organization might have slightly different goals than, say, a Medicaid program or an advocacy organization.

And there could be conflicting eligibility rules and program coordination issues, so that if a person was eligible for one program but their family was not, but it was a family-based intervention, that could be an issue of trying to figure out who is actually eligible for what.

So, assuming that you are taking a population-based approach, you really need information about what the current level of health of the population is, what you want it to be, and whether you are achieving progress on those goals. You need to sort of figure out whether your program is having an impact, and if you don't have that, then it's very hard to justify whether your program is actually improving health or not.

Medicaid is actually falling behind some other federal programs in sort of the way that their data can be used for this purpose. Because Medicaid is a state-based program, and you've heard about data issues from April at many meetings, currently, there are not these sort of sub-national Medicaid data that are available at the federal level that there are for, let's say, the Medicare program, and that's for a variety of reasons. Again, Medicaid is a state program, as we all know. But, also, people go in and out of the Medicaid program, and once you're in the Medicare program, you sort of stay there. So, there are not the sort of population community-based data for Medicaid that there are for other data sets.

There is a considerable amount of work underway, and I presented that, I believe, in the February meeting. Transformed-MSIS is working on typologies of home and community-based services, on better condition codes, on flags that will identify certain groups of people.

There will soon be a Medicaid Consumer Assessment of Health Plan nationally fielded survey, so there will be information on satisfaction with Medicaid care, which is not necessarily outcomes, but they do have a variable on perceived health status on a ten-point scale, so, you know, on a ten-point scale, how healthy do you think you are.

And the Behavioral Risk Factor Surveillance System, which is what CDC uses for most of its population-based, community-based surveillance, until 2013, I think, again, which I mentioned at the last meeting, did not contain a question on whether people had Medicaid or not. It had a question on whether they were insured. So, they had rates of uninsurance at the community level, but not Medicaid. They did add it in 2013, which -- and the data should be out in the summer. It's not clear, however, whether they're going to continue keeping that question on in future years. It depends on funding, and I believe they lost a considerable amount of funding from the ACA.

So, in conclusion, Medicaid, unlike, and probably more so than most other plans that could be considered health insurance, has considerable flexibility to innovate with population health initiatives, and they have done so and they are increasingly doing so. Things like ACOs and value-based purchasing are -- you know, we keep hearing about them more and more. And they have done this on their own, and many of them in partnership with others.

I think everyone is sort of watching to see what is happening, but as the ACA incorporates more people into Medicaid and the exchanges, it could be that the sort of distinctions between the Medicaid population and the general population will start to blur a little more and thinking about things in a more population-based approach, especially when they're still churning, is something that is worth thinking about.

So, I welcome your comments on the chapter.

CHAIR ROWLAND: Thank you. David.

VICE CHAIR SUNDWALL: Amy, thank you. I can't thank you enough for your scholarship and hard work on this. It's really an impressive overview. I mean, this is my work. I'm a Professor of Public Health, but I learned things reading your chapter. It was really helpful.

I do want to just tell you it's more than a philosophy. This is a responsibility, and I'm serious about this, because I take my cue from Don Berwick's Triple Aim. I don't know why it took so long for someone to kind of crystalize the importance of payers helping not just individual patients, which is one of the legs, but also the quality of care and the health of the population. I think our citizens, who pay a whole lot of taxes -- a lot of our Gross Domestic Product goes to health care and it's a national embarrassment that with all the money we spend, almost twice as much as any other nation on earth, we rank poorly in international health comparisons.

So, as a taxpayer and as a concerned citizen and as a physician, I want to make sure the dollars we spend improve health, not just go for services and make providers well off without the benefits for the patient. So, I really appreciate MACPAC devoting some effort to this, and your energy and intelligence is evident in this chapter.

I do think, and big and rich and detailed as it is, I've got a couple of more ideas for you, like under -- I think you mentioned the CMMI grants, I mean, Innovation Center, and they're spending billions on that, I think a $10 billion allotment over time, which is not a great deal out of their Medicare-Medicaid budget, but still, it's trying to innovate, how do we do this. And it's actually the SIMS grants. I don't think you reference them, but the State Innovation -- SIMS stands for, what, State Innovation --

CHAIR ROWLAND: Models.

VICE CHAIR SUNDWALL: -- Models. They have an absolute explicit requirement to improve population health. The other innovation grants are more general, but the SIMS grants, we might want to reference, because to qualify, you must have evidence you're going to improve population health. And isn't that interesting. The payer, Medicare-Medicaid, is that interested that they're funding these grants that focus on population health. The six states have had real initiative funding, 20 planning grants, and there's going to be a second round.

Also, I would hope we could reference in here what I am proud to be still a bit of a part of, and that's ASTHO's -- Association of State and Territorial Health Officers, of course, Mary Selecky came representing that group -- but, they have an initiative on public health primary care-clinical care collaboration.

And Duke University, with funding from the de Beaumont Foundation, has a playbook which we

could reference, because it's just a website, but they've accumulated, I don't know how many scores of examples of where this is working and how they're doing it.

So, there are, like you said at the beginning, there's just a whole lot going on and I think it's great that MACPAC will at least weigh in and acknowledge we're aware of this and we see this particular payer as having a lever to improve the health of our population. So, I think it's a good way to marry public health and paying for health care and the population will be the beneficiary. So, thank you for your work.

CHAIR ROWLAND: Steve.

COMMISSIONER WALDREN: I enjoyed the chapter, as well, and I think it lays out a lot of the different components and what's going on.

One other thing that we may want to look at is there's kind of some frameworks out there of what's a process of going through and actually accomplishing population health and talking about the different pieces of those and what are the challenges or issues around Medicare [sic] and CHIP. So, you have that process set of defining the population.

So, you talked about some of the issues of finding the right targets of the population. The next is identifying what are those actual care gaps.

Then the risk stratifying, which I didn't see a whole lot of discussion in the thing about doing that risk stratification, because there's just too much for anybody to do. So, you just think about prevention, a primary care doctor of a practice size of about 2,500 just doing the U.S. Preventive Task Force stuff is about 7.5 hours in a day to get accomplished. So, that risk stratification is important.

Next is engaging patients, which I can see that there's some real challenges in that for our populations we're talking about.

And the next is actually managing care, and then the outcomes. So, you lay out some of the programs that are going on in each of those, but until you have a process that can step through all of those, it's really going to be difficult to do population health. So, maybe as we think about what are the challenges and where are our levers to do things, you may want to use that as a framework. It's just a suggestion.

COMMISSIONER COHEN: Steve, you just said that so well, I'm kind of loathe to open my mouth, but I will say that those are great points and mine was a more modest set of comments, in the same direction, though, I think.

There's so much information in here. I think the set-up is good. I think the introduction is good and strong. I did feel like, because it's a foundational chapter, we have to pay really a lot of attention to sort of our taxonomy and categories, and a lot of times, it seemed like we were mixing apples and oranges in terms of what's an activity that is using some public health approaches, and what is a regulatory structure that allows you to do that, and what is a relationship that is oriented towards the mission. And I felt like -- you know, the mission of population health.

So, I just felt like there was a lot of description of different kinds of things, but not necessarily divided in the categories that I thought made sense for thinking about work going forward, in other words, thinking about, like, what can you do with a payment lever? What can you do with a regulatory lever? And what are truly the activities on the ground with people that is sort of the goal that we would sort of like to think about Medicaid supporting in a better way, whether it's through collaborations at the government level, agency-to-agency, or whether it's through funding or another mechanism.

So, I felt like that we really needed to do some more work there and sort in categorizing the kinds of

activities that we are describing and thinking about what they kind of mean for both future work and what sort of the ultimate end goals really are, because the end goals are activities that affect people on the ground, I think, and there was a description of lots of things that were sort of enablers and the activities mixed together.

COMMISSIONER ROSENBAUM: I thought it was a terrific chapter and I just want to sort of flag for us that, going forward, I think it raises sort of a complementary question that we might want to explore, which is that Medicaid carries the potential to do a great deal in prevention in various ways. And the question is whether the delivery system on which low-income, medically underserved people and vulnerable populations depend is prepared to take maximum advantage of it, meaning, for example, that in the world of public health agencies, there are a lot of public health agencies that have never developed billing systems. They cannot be network providers. They cannot offer services. I know even -- it took community health centers, which are probably more adept at being part of delivery networks than other safety net providers besides hospitals themselves, it took them a while to learn third-party billing. Title X agencies struggle with this.

And so I think there's sort of this flip-side question. It's not just a matter of Medicaid doing a better job at emphasizing its preventive activities, whatever they are, but it's also whether the underlying delivery system on which patients depend, on which managed care entities depend to build their networks, whatever, are positioned to sort of utilize the program the way it might be utilized, and we haven't really dealt head-on with this, but it might be an interesting issue down the road. How much is the care delivery system able to do what Medicaid as a payer emphasizing preventive services would want to do -- would want to have done?

COMMISSIONER GABOW: Obviously, the Medicaid population is an important issue, and I think given the scope of Medicaid services, this is an appropriate topic.

I do think that trying to think of what is the framework, whether it's the one Steve mentioned or Andy, I think having some more structured framework into which these different pieces fit would have utility.

And in that regard, I really wanted to make the comment that Sara started, which is how does the Medicaid delivery system as we know it interface with population health. I think there are several examples that could be used.

First of all, there are within the safety net, Denver Health being one example, where the Public Health Department is actually integrated into the safety net system so that you are enabled to do things like get a Community Transformation Grant and use it within the bigger system. There are -- I know this was true at Denver Health, and I suspect there are other examples where the WIC program is housed within the community health center, and certainly nutrition being a key public health population thing is another such example. Another delivery example is Medicaid paying for school-based clinic events so that you're really getting down to sort of core population issues.

So, I think creating some structural way in which these pieces are placed, including one about the delivery system piece, would, I think, have utility to give us more direction for the future.

VICE CHAIR SUNDWALL: Just one comment on data. I mean, you know, some health departments and Medicaid are together, like they are in Utah. I mean, they're under an umbrella agency and so collaboration is easier.

When you are talking about data needs to do this, I would hope that we don't imply Medicaid needs

to take on yet another big responsibility on independent data collection, because that collaboration or partnering with public health, you can use their data which would help you measure population health. You couldn't, obviously, be specific about Medicaid made this parameter different, but I think you could have -- you could see some impact if you used existing public health data in areas -- for example, we have an all-payer claims database that Medicaid is part of and we do geo-mapping on what are the prevalence of a disease or illness or problem in various parts of the state, and I think all that, where there is Medicaid coverage, where there isn't in some areas, you can claim, maybe not totally accurately, but claim some benefit from that coverage as contributing to improved health outcomes.

So, anyhow, using those other data sets would be useful to --

MS. BERNSTEIN: Yeah. I don't think anywhere in the paper it says that Medicaid is going to go out and collect any more data. I was just -- I think it was just one potential barrier is incompatibility of data.

VICE CHAIR SUNDWALL: Yeah.

MS. BERNSTEIN: That's all it says.

VICE CHAIR SUNDWALL: That's fine. You're right.

CHAIR ROWLAND: And, Amy, not for this particular version of the chapter, but as we go forward, I think it would be useful to look at whether there are other mechanisms in the Affordable Care Act that are not Medicaid-specific that Medicaid should be taking advantage of or working with. I'm thinking of, like, the Community Needs Assessment that is supposed to be going on, and just thinking about how to -- we should always be aware of how to merge Medicaid into the broader world as well as how to fix Medicaid itself, but I think you've got a great chapter here in terms of starting us down the road to thinking.

CHAIR ROWLAND: We like your chapter, Amy.

VICE CHAIR SUNDWALL: Thank you. It's very good.

CHAIR ROWLAND: Okay. Now, we're going to take a 15-minute break and then we'll be back to look at long-term services and supports.

[Recess.]

CHAIR ROWLAND: If we could please reconvene? During this session we're going to turn back to long-term services and supports and the incredibly important role that Medicaid plays for people with disabilities and for many of the seniors on Medicare who have long-term care needs. I'm going to ask Angela and Molly to begin by giving us an overview of their chapter and then open it up to Commission discussion.

SESSION 6:

REVIEW OF DRAFT JUNE REPORT CHAPTER ON LONG-TERM SERVICES AND SUPPORTS

* MS. McGINN-SHAPIRO: Thanks, Diane.

So as you know, high-cost/high-need enrollees are a priority for the Commissioners, and LTSS is just one slice of their experience. Today we are here to discuss our foundational chapter on long-term services and supports, and as a reminder, back in September we presented a background paper that documented Medicaid LTSS policies as well as utilization and spending among Medicaid enrollees.

In December, we presented a draft chapter to be included in the March report that primarily focused on enrollees' need for services as well as their goals and expected outcomes of the different subpopulations of LTSS users. We received feedback from you that we were not quite ready for our March report, and so

we went back and reframed the chapter, which we are presenting today.

So this is a foundational chapter with no recommendations. In the chapter, we bring back some of the material from previous documents so that we can provide background information to our various audiences, including the Congress and their staff, the states, and other stakeholders, and also to indicate that the Commission understands how the program is structured as well as the challenges that exist specific to Medicaid coverage of long-term services and supports. We include several sections in this LTSS chapter.

First, we discuss the fundamentals of Medicaid long-term services and supports, what services the program covers, and who uses these services, which includes a discussion of how those with long-term services and supports needs generally enter the Medicaid program, and then of those who receive those services, their utilization patterns by dual-eligible status and disability-specific groups.

We then discuss how state decisions and variation in their policies influence Medicaid LTSS utilization and spending, and we conclude the chapter with next steps and identifying various areas in which the Commission can contribute analysis in order to move the Medicaid LTSS discussion forward.

First off, I just want to remind you, enrollees who use Medicaid LTSS are significant to the program. In 2010, 6 percent of Medicaid enrollees used LTSS, but they accounted for over 45 percent of total Medicaid benefit spending. So this number includes all Medicaid spending for LTSS users, including their acute care, but almost half of their spending was for LTSS. And, furthermore, as you may recall, Medicaid is the major financer of LTSS. It was 61 percent of total national spending on long-term services and supports in 2012, and most of the Medicaid LTSS services are not covered by other types of insurance.

So before considering where Medicaid LTSS policy may head in the future, the chapter provides background on two aspects of current Medicaid LTSS policy, including what services are covered and who

currently receives such services.

First off is the discussion of the types of LTSS that are covered under the Medicaid program. The key takeaway from this section is to emphasize the degree of variation that exists across states and the coverage of these services. Where services are covered, the duration as well as the frequency and scope of coverage all vary across states so that individuals with identical LTSS needs may receive vastly different services based upon where they live. Differences in services by mandatory versus optional, state plan versus HCBS waivers, institutional versus community-based settings all add to the variation in this type of coverage.

Furthermore, coverage of services may be influenced by factors other than enrollee LTSS needs, such as the state LTSS infrastructure.

And when looking into who uses Medicaid LTSS, the chapter organizes this information by different population categories and what their LTSS utilization and spending patterns are. Looking into the different utilization and spending data by these different subpopulations highlights what kind of services they use, which can then help identify potential policies and programs that can provide more efficient care and services that better match their LTSS needs. The chapter first examines how LTSS users generally enter the Medicaid program, and because the majority of LTSS users are dual-eligible enrollees, we look at them by dual-eligible status. And, finally, we examine those who use LTSS by their disability-specific group.

After the chapter reviews the fundamentals of Medicaid LTSS, it moves on to identifying specific issues around state variation, which Angela will now discuss.

* MS. LELLO: So the chapter summarizes how state policies for Medicaid LTSS have created a

complex system in which rules for eligibility, covered benefits, and access to services varies substantially across states and among the populations receiving care. So as a result, it can be difficult to determine whether the differences in utilization and spending that Molly summarized are a result of the different characteristics of these subpopulations or whether they reflect the design of coverage and eligibility policies.

So state variation, of course, is the norm in Medicaid, but this variation is even more apparent for Medicaid LTSS. And although one solution may be standardization, the reality is that there's clearly a value in providing states the flexibility needed to manage their programs and target specific populations with certain services.

So the chapter really lays out what we know, which, because of this variation and incomplete or data that's not as good as we would like, it's not enough to craft a solution at the federal level that would result in increased access to care, improved quality, or lower costs for LTSS users.

However, we have identified several areas where MACPAC can contribute to building a better understanding of Medicaid LTSS and how we can move the discussion forward, and these include, first, looking into how states are implementing, or in some cases why they're not implementing, some of the new options under the ACA related to long-term services and supports. And you heard about one of those this morning with the Health Homes Initiative.

Secondly, we're going to look into the expansion of managed LTSS and how states are operating their programs to learn more about this trend. And we recently let a contract to conduct site visits to several states in order to learn more about how they're implementing these programs and the effect that managed LTSS may have on Medicaid LTSS users.

We will also continue analyzing how states use HCBS waivers and how states respond to

significantly increasing demand for HCBS within current constraints. We will conduct further analysis of the many issues related to functional assessments in Medicaid LTSS and identify the ways in which states have collected standardized information about enrollees' functional needs in order to guide LTSS service delivery.

And, finally, we are going to enhance our work by looking for ways to better use available data that may illuminate some key information that could be useful in future policy discussions.

So, with that, we'd like to hear from you as to whether or not you think we've hit the mark with this as MACPAC's first statement on LTSS, and we appreciate your comments on the chapter. And assuming you agree with the next steps we've presented from the chapter, you can expect to see from us areas -- or work in these areas in subsequent meetings. And since this chapter contains no recommendations, we, however, do expect to return to the Commission with more descriptive work and potentially policy options as our analysis ripens.

So, with that, we look forward to hearing your comments.

CHAIR ROWLAND: Thank you.

COMMISSIONER RILEY: Well, this is an enormous undertaking. You've done great, great work, obviously. There's so much information that you feel sometimes lost in it, and I particularly appreciated the chart on the sister agencies, which I think is a nice flow from our administrative work as well. So the richness of the work is extraordinary, which is why I've been struggling with why I have difficulty with this chapter, because there's so much here, and I think to Steve's point earlier, it needs some structure.

So it seems to me that maybe -- what I have trouble with is taking one slice at this. It seems to me

in the ACA we've streamlined and modernized one part of the Medicaid program -- the younger part. Here we have a legacy Medicaid program, and so it seems to me we need to invite Congress to think about the next step in reform, which is to take the legacy Medicaid program for people with disabilities and the elderly, who are the high spenders, and really begin to take a look at where it needs to go.

This population particularly is higher income. I mean, it's important to sort of point out this is a very different function for Medicaid than what we've been talking about in the Medicaid expansion in the ACA. And I would start the paper with page 40 and this fabulous chart you've put together on long-term -- Table XA-5. You've all memorized this. I have. I love this chart.

[Laughter.]

COMMISSIONER RILEY: I have. It's great.

COMMISSIONER GABOW: You should get together with Mark.

COMMISSIONER RILEY: We could be in heaven, an actuary and a --

COMMISSIONER CHECKETT: That would be a date.

[Laughter.]

COMMISSIONER RILEY: Long term -- see, I don't even like this construct of -- I want it to be around the people, but it's the spending for Medicaid only, long-term services and supports users by eligibility pathway. It's great, and it includes acute spending. And so that's where I -- I wouldn't start by the subset of home-based care or the subset of long-term services and supports, but the population. And to look here at -- look at the per capita spending, and you note that two of the three biggest per capita spending are medically needy and special income limits. So it's a different population, it's a richer population, because private insurance doesn't work for these services.

So I'd start with who. Who are our demographics? Who are the populations? I'd talk a little bit about the changing demographics. We know, for example, that the autism spectrum has brought in a whole new category of populations. We know that the growing rates of dementia among the elderly mean that there are new challenges for what to do about so many people with Alzheimer's, and it may require us to reinvent the nursing home or some kind of residential setting rather than think only about home care.

Then I'd ask: How did we get here? It's an old model. It was based on a movement away from institutions. We've got a long history from the channeling demonstrations through case management, through home-based care. What did we learn from all of that?

How did we get here? It's an old model. We knew we wanted to move away from institutions, both the DD and for the elderly.

It's a model that has been influenced by the ADA and Olmstead and by the courts and consent decrees. So it's very much prescriptive from either the federal level or the court level. It has been incremental reforms by Congress that have created these silos, and I think the strength of the paper here is the complexity of the pathways. So the Congress has created so many different approaches to this population that it's almost -- it almost is buried by its own weight.

Then I'd say, okay, who are they? How did we get here? What's the result? The result, I would argue, is an accidental system, a really complicated system of different pathways for these populations. Very costly services that you point out. Very little known about what the standards of care are, what the goals and outcomes of care are. It's just sort of a patchwork of services. And we may, therefore, need new models.

To Patty's points in earlier meetings, what are our expectations for these populations? And they're

very diverse, as you very effectively point out. What are the goals of treatment? What are the expected outcomes? And what are the standards of care? And those are areas where we don't have a lot in these populations.

And then I think I'd end with sort of emerging issues. My favorite -- and I may be the only one -- is the Jimmo case that says that Medicare, of course, can no longer hold a standard of improvement. So does that mean that Medicare may, in fact, and should, in fact, pay for more of the services Medicaid has traditionally for the duals?

And then I'd talk more about housing. I think when we go back to the old model—the old model took a model in which everything was paid for the key populations under one roof of one payment source. Room and board, the windows were clean, the lawn was mowed -- everything was done through the payment. Yet when we take that same person and put them in the community, we say, no, no, you can't pay for all those supportive services, you can only pay for some services.

So I think we need to rethink the model, rethink housing, look at the New York initiative about health as -- housing as health, and really begin to sort of help the Congress see a way clear.

So I think at the risk of giving a speech here -- which I guess I've just done. Too late. At the risk of -- I think instead of sort of taking the narrow view, we need to step back and say where should the Congress be moving to effectively care for these very diverse populations. And I think most of the materials here -- it's a structuring and a reorganizing.

CHAIR ROWLAND: But, Trish, your discussion leaves out another issue that at least needs to be raised, whether this should be the only way that people can obtain access to these services, which goes to the broader issue of the joint Bipartisan Policy Committee is supposed to be looking at the other ways -- the

role.

COMMISSIONER RILEY: Right.

CHAIR ROWLAND: So I think --

COMMISSIONER RILEY: And that's where I would start with the demographics, because this is a population who is higher income than most Medicaid, and it may be that there are private solutions as well, and others.

CHAIR ROWLAND: A lot of them aren't higher income, though.

[Inaudible comments off microphone.]

COMMISSIONER ROSENBAUM: I thought Trish was right on, and the only other thing I would add is that the structure of the Affordable Care Act raises an additional question because, of course, if you look at XA-5, you know, the tremendous spending line here is for what's called acute-care services, which, of course, raises the question, at least for higher-income people, not the lower-income people -- but for the higher-income people what the pros and cons of keeping Medicaid as the primary insurer are, because some of these people, of course, will have incomes, if they are younger especially, will put them into exchange range. Should Medicaid be acting as a supplemental insurer for that population the way it does for Medicare actually? Or are we better off for all kinds of reasons actually keeping Medicaid as both the primary and the supplemental insurer? Which I think, you know, raises another aspect of Medicaid that's not often talked about but is incredibly vital, which is that because Medicaid is sort of a shock absorber for the system, it has made the functioning of a market-based solution for people with what we could think of as sort of the average range of health needs possible because Medicaid picks up people who otherwise might end up in an exchange. And I think it's an important question to ask because of this relationship, but it's

also an important question or issue for us to point out because it shows this vital role of Medicaid that is very seldom understood: that it is a substitute insurer for a population that otherwise would be looking to a much less elastic market solution. And, you know, that's a tremendous contribution of Medicaid that many, many people don't understand. It enables a normative market to go on where it might not otherwise.

COMMISSIONER CHAMBERS: Thanks. Trish and Sara have been very eloquent.

This chapter was -- for someone who knows something about this, it was mind-boggling, quite frankly. I got to about -- you know, it's 29 pages of text and then the supplements, and I got to about page 10, and I was re-reading paragraphs because even I couldn't -- I mean no disrespect to -- the facts were correct. It's just mind-boggling trying to understand what it does.

The boxes are really illustrative. You know, that's what just made me almost want to stop reading, was when I read the examples of, you know, you get married and you go to another state and you got something in another state, now you do not get it. And then with the delivery systems and different state agencies that administer, and the graph that shows what states have what agencies do what with what programs and how many different programs there are. It almost reminded me, if anybody has ever been house hunting and you shop an existing house, you know, a 20-, 50-year-old house, and you go in and you can't quite figure out, like it doesn't -- you go from room to room, and you think -- and the real estate agent tells you, "Well, there's been five owners and everybody added a room, but each owner added their own room." And then you say, "This house just doesn't quite work." You know?

I just see that what we've created is just -- you know, it's almost like a tear-down. Of course, I'm a believer of let's start over, because certainly it meets so many needs of so many people, but comprehensive

needs.

I don't know if the chapter has to -- I think Trish, you know, had ideas. I think thinking who our audience is, who we're trying to explain this to, you know, how it could be simplified or even almost, you know, sort of an executive summary or something up front is, like, What are the key points? What facts -- what are we trying to say or do or -- I know there's no recommendations, or going to be. But I'm just fearful that folks will just not be able to quite understand what it is. Trish, I think you laid out some great ways of organizing it and trying to make it -- because at the end I was trying to figure out what is our point here, like what is our next step.

I appreciate your comments. Thanks.

COMMISSIONER CHECKETT: Well, I guess I am going to say two things that, you know, are now consistent. It was an excellent chapter, and it was equally mind-boggling, just really at the complexity of the program, and also the fact that the text was really dense. And I really do -- you know, whether it's Trish's suggestion or something else that you all come up with, but just how can we simplify it more so the people can actually really get through and understand it? That's my concern about it. It is a foundational chapter. It's very, very important. It is just really complicated.

One idea I had -- and it wouldn't be so much perhaps to replace this, but maybe subsequent chapters to this, because I think this really is our foundational chapter -- would be to focus in more on the large sub-groups of these populations. So something for people who are senior, and the spend-downs more, because that really is -- you're right, Trish. That's a really different -- they are higher income, many of them are, or they once had assets, and they have family resources that still have assets that actually, for instance, pay for the hair cut even if Medicaid won't pay for them to get their hair cut in the nursing home,

that type of thing.

But then we have the IDD population, which in Louisiana is going to go into managed care, is the current plan. You know, somebody else talked about Alzheimer's, and not to drill down to too minute, but they are different subsets, and I think one group in particular you're going to find at home and community much more than another group who you're going to find more in a nursing home setting. So that would be another construct to look at.

And I'll stop there. It really is a really good chapter, and I know you guys have spent a lot of time on it, so I appreciate that. Just a really complicated program.

COMMISSIONER GABOW: Well, I would agree with what was said, and I'm wondering whether there's a visual of the components, to your point of the house, of the rooms that have been added on, or some -- because I agree with the density of this, and if you're not someone who has been in this terrain very much, you really get lost in the abundance of information.

So could there -- whether it's a reorganization, which you may need, or also a visual picture of how this fits or doesn't fit together would be, I think, useful. I'm not good at coming up with those kind of drawings, but someone may be.

Then I have several other comments. I found it fascinating -- and I'm sure someone knows the answer to this sitting around the table, but the individuals who are getting around-the-clock care at home and how it's much more expensive than if they were in a facility where you have more people spreading the cost, someone must have decided that there was some benefit to this increased expenditure. But it would be nice to know what that was.

We also talked about at one time there are lots of people on the waiting lists in states for home and

community-based services, and knowing what the wait list is and also knowing the outcomes of the people who have been on the wait list versus the people who got the service, whether, in fact, there -- what is the value of the service, that's a control group that could be used for thinking about some of outcome data which isn't there.

And my last comment is there is a comment about that people have to have conversations about planning for long-term care needs, family participation, et cetera. And I think we have to add we have to have a discussion about end-of-life care as a country, and this is an area where that dialogue is appropriate. Whether we as a Commission have to have that dialogue is a different question, but I think when you're listing the unresolved conversations, leaving that conversation out, which is pivotal, would, I think, be a mistake. Thanks.

CHAIR ROWLAND: I think one of the challenges here is that it is such a diverse population, and that there are really significant differences between the individuals who depend on Medicaid for their coverage as a disabled individual where they need both acute and long-term care services, then what happens to them when they qualify for Medicare, if they qualify for Medicare, or if they age into Medicare. And there's always been a big difference between who uses the institutional services and who uses the community-based ones. And it's why we're always kind of threading around, because we're trying to talk about it as if it is a system, and it's not a system. It's a collection of diverse individuals getting a whole different array of services from Medicaid and then even more complicated when they also have Medicare. And as Sara points out, some of them will eventually also have private health insurance and Medicaid will become more of a wrap-around, and that will be another coordination issue.

COMMISSIONER ROSENBAUM: I just have a question, a factual question, again, going back to

Table XA-5. I'm sorry. It's page 40. It's the Trish Riley Memorial Table.

I noticed that for many of the populations the breakout is about 50/50 in terms of long-term care spending versus acute-care spending. But, of course, the figures are extremely different for the poverty-related and the 1115 waiver groups where it's heavily, heavily acute care versus a relatively small amount of long-term care.

On the other hand, if you look at the poverty-related user group, the Section 1115 group is pretty small. The poverty-related group is actually a very large group.

I assume that this is -- what we're looking is children with disabilities who are living in the community and getting things like services attendant to an IEP or children in the child welfare system. In other words, can you give us a sense of what a person in the poverty-related group is like, what a person in the Section 1115 group is like?

MS. LELLO: Okay. So, first, I don't think we have the level of data right now to answer your question specific to kids. But, in general, a person in the poverty-related group, A, has a functional disability; B, has an income at some point between SSI, which is around 70-something percent of poverty, and 100 percent.

COMMISSIONER ROSENBAUM: Right.

MS. LELLO: And they are -- routinely the benefits provided to them are state plan Medicaid, so the LTSS they would be getting would be any institutional services in the state plan, which is routinely ICF or nursing facility. If they're children, some states may provide inpatient psychiatric facility services to them. Adults might access personal care services. A lot of people with mental illness who receive long-term services are getting targeted case management and psychosocial rehabilitation services.

And so it depends on the state, first of all, and then in general, that's sort of what that population is like. They're people who would be getting for the most part state plan LTSS.

COMMISSIONER ROSENBAUM: So it's a lot of people, according to the chart above, but a relatively low level of spending in relation to acute care below. My suspicion is what we're looking at, because up until, of course, the Affordable Care Act went through full implementation, the people in a poverty-related group are going to be pretty much children and pregnant women, and I'm assuming that it's ambulatory chronic conditions mostly. And it would be interesting -- one of the things I recall from prior studies that have been done is that an astounding proportion of children with functional limitations, something like the majority of children with functional limitations come into Medicaid on other than an SSI pathway. And I think that that's also one of these gems in here that we want to point out, that people do not come in with labels on their heads, you know, "I am a person with a disability." They are actually coming in as people on just an income-based pathway who have significant burden of poor health or health needs, and to assume that you can sort of nicely separate the world into people with disabilities and all other people is not correct, and that group may show it better than almost any other on your chart. And I think it's a point that's worth driving home.

COMMISSIONER HOYT: I am so excited to have a fellow math geek now.

[Laughter.]

COMMISSIONER HOYT: My new favorite Commissioner.

I actually had a couple of comments on Tables 4 and 5. I don't know whether there is a problem or not. I notice like on the top line in 4, the total number of dual eligibles, the dollars per person do not add across to the $32,000 number; whereas, the two columns do add for everyplace else in the table. So it

makes me wonder if there is not some kind of cell formula error or reference something going on there. The two top numbers look too low. Do you see where I am talking about, Molly?

Okay. Then the other concern I had, just thinking about a congressman, a layperson, anybody else reading this -- I am down to Table 5 now -- if you look at total Medicaid-only enrollees, this says the spending per person on HCBS is $13,459, but it is only $9,500 to be in an institution. I am being facetious here, but you would read that and go, "Why the heck are we writing like 400 HCBS waivers and sending everybody to HCBS? That is costing me money."

So what I think the answer is -- and I don't know whether you could fix this or comment on it or something else -- here again, these numbers do add across to, on that line, $23,006. What I think you've got is you have a discrete breakdown on the dollars on institutional and HCBS, but you don't have a break on the users, so you are dividing by all the users.

To oversimplify, if 30 percent of the people were in HCBS and 70 percent were in institutions, you would get different numbers there that I think would be more reflective per user. They wouldn't add any more to the 23,000. Probably, on acute care, you're fine, because probably everybody uses acute care, but most people -- there would be some overlap.

CHAIR ROWLAND: Three times as many people use home and community-based services as are institutions.

COMMISSIONER HOYT: Yes. So I think you could walk away from this with kind of a false read; that it would be wise to at least address, if we don't have some way to fix it.

EXECUTIVE DIRECTOR SCHWARTZ: Maybe we can -- the problem is that some of these distributions are going to be different in each of these rows, but we can think about adding a distribution,

some distribution lines here. That would give more context.

COMMISSIONER RILEY: Well, again, I think the other piece of the demographics is also that not only are these a different population in terms of eligibility, it is also a different provider system, not for the acute care but for all the other services. It is a largely Medicaid-only or Medicaid-created provider system.

I would just urge us whatever we do, however we restructure this, is we spend less time being service-driven and more time being client-driven, enrollee-driven, because I think we really do need to invite the Congress to think about new ways of delivering services.

The point that we talked about early on in this discussion was about the functional assessment and how important that was. With all the great work here, I don't think we have made the case for why might need to be a standardized assessment, and I think if you think about the pathways, before you get to the pathways, we have the complex income eligibility, multiple ways, multiple pathways. Then the function is what level of disability cuts across, and at that point, I think we could make the case for functional assessment, but we really need to be a little bit clearer, I think, about the financial eligibility versus the functional eligibility and make the case for why functional eligibility is important and why an independent and standardized assessment might make sense.

CHAIR ROWLAND: There is one piece here that I don't want us to overlook, though, that I think is really strong and that we really need to have in our chapter that goes along with the administrative chapter, which is the tables that follow Trish's favorite tables that really look at where the responsibility is for these services. It is that we have got a patchwork of programs and laws, but we have also got a patchwork of who runs these programs and who manages, and we clearly got that from the Medicaid

directors when they were here that they are the single-state agency, but someone else is controlling the budget, deciding what providers to work with. And if we are ever going to move to try and get a more organized and integrated way of handling both acute and long-term care, it also involves smashing down some of these barriers.

So I think that the framework by which these services are delivered is a very strong case you have, and you need to make that in the chapter as well.

Sara.

COMMISSIONER ROSENBAUM: One other question. I was looking at Table 6 here and wondering myself. I don't understand how this table is consistent with the single-state agency requirement. I am sure this is a naive question on my part, but how can it be that you have an agency -- I absolutely appreciate that agencies have huge rules in running Medicaid, other than the Medicaid agency, but how can it be that they are not in fact accountable to the Medicaid agency?

MS. McGINN-SHAPIRO: I think this table was trying to capture -- they are all accountable to the -- yeah, making it clear that Medicaid agency has oversight.

COMMISSIONER MOORE: I think they have to have an MOU, and I think that means that --

MS. McGINN-SHAPIRO: Right. They have an MOU. Right.

COMMISSIONER MOORE: Yes.

MS. McGINN-SHAPIRO: Right. Yes, exactly right.

COMMISSIONER ROSENBAUM: You might want to clarify that.

MS. McGINN-SHAPIRO: Right, right.

CHAIR ROWLAND: They are linked, but it is a tenuous link.

MS. McGINN-SHAPIRO: Yes.

COMMISSIONER CHECKETT: And I will jump in, because there are some states where the single-state agency authority actually is in the governor's office.

COMMISSIONER ROSENBAUM: Yeah, yeah.

COMMISSIONER CHECKETT: And that was taken away from the Medicaid agency because of internecine wars, as we refer to them, those of us who survived them, and so that actually sometimes is the case.

But I do agree we need to clarify it, because that's not frequent.

CHAIR ROWLAND: Mark.

COMMISSIONER HOYT: It is sort of a related comment, but I don't know if it fits in the very first chapter we write on this. But it is related to the multiple agency thing. I am sure other people have seen this too where you have -- I am thinking of a state where there is a long-term care agency or group or division, and then there is a District counterpart, and they both go out and contract for the same services, but they don't talk to each other. And there are just huge disparities in the rates and how they pay and even units, how those are defined. You have probably seen too. Even to where they are paying the exact same person or provider agency wildly different rates for the same service.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: I wonder if an addition to this might be to talk about who provides the match, because frequently, it is the sister agency that is providing the state match, which puts the sister agency in a pretty powerful position.

CHAIR ROWLAND: Richard.

COMMISSIONER CHAMBERS: You know, something to think about is the whole question about quality, and in the long-term care system, the strongest quality oversight is on nursing facility where it is very clear in the state agencies that do licensing. But when you start going down from there is the licensing of -- again, I will just talk about my experience in California -- is the licensing of group homes, which there is very little oversight other than initial licensing as opposed to -- I don't know. It's just because of the advocacy groups that nursing home residents with ombudsman programs and just focus. Then you go beyond that into community-based services.

I don't want to add even more complexity, but we are just talking about organization delivery and payment of services. It's what the quality component that goes along with it, so just something to think about for future work. Once we sort out all the other problems, maybe we can get to quality.

CHAIR ROWLAND: So we are going to take this chapter, and we are going to somewhat reorganize it. We are going to flag areas that need to be pursued in the future, and we are going to try and structure it, I think, according to, as Trish laid out, some of the themes or questions we want to answer about Medicaid's role in helping individuals who need long-term services and supports: who are they, how did they get there, what services do they get; how is that organized and disorganized, getting to the administrative structures; and then where do we need to go from here; if we can't start over from scratch, how do we go forward; and weaving into that the context of this is an area that is not solely under the discretion of the Medicaid director.

It is one highly influenced by the courts. It is also influenced by years of Congress adding new patches and new changes in part because they never wanted to take on long-term care in the big way. So they took it on as, well, we would like to support people who have disabilities who want to go back to work,

so we will let them stay on to the program, or we want to support other things, so I think a little bit of sort of the history of how it came to be such a patchwork. But obviously, this it is the first attempt into a very complex area, and I think we have got a lot of meat in this chapter, and it is really just how to organize it, so that people can digest it and use it, and that it sets up where we want to go forward.

And if we were to make a recommendation, it would be that we would start all over again, but we are not going to make that recommendation.

So thank you both. I know this has been an incredible struggle. It is almost over, and it really gives us such a wealth of information that it's very hard to figure out how to digest it, and I think we are trying to figure out the framework that lets us digest it in bigger chunks. Thank you.

And now, just because we like to be waiting in areas of data confusion and complexity, we have called April back to the table to talk to us about how we evaluate Medicaid managed care enrollment encounter data for policy analysis, and I hope that she is going to just say, "Oh, you just plug this little software program into your iPad, and there it goes."

SESSION 7:

EVALUATING MEDICAID MANAGED CARE ENCOUNTER DATA FOR POLICY ANALYSIS

* MS. GRADY: Thank you, Diane. That would be great. That is my Fantasy Land, but unfortunately --

CHAIR ROWLAND: As long as it is not Richard's iPad.

[Laughter.]

MS. GRADY: It is a little more complicated than that, but I will try to simplify as much as I can.

Before beginning, I want to acknowledge that the work I am presenting today has been a group effort with valuable contributions from MACPAC staff, Chris Park in particular, as well as programming support from Acumen, our contractor.

So I will start with a little background information on encounter data use and reporting. You have heard some of this presented before in previous meetings. I will talk a little bit about previous studies that have examined the usability of managed care encounter data from federal sources, and then I will give you some draft results from a MACPAC analysis of comprehensive managed care encounter data for 2010.

One thing I want to be clear about is the purpose of this session, which is to provide information that describes how we are building our analytic capacity at MACPAC and our ability to examine service use among managed care enrollees. This is a little different than most of the presentations you have heard today, which are focused on information that might lead to a specific MACPAC product or recommendation, and here, this is just about getting us to a better place with our analytic work.

CHAIR ROWLAND: This is not a chapter you have to edit. There is no chapter involved here. This is background on how we can do our work.

MS. GRADY: That's correct. Yes, lucky me.

COMMISSIONER CHECKETT: We will edit it, anyway.

MS. GRADY: I'm sure. I look forward to your contributions.

[Laughter.]

MS. GRADY: As you know very well, the importance of encounter data is growing. Managed care is large. It's a growing share of the Medicaid program, increasing from less than 40 percent of enrollees to about 50 percent over the last decade. Most people who are gaining eligibility in 2014 are

expected to enroll in managed care, and encounter data provide a record of the services provided to these enrollees, so we need this information to understand what's going on for the program today.

There are a number of potential uses for encounter data that we collect at the federal level. For example, it could be used to monitor and compare access to and quality of care in fee-for-service and managed care systems, both nationally and across states. I will point out that, of course, some states already do this on an individual basis, comparing the measures that they have in their fee-for-service and their managed care systems.

And I don't want to make this sound like a walk in the park, because comparing fee-for-service and managed care is not necessarily a straightforward exercise. Even for states that have more detailed data than we do at the federal level, there are issues with apples-to-applies comparisons, because managed care plans are more likely to augment their claims analyses with medical record reviews and other things that are much more difficult for states and fee-for-service systems to do.

There's also, of course, different populations enrolling in fee-for-service and managed care, and that has to be something that is taken into account when any comparisons are done. And there also may be additional measures that are appropriate beyond a basic set, depending on the complexity of the population that you are talking about, so there's some things to pay attention to there.

So in addition to monitoring and comparing systems, one of the things that could also be done with federal data, encounter data, is reduced need for additional state reporting. Right now, we have states submitting reports that in theory could be calculated using the raw encounter and claims data at the federal level, and we could potentially back off of some of that duplicate reporting.

The examples I have here are the CMS-416 data on early and periodic screening, diagnostic and

treatment benefits, in Medicaid for children, EPSDT. The other example is child and adult health quality measures. Right now, these are voluntary, and not all states report measures, particularly for adults. Those are newer and just beginning to come on board.

So at the state level, of course, the encounter data are used for a variety of purposes, and I have got a long list here that you can look at. States face a number of challenges, of course, in collecting, validating, and reporting that encounter data, and in recognition of that, the Centers for Medicaid and Medicaid Services has recently been providing technical assistance to states who need and want it.

And just in terms of these challenges, if you think about it, the provider has to give data to the plan. The plan has to give data to the state, and then the state has to give data to the federal government in order for this to work, and there's many things that can happen along the way. What we end up with at the federal level is highly dependent upon what goes on at the provider, the plan, and the state level, so we're doing the best we can, but there's a lot of steps in the process.

Most analyses of Medicaid claims data that we see to date from federal sources have a fee-for-service focus, and that's for a number of reasons. Of course, as we have discussed ad nauseum, I think, within the Commission, that is due in part to a lack of information about what is actually in the data itself. There were few analyses that were looking at the completeness and the quality of the data that was being submitted in the MSIS, the Medicaid Statistical Information System, which is a key data source for us.

And of course, this fee-for-service focus is problematic, because fee-for-service enrollees may not be representative of the overall Medicaid population. In addition to those population differences, of course, there are structural differences between fee-for-service and managed care that may influence the service use and spending patterns. Even if you had the same enrollee population in both systems, utilization

management, provider networks, a whole host of things may lead to differences between the two.

And these last two points are things I will circle back to at the end of the presentation about why this encounter data matters.

So there have been some recent analyses of the encounter data in the MSIS, and the associated Medicaid Analytic eXtract, or MAX data that researchers commonly use, to examine how good the encounter data is. Looking at comprehensive managed care plans for 2007 through 2009, it appears that a majority of states may have data of reasonable completeness and quality for research purposes, and there were some improvements in the number of states with usable data over these 3 years, so things seem to be getting better.

With regard to behavioral health plans in 2009, things were a little more problematic. There were, first of all, a fewer number of states with behavioral health plans, but among those states, there was a smaller number submitting data, and when they did submit data, it wasn't necessarily complete or of high quality, to be usable for research purposes.

So that is the previous work that we were building off of. What we did was to analyze encounter data for comprehensive managed care plans or enrollees in 2010 using methods that were similar to the 2007 through 2009 study that I noted.

The punchline here that we found, that the majority of states with comprehensive managed care had potentially usable encounter data, with some variation by the type of event that we were looking at. We looked at outpatient visits, inpatient hospital stays, and drug prescriptions, and there was some variation by eligibility group as well.

So for those who want the gory details, I will walk you through now how we got to that punchline,

but if you don't want to know, I guess you can tune out at this point.

Just a little bit of background on our methods. These are described in much more detail in the background paper that was included in your meeting material. I will just touch on them briefly here.

As I said, we used MSIS data for 2010 on outpatient visits, inpatient hospital stays, and drug prescriptions. We focused on full benefit, non-dually eligible enrollees, for reasons that are probably obvious.

We also required states to meet comprehensive managed care enrollment and encounter data submission thresholds, and that was partly because we didn't want small numbers of people and small submissions to skew our results. So if you didn't enroll at least 10 percent of a particular eligibility group in comprehensive managed care, we didn't look at that group. And that might be a second-stage analysis that we do.

So what we did was to compare what we saw in the encounter data for some completeness and quality measures. We compared those measures for the encounter data to some benchmark ranges of fee-for-service values that we calculated for states that do not have comprehensive managed care, so does this encounter data look reasonable, given what we know about fee-for-service programs?

As I mentioned, again, these methods were similar to those in the 2007 through 2009 study that I mentioned earlier, and we did this so that we would have a point of comparison to begin our own work.

Here, there's a lot of numbers on this slide, so I am going to walk you through an example here looking at the inpatient numbers in the center of the chart. What this is showing is the number of states that were included in our analysis.

If you look at the inpatient bars in the middle here, what this is telling you is that on the right side

here, there were 15 states that did not have comprehensive managed care in 2010, so they were not part of our encounter data analysis.

For the adult eligibility group, there were two states that had comprehensive managed care, but we didn't include them because they had very low enrollments, less than 10 percent of their population, so again we didn't examine those small numbers in this initial analysis.

Moving leftward a little more, there were six states that again had comprehensive managed care and they met our enrollment threshold, but they were not included because they were submitting very little or no encounter data, so there was no usability to assess in that situation.

Then what we were left with on the left side is 28 states where they had comprehensive managed care, and they had enough enrollment and enough data for us to look at.

Unless there's any questions, I will move on.

Okay. Yes.

COMMISSIONER GABOW: I wasn't clear when I read through the paper why you picked certain thresholds. How did you test the validity of 200 people or 10 percent?

MS. GRADY: Sure.

COMMISSIONER GABOW: I wasn't clear about that.

MS. GRADY: Sure. Well, first of all, as I said, we used methods very similar to those early studies, so that we'd have a point of comparison, basically. This earlier study had used 10 percent, so that was one reason, is that we wanted to have a point of comparison for our work on 2010.

The other reason is, as I said, it is arbitrary. We could have looked at everybody who submitted, who had at least some managed care enrollment. We didn't have to restrict it to at least 10 percent of your

folks being in managed care, but the concern was if you had such a low number in managed care, number one, you might not be very focused on getting good encounter data, and so, you know --

COMMISSIONER GABOW: It wasn't so much that you excluded people with 1 percent. How did you decide that 10 percent was sufficient?

MS. GRADY: It was arbitrary. Arbitrary. That is the best answer. Again, replicating an earlier study, but one thing I would like to do in our future analysis is to look at all of the states with managed care enrollment and not impose the 10 percent threshold.

Okay. So for the next few slides, I am going to walk you through results for individuals who are eligible on the basis of a disability.

CHAIR ROWLAND: You only really lost two states, right, with the 10 percent?

MS. GRADY: Yes. Because if you have comprehensive managed care, for the most part, you are enrolling a substantial number of people.

Now, of course, that varies by eligibility group. We only lost two states for adults, but for individuals with disabilities, we lost eight states, because they don't enroll a large number of those people. But we could be looking at those states as well if we wanted to.

So what I want to do on the next few slides again is walk you through the results for individuals who are eligible on the basis of a disability in order to explain the numbers that you are seeing here. I am showing you adults, children, folks with disabilities, and people age 65 and older on this slide, but I am only going to focus on the disabled column.

I am going to focus on inpatient hospital stays, but as described in your background paper, we also looked at outpatient visits and drug prescriptions.

To determine whether a state's encounter data are potentially usable, we looked at measures of both completeness and quality, and we compared those values to fee-for-service values.

Here in this slide, we are showing the measures we determined, we used to determine whether encounter data on inpatient hospital stays were complete. So there were two completeness measures that we looked at, and the first was the percent of enrollees with an inpatient hospital stay, at least one stay, and then among those with a stay, the average number of stays per person.

And as you will see here, our benchmark fee-for-service range for the percent of enrollees with a stay among the group of people who are eligible on the basis of disability was 5.3 to 29.6 percent, and you will see that 19 out of 24 states had encounter data values that fell within this range.

Similarly, we looked at the average number of states per user, and the benchmark range there was 1.4 to 2.0, and 20 out of the 24 states with encounter data fell within that range.

I am getting a quizzical look from a Commissioner, but I will wait until the questions come.

Here, we are looking at the measures we used to determine whether the encounter data on inpatient hospital stays were of high quality, and we looked at four quality measures: the average length of stay in days, the average number of diagnosis codes per stay, the percentage of stays with a procedure code, and the percent of stays with an accommodation code.

I am not going to run through all of these measures. I will just give you one example here. Looking at the benchmark range for the average length of stay, that was 5.1 to 10.5 days, and 21 of the 24 states had encounter data values that fell within that range.

As you can see here, there were three other measures that we looked at when we went through this.

Okay. So here is a summary of what we found overall in terms of the number of states with

potentially usable encounter data for outpatient visits and inpatient hospital stays and prescription drugs. A state's data for a particular service category here, and eligibility group combination, was deemed potentially usable if a specified number of their completeness and quality measures fell within the benchmark ranges that I described to you.

I don't want to focus too much on the particular numbers you see here in part because the number of states that are considered to be usable depends a lot on the benchmark that you choose for acceptable values. As I said, we came up with this fee-for-service range, but if you set a different range, a different number of states may fall within the acceptable or usable category.

One thing I will say is that states didn't always have usable or potentially usable data for all three service categories. For example, we saw instances where the outpatient visit and the prescription drug data seemed to be usable, but inpatient stays were not, for whatever reason.

Okay. So I showed you a lot of numbers, but I want to bring us back around to why we are doing all this work and how it matters for a policy analysis. As I mentioned earlier, most analyses of Medicaid data, claims data from federal sources, focus on fee-for-service enrollees. However, what we are showing here on this slide is that the inclusion of managed care enrollees and encounter data can make a big difference in the service-use statistics that you see.

As with earlier slides, I am continuing to focus on inpatient hospital stays for people who are eligible on the basis of a disability, and the first thing I want you to focus on is the columns that say fee-for-service enrollees. What we are showing here, for example, is that the percent of fee-for-service enrollees with an inpatient hospital stay varies from 10 percent to 31 percent among these three states that we selected as examples here, so that's your fee-for-service percentages.

This is part of the explanation for why our benchmarks for fee-for-service have such wide ranges of acceptable values. I assume that might have been the sources from the quizzical looks earlier. We just observed a lot of variation in fee-for-service, and that is why we have these wide ranges of what might be acceptable for what we are seeing in the encounter data.

The second thing I want to highlight here is that the addition of the managed care enrollees and the encounter data affects the service-use statistics, and that can work in both directions.

If we look at State A here, 31 percent of their fee-for-service enrollees had an inpatient hospital stay among folks who are eligible on the basis of a disability, but when we include the managed care population and the encounter data, that goes down to 24 percent. That may indicate that the managed care population is healthier. It may mean any number of things.

In State B here, we have 10 percent of fee-for-service enrollees with an inpatient hospital stay, but when we add in the managed care data, we see that actually 15 percent of the population had an inpatient stay.

Again, State C here, about the same percentage of fee-for-service and managed care enrollees had an inpatient hospital stay. So, the addition of the data tells us a different story, basically, and it's with the average length of stay here, we see that, actually, it consistently went down with the addition of the managed care data. You know, some of these differences may be due to population differences, health of the population overall, but others may be due to structural differences in the managed care and the fee-for-service systems. If the managed care programs have utilization management and other techniques in place that the fee-for-service programs don't, that may be part of the explanation for why you see a reduction in the average length of stay. But, this is speculation and examples of the kinds of questions we

might ask when we look at these results.

So, to wrap up here, these are some of the things we want to consider for our future analyses, and the first one, I've already mentioned, is alternative benchmarks for evaluating the usability of encounter data. As I said, our current analysis used fee-for-service as a benchmark, but we're not sure that's necessarily the right way to go and there are alternatives to consider.

Another thing we'd like to try and do is to attribute the encounter claims to specific plans in our data. Unfortunately, we have a bit of a problem with the ID numbers. You'd think it's easy to say, if this person is enrolled in a managed care plan, these claims are associated with that managed care plan, but it's not so simple because the ID numbers in the enrollment file are different than the ID numbers in the claims file, and so that's caused us a bit of trouble.

Of course, we want to look at additional services and managed care plan types, potentially.

And then, fourth, I think we need to consider how we present service use and other statistics on fee-for-service and managed care once we start to incorporate this data. And it's great that we have more data, but it clearly adds complexity in how we present the information, in how we discuss it, how we interpret it, especially when not all states will have usable data. And our future analyses can make use of this encounter data, but I think we need to think a bit more about the best benchmarks for determining completeness and the quality and usability before we begin to publish this information.

So, I look forward to your comments. Thank you.

CHAIR ROWLAND: Thank you, April.

Burt.

COMMISSIONER EDELSTEIN: April, really appreciate the complexity and the endeavor of

trying to figure this out, but I'm not sold, and I'm not sold on the conclusion that the majority of the states have usable data because you may not be comparing apples with oranges, but one variety of apple with another variety of apple. The ranges are so wide as to suggest that it would be remarkable if a state didn't fall into the area that was under the curve. And the findings at the end, that managed care data consistently showed lower results, raises questions about not just the health of the population, but whether there's underreporting.

Unfortunately, there's no way to do what it is you're trying to do, and so I appreciate that this is a lot of effort to show the best you can possibly squeeze out of incomparable data, but I'm still not sold that we know much about what goes on in the reporting of managed care encounter data.

MS. GRADY: Well, to be fair, we did say "potentially" usable. We did put that word in there deliberately.

[Laughter.]

CHAIR ROWLAND: But, a lot of work to determine what it is.

COMMISSIONER HOYT: I'm really glad you worked on this. It raises some more questions for me, not the least of which is, what is the federal role here? You've kind of circled back to -- when Christopher Truffer was here, I kind of beat him about the head and shoulders because I do feel like CMS has approved countless waivers to approve putting people in managed care, but they don't spend any time trying to figure out some of these issues. What is the service utilization? And I think I was asking him more, what do you guys think? Does it save money or not? If it doesn't, that might be okay. Are they getting better service or something that they didn't get before?

So, that might be politically sensitive and we don't want to go there, but it sure -- I mean, you had to

do all this yourself, right? There's, like, nothing they're doing that's comparable to this to try and sort this out, is there?

MS. GRADY: They supported the research that I cited earlier. So, the studies that we do have were part of the technical assistance and analytic contract that they have ongoing right now to try and improve the encounter data.

COMMISSIONER HOYT: The one other comment or question I had was, and maybe you're just not there yet, any best practices or states that stand out or things they do. Maybe they -- it's just a matter of time, or they've sanctioned providers or plans or how they work with them. One thing I'm convinced of from an actuarial point of view is states that have implemented risk adjustment, it's guaranteed you will end up getting better encounter data, because I've seen it play out countless times. What you'll get is a more nuanced encounter data set because the typical risk adjustment tools will pull up multiple diagnoses or problems, and at least in the past, a lot of plans would just do the top one, you know, and that's it. And once you go to risk adjustment, then they're penalized for not reporting a more robust set.

MS. GRADY: Also, as part of the technical assistance contract that I mentioned, there is a report that CMS put out on best practices with some case studies and discussion of what states can do to improve the situation.

COMMISSIONER GABOW: I am sort of weighing in with Burt. I'm not sure how to use this. I mean, if you just look at the ranges in your quality data, in the column for disabled, like, percent of stays with procedure codes, 25 to 75 percent? Well, you know -- I mean, well, what does that mean?

If you tried to ask the question, what's the correlation by state, I mean, if a state had only 25 percent of their fee-for-service having a procedure code and only 25 percent of their managed care patients having a

procedure code, wouldn't you say that state has an issue? I mean, I'm coming to a different set of conclusions.

So, some of these, you would ask, why are they both low, and if one is -- if, in the same state -- so, given this range -- I'm sorry I'm being inarticulate, because, basically, I'm confused. I'm like the people who love tables. I guess I wasn't born with that gene.

But if you take this percent of stays with procedure code, how are you thinking about a state where fee-for-service is at 25 percent and managed care is at 25 percent, versus a state where they're both at 75 percent, versus a state where one is at 25 and one is at 75, because by using this, they would both be -- all three of those would be blessed as okay. Okay, kids. But, that's very different information. So, I'm struggling to try and understand how you think about something like that.

MS. GRADY: I think it's a fair question and it's something we're struggling with right now, as well, because I agree that these ranges are awful wide and we need to think harder about what the appropriate benchmark may be. Just because a number of states have 25 percent with a procedure code, for example, is that acceptable? Should we say, well, we'll take that because that's what we see among fee-for-service? I think it's an open question about how to define what's usable.

COMMISSIONER GABOW: [Off microphone.] -- if they don't -- they aren't following in parallel either direction, and yet they would still fall into the same group, something about that doesn't strike me right, but --

COMMISSIONER WALDREN: I was just going to say, I mean, I think the issue is it's a precision issue, not an accuracy issue. So, fee-for-service is our first dart. It may be nowhere close to the bullseye. But the question is, is how close is the next dart, which is the encounter data. So that's -- because she can't

see the dartboard. All she can see is there's one dart, and you throw the next dart and how close is it to that? She doesn't know if they're right or wrong, or they're this close together, but is the bullseye here or is the bullseye here? She can't know --

MS. GRADY: Yeah --

COMMISSIONER WALDREN: The precision issue --

COMMISSIONER GABOW: But that's the kind of question that I was asking. If one dart is at 25 and another state is at 75 and another state is at 25, and they aren't -- yet they're in the same bin, but they're very differently placed, what does that tell you?

COMMISSIONER WALDREN: Well, my assumption, too, is each state has their own dartboard, because if they have their own population and their own issues and who they've decided to put into managed care and who they decided not to put into managed care, it could be different. So, she's got -- every state has their own dartboard and she only has one dart in each dartboard and she's just trying to figure out, this other dart, does it look like they're close together so at least they're reliable. They're either reliably correct or reliably wrong.

CHAIR ROWLAND: I think, in fairness, what April is trying to do is to show us how difficult it is to go from the fee-for-service data, which we are used to looking at and which is countable, to the world of managed care, when encounter data is neither uniform nor provided all over. But, it's a good beginning of saying, this is why, when you tell us to evaluate how well managed care is performing, we have some challenges.

And Donna is going to just solve it all by telling us what encounter data should look like.

COMMISSIONER CHECKETT: This has been a very interesting discussion, and I don't have

one of those brains, either, that reads charts and does mathematical calculations well, but I really get the importance of encounter data.

But, for me, it is -- and so it is a great chapter, even though apparently we're not allowed to edit, but it is --

[Laughter.]

COMMISSIONER WALDREN: The start of a chapter.

COMMISSIONER CHECKETT: It is not a chapter.

CHAIR ROWLAND: [Off microphone.] It could be a background paper.

COMMISSIONER CHECKETT: It could be, and I think it should be, because what concerns me, actually, is do the states realize that -- or do they see it? I mean, I could probably continue Steven's analogy. Do they see this as a problem? Do they see 25 percent reporting for a procedure, compared to fee-for-service which is coming in at 100, but, actually, it's just 100 of billed and paid claims, is all it is. And so then you've got, maybe, 25 percent. And it concerns me on rate setting.

And I would say that, you know, really, when you look at is managed care effective, what we look at as an industry is actually national standards around HEDIS and other measures that don't actually -- they rely some on encounter data, but they actually have much more sophisticated other ways of measuring behind them.

So, I'm not sure what the point is of my speech here, other than, one, it's very interesting, and two, it actually concerns me when the role of encounter data in rate setting comes in, and that might be another thing to explore at some point, so it's interesting.

COMMISSIONER WALDREN: So, I think this would be even more difficult than what you've

already done, but it seems there are a couple of places in the U.S. that there are established health or patient exchanges. I think of Indiana and a couple other places. It would seem like, is there a way to look at one of those areas that would be a way to get some clinical data, and then look at the fee-for-service data and the encounter data that's related to that, because they have to have an EMPI to match those up.

I think there would be challenges in getting access to the data and getting permission to get all that set up, and then there's going to be another layer of kind of crunching, but now you have an actual clinical data that's supposed to represent what happens to the patient, and then take those two longitudinal views of the fee-for-service data and the managed care data and say, how close do these three match to each other.

MS. GRADY: I'm not sure about the HIEs, in particular, but I think the issue that you all are raising is we're using fee-for-service as a benchmark for our encounter data analysis, and if the fee-for-service data aren't right or there's something wrong with those, how do we figure out what they should look like or what the deficiency is? And in some cases, it may be enough just to know that the level just doesn't look right. You know that more than 25 percent of claims should have a procedure code and, therefore, you know, you flag that as a problem.

So, I think what I'm hearing is, take a step back, and if available, are there other points of comparison, even for the fee-for-service data, before we decide to set our benchmark for encounters.

COMMISSIONER EDELSTEIN: I wonder if it would be valuable to take a look at how AHRQ does its look-back in MEPS, because they're trying to establish the same sort of validity for family reports of services received and they do a subsample, go back and look at the actual contact with the providers. There may be some way, analogous to what Steve was talking about, of getting back to clinical data. Even if it's for a small subset, it would be more reliable and more valid than a large data set that is just

unknowable.

CHAIR ROWLAND: Okay. Well, April, thank you for bringing this fascinating topic to us. It's great at the end of every Commission meeting to have a long discussion about data and methodology. I think it's been a very instructive discussion of how hard it is to really be able to put together the kind of data that we ask you to report on and give us so that it's instructive to have the Commission members understand, even when you do as much work as you did to try and show how this works, that we still don't have the gold standard that we want to compare to. So, we will obviously continue this discussion.

And, I do think the suggestion that even developing a background piece on the difficulty of trying to use encounter data would be a very useful contribution from the Commission, so thank you.

And if there is anyone who has now listened to our data discussion who would like to come forward and offer a comment from our audience to the Commission for its consideration, we will now hear any such comments.

PUBLIC COMMENT

* [No response.]

CHAIR ROWLAND: There is a long line of comments, I see.

[Laughter.]

CHAIR ROWLAND: Seeing no one arise, I will, therefore, adjourn this session of MACPAC, though I would ask the Commission members to stay for a few minutes afterward. Thank you.

* [Whereupon, at 4:29 p.m., the meeting was recessed, to reconvene at 10:30 a.m. on Friday, April 11, 2014.]

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

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

Friday, April 11, 2014
10:37 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
PATRICIA GABOW, MD
DENISE HENNING, CNM, MSN
MARK HOYT, FSA, MAAA
NORMA MARTINEZ ROGERS, PhD, RN, FAAN
JUDITH MOORE
TRISH RILEY, MS
SARA ROSENBAUM, JD
ROBIN SMITH
STEVEN WALDREN, MD, MS

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S [10:37 a.m.]

CHAIR ROWLAND: Okay, if we could please come to order. We want to return this morning to the discussion that we were engaged in yesterday about the Commission's proposed policy on the future of CHIP coverage for children, and so we're going to turn to Chris and ask him to try, as best he can, to summarize where the Commission came out yesterday and where we are going. Chris?

SESSION 8

REVIEW ACDTIONS, RECOMMENDATIONS ON CHIP

* MR. PETERSON: Great. Thanks, Diane. And, first, although I'm sitting up here by myself, I want to acknowledge again the contributions of my colleagues Lindsay, Ben, and Veronica, for their contributions and their work and due diligence on many of the complicated areas that are covered in the chapter.

For today's discussion on the recommendation, part of the chapter yet to be written, you have discussed the future of CHIP in every meeting this report cycle, so beginning in September. And as part of those discussions, you have considered a range of options which you want to see described in the remainder of the chapter from allow current law to stand, so CHIP funding would run out in about -- begin to run out in about a year and a half -- to recommend a longer-term extension of CHIP. And you seem to have coalesced around a shorter-term recommendation, and that's what we're bringing to you today.

So you considered allowing current law to stand as a recommendation but found that that was unacceptable for several reasons: that the number of uninsured children could increase significantly, that cost sharing for affected children's health care services would increase significantly for many families, that during the maintenance of effort there's kind of an inequity between states with respect to how they would

be treated in their financing. And it's unclear whether or not exchange plans are ready to serve as an appropriate alternative.

You also considered a longer-term extension of CHIP but found that you're not committed to having a stand-alone children's program like CHIP continue indefinitely, particularly in the context of the new affordability options available through the ACA; and also that extending CHIP for too long could remove the impetus for making changes that could delay focus on improving children's coverage through other sources.

So the recommendation that we are putting up here today in response to the conversation yesterday is that the Congress should extend federal CHIP funding for a transition period of two years, during which time the key issues regarding the affordability and adequacy of children's coverage can be addressed, with the rationale for a two-year extension being, again, that the Commission is not recommending a long-term extension of CHIP but recognizes that changes must be made to alternative coverage options, including exchange coverage, to ensure that coverage is affordable and adequate for children, and that some of the key issues that need to be addressed in the interim have to do with eligibility, for example, what is for shorthand called "family glitch," affordability with respect to both premiums and cost sharing, which can differ across the income scale for kids currently enrolled in CHIP, benefits, for example, the availability of dental coverage, and financing dealing with what the implications are for the federal and state government and their spending; and that as solutions to these issues are developed, CHIP should remain as a source of coverage for children.

And so now I will put the potential recommendation back on the screen for you to open it up for your discussion.

CHAIR ROWLAND: Great. Comments?

COMMISSIONER COHEN: Thanks. From my perspective, Chris, a great summary of where we are and how we got here. You know, I just wanted to run through a little bit more of my thinking about how we get to this place.

I think that, you know, we all recognize that CHIP reflected -- you know, when it was created, reflected a fairly national consensus that prioritizing the coverage of children was where we wanted to go as a country, and the program has had incredible successes in some areas: improving coverage, teaching us more things about outreach, and many other things, more lately sort of looking at issues around quality of care, improved coverage for oral health, and other things.

So I think what we are trying to do is sort of channel our understanding that that's really a priority with an appreciation that the landscape has changed, that having many separate programs comes with harms to people who fall between them. It adds complexity to our system, and so we are basically sort of looking for a two-year period in which we can sort of harmonize this desire to simplify, reflect a new landscape with new coverage opportunities, keep families together or that make sense, but to recognize that, you know, we don't think it has changed that we should be prioritizing coverage of children.

So I just wanted to add a little bit of my personal sort of framing for how I got to this place, and thank you for the great job you did.

VICE CHAIR SUNDWALL: I just wanted to emphasize the importance of CHIP when it was enacted. My former boss, Senator Hatch, and Senator Kennedy joined together and were championing this, and it really was important. And I think as Andy has said, it has played out well.

I do think, however, the landscape has changed. Our hope is that we'll have everyone having

insurance coverage, and the complexity of having the separate CHIP program is not ideal. We don't want for kids to fall through the cracks or have uninsured children as a consequence of a precipitous stop in CHIP funding. But I also support the transition period for at least -- not "at least -- for two years, hopefully.

COMMISSIONER CHAMBERS: I'm going to sound like a broken record, but I'm just supporting my two colleagues. A simplification will be good. California in 2013 transitioned from a separate CHIP program to having Medicaid expansion, and while it was a painful process, it was just completed, and I think in the long run in that case it makes it simpler for families and coverage. But I think at the same time, as we're making sure we protect -- what happens to these kids either becoming Medicaid or going into exchange products, is that coverage is adequate and affordable. And I think it is our course of action over the next couple years, and trying to lead to that is the right way to go.

Thanks.

COMMISSIONER ROSENBAUM: I think this is a good compromise. My concern has been primarily on what I see are weaknesses -- as being weaknesses in the structure, the current structure of the exchange marketplace. And I think as Chris appropriately noted, we have weaknesses going to affordability; we have weaknesses going to the value of the insurance coverage itself, a level of financial protection we're giving families in the area of pediatrics. We have, of course, very serious problems with the alignment of the subsidized dental benefits for children; and then, of course, the problem known as the family glitch problem in which children and families that just simply cannot afford family coverage by any measure, whether we use the somewhat high legal affordability measure of the Affordable Care Act or the actual costs that are being -- that families are confronting.

I think these are very serious problems, and there has to be a way for this country to be able to build a national scheme for health insurance that reflects sound pediatric policy, and CHIP -- thank goodness we've had CHIP to act as a safety net in all of this. But I think it's incumbent on the Commissioners to, as clearly as we can, signal to Congress that our recommendation is really to not keep limping along with this patch, but instead to confront the issues that we have to confront in health reform.

COMMISSIONER CHECKETT: Following up on Sara's comments, I think that the chapter that this recommendation stemmed from is really important reading. I encourage people in the audience, I encourage everyone to get everybody to read it, because I, until I went through that, had absolutely no idea that with all the intention of CHIP in bringing Medicaid and the Affordable Care Act, that this -- what I think we called in graduate school "unintended policy consequence" had developed with really potentially signification implications for families and children. And I think when you look at premium stacking, you look at the family glitch, you have a population that the country has actually always intended to help that, oops, are really potentially left out, and it could be millions of children. We don't know the number, but I think it's very important work. I'm really pleased with the recommendation and fully support it.

CHAIR ROWLAND: I think that we have come to a point where Sharon gets to speak.

[Laughter.]

COMMISSIONER CARTE: Thank you. I need to correct a statement I made yesterday on my reading of the chapter where it talks about potentially two million children losing eligibility, and I had looked at a later reference, and I thought that it was additive that there were as many as four million. I guess I was focused on the American Academy of Pediatricians five million estimate. But I would like to note that in the issue of affordability, that as families who participate in separate CHIPs, then would later be

expected to go into the exchange and get coverage, that I think that they would be facing a very steep curve in terms of affordability going from -- even in a state like West Virginia that charged more than a nominal premium, where we've done surveys, it seems to indicate that those families would not find exchange coverage affordable. And we will not -- we do not have the data for that here, I understand, and that's still to be determined.

So I have to say that it really concerns me that children will face a setback in coverage, which is for a CHIP Director painful to complete.

COMMISSIONER HOYT: Is there any reason we would not want to go on record as suggesting they fix the family glitch?

CHAIR ROWLAND: I think we are going on record as saying that they fix the family glitch.

COMMISSIONER HOYT: Where?

CHAIR ROWLAND: It's part of our rationale for --

COMMISSIONER HOYT: Directly, in a recommendation.

CHAIR ROWLAND: We are listing out all of the things that we think need to be addressed and fixed in order to have comprehensive coverage. One of those will be the family glitch, and that will be spelled out in the chapter and in the rationale for this recommendation.

Obviously there are cost implications for some of these fixes that will have to be dealt with in future work we do.

I mean, I think that where we have come at this point is we have a very strong chapter that lays out the important role that CHIP has played, that looks at some of the challenges in fitting CHIP into the new landscape and what that means for coverage of children. Our concern here is that coverage of children be

maintained so that we don't reverse the progress that has been made and continue to move forward to provide children in America with the kind of care and coverage options that will enable them to live healthy and productive lives, to become adults, and that we now are recommending, though, that we take a short-term funding extension so that we can fix the various glitches that we have identified in this chapter so that at the end of the day children are in a smooth transition to coverage, whether that be through the exchange, through employer-based coverage, through Medicaid, or through other sources that the Congress may want to develop as well.

But that is the vote that we are presuming to take, so I'm going to ask Chris to read once more the potential recommendations and then call for the vote.

MR. PETERSON: So the wording of the recommendation is that Congress should extend federal CHIP funding for a transition period of two years, during which time the key issues regarding the affordability and adequacy of children's coverage can be addressed.

VICE CHAIR SUNDWALL: A clarification. I want to make sure that we understand that that is an additional year to what the funding already exists.

CHAIR ROWLAND: It's two additional years.

MR. PETERSON: Yeah, two years.

COMMISSIONER ROSENBAUM: Two years beyond current [off microphone].

VICE CHAIR SUNDWALL: Pardon?

COMMISSIONER ROSENBAUM: Two years beyond -- sorry. An additional two years.

MR. PETERSON: Right.

COMMISSIONER ROSENBAUM: So the end date would be when?

MR. PETERSON: So right now allotments under current law are provided through fiscal year 2015.

VICE CHAIR SUNDWALL: Right.

MR. PETERSON: So the money will start running out under current law in about a year and a half. So this recommendation would say provide an additional two years of funding, so that would provide additional fund -- it would provide an allotment for 2016 and 2017.

CHAIR ROWLAND: Giving Congress a window to address the concerns that we've raised.

PARTICIPANT: And states [off microphone].

CHAIR ROWLAND: And states.

COMMISSIONER ROSENBAUM: So we might want to, though, recognizing David's question, we might want to slightly wordsmith this just to clarify that it's a two-year period beyond the end date now set in law, so that we're quite clear.

CHAIR ROWLAND: A transition period of two years through --

COMMISSIONER CARTE: Or beyond the federal [off microphone] --

COMMISSIONER ROSENBAUM: Beyond --

CHAIR ROWLAND: Beyond the federal fiscal year 2015.

COMMISSIONER ROSENBAUM: Right, exactly.

MR. PETERSON: So is it, "The Congress should provide an additional two years of CHIP funding"? Is that the way to say that?

CHAIR ROWLAND: Of two additional years beyond--

COMMISSIONER ROSENBAUM: Yeah, two additional years beyond FY2015, I would think.

CHAIR ROWLAND: I think that can go actually in the rationale.

COMMISSIONER ROSENBAUM: Yes.

CHAIR ROWLAND: The clarification.

COMMISSIONER ROSENBAUM: But maybe the word "additional" should go in there just to signal that we don't mean two years from today.

CHAIR ROWLAND: Two additional years.

COMMISSIONER ROSENBAUM: Yeah.

CHAIR ROWLAND: So add the word "additional" and then clarify the time frame within the rationale.

MR. PETERSON: Okay. So all I did here was add the word "additional."

CHAIR ROWLAND: "Additional."

COMMISSIONER ROSENBAUM: Yes.

COMMISSIONER CHAMBERS: Is there any reason why not put "through fiscal year 2017," so it's very clear to people, so you don't have to read the rationale?

MR. PETERSON: Well, I would say the only confusion is even with the chapter, where we say the allotment's provided through 2015, the money begins to run out in 2016, there can be confusion around that. So I think Diane's strategy, that would be one reason to say --

CHAIR ROWLAND: And the rationale to explain what the time framing is.

MR. PETERSON: Yeah.

COMMISSIONER MARTINEZ ROGERS: I'm not sure that people read all the rationale. I think it should be in the recommendation.

CHAIR ROWLAND: I think that the problem is that it's not easy to -- well, we could put it in the -- but then the rationale can explain this issue of when the funds actually --

COMMISSIONER ROSENBAUM: Right, exactly [off microphone].

CHAIR ROWLAND: And which would be quite complicated to put in the recommendation.

COMMISSIONER ROSENBAUM: Right, because it's not -- it's not like a discretionary appropriation. In other words, there's the potential to carry over into years beyond 2015. And so what we're really saying is that essentially authorized -- they're authorized to expend sums beyond 2015. They may actually dribble over into additional years. So I think to try and get all of that into the recommendation technically is not easy and probably will end up doing more -- adding to the confusion. So I would strongly recommend that we go with the briefer language here and let Chris then spell it out in the rationale.

CHAIR ROWLAND: Okay. Anne, do you want to take the vote?

EXECUTIVE DIRECTOR SCHWARTZ: Sure. Sharon Carte?

COMMISSIONER CARTE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Richard Chambers?

COMMISSIONER CHAMBERS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Donna Checkett?

COMMISSIONER CHECKETT: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Andrea Cohen?

COMMISSIONER COHEN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Burt Edelstein is not present.

CHAIR ROWLAND: But Burt has requested that he be recorded as in support of the recommendation, and we have documentation for his support.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. Patricia Gabow?

COMMISSIONER GABOW: yes.

EXECUTIVE DIRECTOR SCHWARTZ: Herman Gray is not present. Denise Henning?

COMMISSIONER HENNING: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Mark Hoyt?

COMMISSIONER HOYT: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Norma Martinez Rogers?

COMMISSIONER MARTINEZ ROGERS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Judith Moore?

COMMISSIONER MOORE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Trish Riley?

COMMISSIONER RILEY: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sara Rosenbaum?

COMMISSIONER ROSENBAUM: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Robin Smith?

COMMISSIONER SMITH: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: David Sundwall?

VICE CHAIR SUNDWALL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Steven Waldren?

COMMISSIONER WALDREN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Diane Rowland?

CHAIR ROWLAND: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: That's 15 total present. I've marked Burt Edelstein recording his support although not present and Herman Gray as not present.

CHAIR ROWLAND: Okay. And so the staff will add this material into the chapter that we have been reviewing, and I've asked that before this go to print that Anne circulate the revised chapter to all members of the Commission. Thank you, Chris and team, for your effort.

COMMISSIONER WALDREN: I'd just request that we start working on a project plan to do our work to help Congress address those issues, because I don't want to be here two years and do the same vote. So thank you.

CHAIR ROWLAND: So ordered.

EXECUTIVE DIRECTOR SCHWARTZ: We're on it.

CHAIR ROWLAND: And now we have one additional CHIP issue, the CHIPRA bonus payments, and Lindsay is going to come and present us with some of the work that's going on looking at that.

Thank you to the staff for the excellent work on developing the chapter and the materials on the CHIP program for our review. It really did facilitate our discussion and provided us with, I think, the evidence we needed to both identify the problems and now to follow Steve's suggestion of developing our next work plan.

Lindsay. And this is at Tab 9 -- no, 10. Tab 10.

SESSION 9:

CHIPRA BONUS PAYMENTS

* MS. HEBERT: Thank you.

In this session, I will first provide you with a brief background on the bonus payment program. Next, I will present information on the extent to which states were incentivized to participate and also on trends in uninsurance rates among eligible but unenrolled children over the program's duration. I will conclude by outlining policy options for Commissioners to consider regarding the future of the bonus payment program.

And just to note, this presentation is separate from our work on the future of CHIP and is a first step in a series of inquiries we are doing on children's coverage. Depending on your interest, we can follow up with more information on this in the fall.

CHIPRA bonus payments were established to promote enrollment among eligible but unenrolled children in Medicaid and CHIP. Bonuses were authorized from 2009 through 2013, and over those 5 years, a total of $1.1 billion was paid to 27 states that earned bonuses.

In order to earn an annual performance bonus, states had to both experience a substantial increase in child Medicaid enrollment for the year, and they had to have implemented at least five of eight specified strategies in their Medicaid and CHIP programs.

The eight enrollment and retention strategies are listed here. At the time that CHIPRA legislation was being developed some states had already been testing these in their Medicaid and CHIP programs, hoping to make the enrollment process easier and more effective. There was evidence that some of these strategies were promising strategies for increasing enrollment.

The size of state bonuses was dependent on the increase they had in child Medicaid enrollment for the year. Bonus payments were categorized into two groups: Tier 1 and Tier 2 bonuses. Tier 1 bonuses were granted for enrollment increases up to 10 percent of the state's established baseline, based on enrollment data from 2007.

Tier 2 bonuses were granted for enrollment in excess of 10 percent of the state's established baseline. The calculations for these two tiers can be seen on the slide.

As you can see, states achieving enrollment increases high enough to earn Tier 2 payments receive larger bonuses than those qualifying for Tier 1 payments only.

The requirement for child Medicaid enrollment to exceed a set percentage above the established 2007 baseline may have posed a disadvantage to states whose child Medicaid enrollment was particularly high in 2007 and may have conversely posed an advantage to states that had low enrollment numbers in 2007.

The Affordable Care Act had significant implications for CHIPRA performance bonuses. As of January 1st, 2014, four of the eight strategies became required for states, and they are listed here.

These four ACA-required strategies were the most frequently implemented strategies among all states in 2012 and 2013. The maintenance of effort guidelines specified in the ACA and later detailed in the state health official letter released by CMS assert that states cannot adopt eligibility standards, methodologies, or procedures under the Medicaid program or any waiver that are more restrictive than those in effect when the ACA was enacted.

This suggests that states are not permitted to scale back the eligibility and enrollment efforts they had already adopted as of March 23rd, 2010. These MOE provisions for children in both Medicaid and

CHIP are effective through September 30th, 2019.

In addition to requiring these four strategies, the ACA also explicitly called for the termination of bonus payments in 2013.

Two questions come to mind when considering the impact of bonus payments. First, were the payments effective in incentivizing states to implement enrollment strategies; and second, did the bonus payment program lead to reduction in rates of uninsurance among eligible but unenrolled children? There has been no formal evaluation of the bonus payment program, but we have compiled a variety of data points and gathered evidence that aim to answer these two questions.

Some states reported that the presence of potential bonuses was a catalyst in moving them to reexamine enrollment and retention efforts. Nearly half of a small sample of states that implemented Express Lane Eligibility in both Medicaid and CHIP reported that the performance bonus was a motivator in making the decision to adopt the strategy.

Additionally, the number of states qualifying for bonuses grew over time. In 2009, 10 states qualified for and received performance bonuses. In 2013, 23 states earned bonuses. Of the 27 states that received bonus payments, most, 22 states, received three or more annual performance bonuses.

It's important to note that nearly 74 percent of the states awarded bonuses in 2012 and almost 70 percent of the states awarded bonuses in 2013 were implementing exactly five of eight strategies, which is the minimum requirement needed to qualify for a bonus.

Some states implemented strategies knowing it was unlikely they would earn a bonus payment, given the high enrollment baseline they would need to exceed. Analysis of data from the CHIP annual reporting template showed that Maine implemented five strategies for the duration of the program from 2009 to 2013

but never received a bonus payment, and as of 2012, Massachusetts was also implementing five strategies but did not qualify for a performance bonus that year or the next.

Officials in Massachusetts stated that they knew it was unlikely they would earn a bonus, since the state's child Medicaid enrollment baseline based on 2007 enrollment was so high, but they were still interested in streamlining enrollment, so they elected to pursue the strategies anyway.

With respect to rates of uninsurance among eligible but unenrolled children, we do not have clear data spanning the duration of the program, nor do we have data that speak specifically to the effect of the bonus payment program on reducing uninsurance. But we do know that between 2008 and 2011, the number of eligible but uninsured children declined by 18 percent. From 2008 to 2012, the national average for Medicaid and CHIP participation rates rose by 6.4 percent, but as I stated, causation cannot be determined, as many factors may have contributed to these successes.

As of 2012, more than 36 percent of all children who are eligible but uninsured lived in one of three states: California, Florida, or Texas. None of these states received a performance bonus, and none implemented the requisite number of enrollment strategies. Overall, almost 6 out of every 10 children who were eligible but uninsured in 2012 were living in a state that up until that point had never received a bonus payment.

The extent to which the Bonus Payment Program was instrumental in incentivizing states to implement strategies and reducing uninsurance among children who were eligible but uninsured is not clear. Even so, some members of Congress would be interested in learning the Commission's views as to whether a new updated bonus payment program is warranted.

In thinking about the future of a bonus payment program, some policy options might include

leaving current law intact, allowing the bonus fund to remain closed, extending the bonus fund under the original requirements for additional years. This would allow states to implement one additional strategy in addition to the four now-required ACA strategies and would also continue to utilize the 2007 Medicaid enrollment numbers to establish baselines for states. A third option would be to extend the bonus fund for additional years but with modifications to the strategies, the baseline, or a combination of the two.

Bonus payments could also be structured to reward policy interventions beyond enrollment. These might include efforts to improve quality of care, strategies aimed at promoting program integrity, or strategies aimed at reducing health disparities, for example.

I look forward to your feedback on additional analyses that may inform future work and thoughts on the direction of the Commission's work in this area.

Thank you.

CHAIR ROWLAND: It seems hard to disentangle whether it was the bonus payments that made a difference or the methods that were specified to be used, and as Congress has now adopted four of them to become a part of the requirement, it seems that it is the methods that may have been the most helpful. In any of the evaluations, has that been teased out?

MS. HEBERT: Unfortunately, it has not. There hasn't been a formal evaluation.

CHAIR ROWLAND: Okay. Sara, then Mark.

COMMISSIONER ROSENBAUM: Two things. One, I am just looking at the slide, and I see that 27 states received the payment in -- this is your Slide 7. But I am wondering, did all states attempt activities that would qualify them for a bonus, or was it only a subset of states that attempted to obtain a bonus, number one? In other words, what is the universe of states? Did everybody who attempted get a

bonus, or were there states that tried and didn't get a bonus?

MS. HEBERT: We don't have clear information on that. What we do know from some anecdotal evidence is that it was usually the case that states did not try to implement a lot of these strategies unless they could forecast that they might be able to --

COMMISSIONER ROSENBAUM: So we really only have potentially only half of the states having undertaken activities that were bonus activities, so that's one question.

And then the other observation I would make -- and I must say I really have not thought this through, but the question is, What do we want to incentivize in a world in which you must enroll in insurance?

Obviously, we want to do things that would ease people's -- potentially, we want to do things that would ease people's ability to fulfill their obligations and their obligations on behalf of their children, but because it's such a different construct now, the interesting question to me is of the things that are here, which ones have been the most helpful in making it easier for families, really. And that becomes a really important question, given the fact that now they are obligated to enroll if the coverage is affordable, so --

CHAIR ROWLAND: We've also just totally revamped the way eligibility and Medicaid works --

COMMISSIONER ROSENBAUM: Right.

CHAIR ROWLAND: -- so that we're in a very different situation.

Mark.

COMMISSIONER HOYT: In the chapter, you explain the formulate behind how the bonuses are calculated. Then you've got a table with all the dollars in them. I'd like to ask, if you would, to do a second table and show what that percentage is against the overall CHIP allocation per state, so that when

you're done, was that like 1 percent more money for Michigan?

MS. HEBERT: Sure.

COMMISSIONER HOYT: Just making up a state. Or was it 11 percent more money? Expressed that way, I think might be helpful too.

CHAIR ROWLAND: Yeah.

Other comments?

This is not a chapter for our June report. This is an early view of a chapter we are developing.

EXECUTIVE DIRECTOR SCHWARTZ: Right. And I think that it comes right on the heels of this chapter that has just been completed, and the question is, I think for the staff, we've gotten a few suggestions here, but what kind of work would you like to see? Would you like to see work that would develop other types of ways to use the bonus payment? Would you like more information about what happened with the bonus payment? I guess a little bit more direction about what you think would be helpful in a next step.

CHAIR ROWLAND: My preference would be if the goal is to increase enrollment of those who are eligible but not enrolled, what are the best strategies for doing that, and bonus payments may be one of them. But there obviously are other ways, and I think that Congress has acted through the Affordable Care Act to put new mechanisms out there for eligibility and enrollment, so that it seems to employee that the current bonus payments were based on the pre-ACA world, and that we need to look at really what strategies will help improve the enrollment process and eligibility. So I think we need to take a broader look than just focus on the bonus payments themselves.

Trish.

COMMISSIONER RILEY: In our discussion yesterday about administrative issues, it seems to me as we try to think about administrative structures and incentivizing states to strengthen that, just learning generically about what bonus payments are and how they work and whether they're a mechanism that could do other kinds of things would be useful.

CHAIR ROWLAND: Okay. David, then Denise.

VICE CHAIR SUNDWALL: Was this a study done at the -- did someone in Congress ask us to evaluate this or see what has happened with the Bonus Payment Program?

MS. HEBERT: Yeah. So Diane actually testified in December on some of the extenders, and it was brought to our attention that we should look at the CHIPRA bonus payment program.

VICE CHAIR SUNDWALL: Based on what you've told me in the very fine presentation -- thank you -- but I don't think it merits the Commission focusing on an already-obsolete effort. I think more generally, what we do to encourage enrollment would be fine, but I don't know that we need to invest more resources in evaluating the bonus program, which doesn't exist anymore, and the policies have been adopted.

CHAIR ROWLAND: Denise.

COMMISSIONER HENNING: I feel about this about the same as I do about the primary care physician bump-up, and that is I just don't understand why you write into a law, you know, we're going to give you X number of dollars to do this particular thing, without also putting into that some way to evaluate the consequence or the outcome that you get out of it when you get done. So I don't really understand the whole process of why you would throw a bunch of money at a problem and not have a way to evaluate whether what you did was effective or not.

CHAIR ROWLAND: Well, it did evaluate what it did in terms of increasing the enrollment of children, but the result of which states got the bonus was the states that had moved their eligibility in the most positive direction. It wasn't just whether they adopted the strategies, but it was what did those strategies do to increase their enrollment.

But I think that David's point of we really -- what we want to do is really focus on how do you maximize enrollment of people who are eligible for coverage, and I would be much more interested in seeing whether some of the new streamlining that has been put into effect is really improving.

And what we anecdotally hear is that a lot of the new enrollment, especially in states that have not opted for the expansion, is coming from enrollment of children who were previously eligible, and that might be an area we could look at.

Sharon.

COMMISSIONER CARTE: I think we see some evidence, and maybe this could be looked at later on, but even in the ACA enrollment where the SNAP fast track or expedited process was used, I know it was highly successful for some states, and that is one of the elements.

CHAIR ROWLAND: And certainly in the panel, we had --

COMMISSIONER CARTE: Express Lane eligibility.

CHAIR ROWLAND: -- Express Lane eligibility. That was one.

COMMISSIONER CARTE: It speaks very highly to this issue.

CHAIR ROWLAND: Mark.

COMMISSIONER HOYT: I don't know if you did this or not. Maybe you did. Did we call some of the states that didn't receive any payment and just ask them directly how come you didn't chase

down the bonus money?

MS. HEBERT: We did speak to some states, and like I said earlier, it seemed to be the trend, although it may not be the case for all states that if they didn't predict that they would receive a payment, it may have not been worth implementing all the strategies -- or if the payment was not going to be substantial enough.

CHAIR ROWLAND: Even though those strategies might have resulted in more people being covered in their state. It costs money.

Any other questions for Lindsay?

[No response.]

CHAIR ROWLAND: Okay. Thank you, Lindsay.

We will now at this point ask if there is anyone from our audience who wants to make a statement or address the Commission to please come forward.

Yes? No?

PUBLIC COMMENT

* [No response.]

CHAIR ROWLAND: Well, we have obviously spent the last day and a half really looking at many of the issues that will be coming out in our June report as well as we'll frame the work that we will be having going forward, so I think at this point, I would like to thank the Commission members for their diligence in working through these issues. They can expect to see the next report in draft form before it's printed, but it will be out and delivered on time, as always, on June 15th.

And I want to thank especially Anne and the staff for the tremendous work and the development of

their work over this past year. Since we began with these discussions in September, I think we've had just a wealth of information to inform our deliberations. I think the quality of the work increases every time we see more work, and so I want on behalf of the Commission to give a round of thanks to the staff for the great work that they have done.

[Applause.]

CHAIR ROWLAND: And I thank everyone, and so we stand adjourned until September.

* [Whereupon, at 11:18 a.m., the meeting was adjourned.]