Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

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

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10:34 a.m.

COMMISSIONERS PRESENT:
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AGENDA PAGE

P R O C E E D I N G S [10:30 a.m.]

CHAIR ROWLAND: Thank you. If we can please convene. It is my pleasure this morning to start our MACPAC meeting by welcoming Chiquita Brooks-LaSure, who is going to set the stage for our understanding a little more of what is happening with the Center for Consumer Information and Insurance as we move forward to look at the ACA implementation. As you know, following this, we are going to be discussing more of the waivers and ways in which Medicaid has been structured, but we wanted to begin today by just asking Chiquita to give us an overview of the implementation of the ACA from that perspective. And I understand that if there are any questions from the press, you can follow up with the press officers afterwards. So this is Chiquita's time to talk to us as a Commission. So welcome.

SESSION 1: UPDATE FROM THE CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT (CCIIO)

* MS. BROOKS-LASURE: Great. Thank you so much for inviting me to be here. It is really a pleasure, and I know all of you have been working so diligently and looking at the Medicaid program, so it's really an honor for me to be here to talk to you today a bit more about the marketplaces.

Obviously, the marketplaces represent a huge step forward in covering the uninsured. Despite the fact that collectively Medicaid and the State Children's Insurance Program covered an estimated 73 million, there are still many Americans who remain uninsured; 47 million are still uninsured in America.

You already know better than anyone why people are uninsured, but I want to just say a few things about some of the people in our country who are not covered today.

Twelve million of the uninsured speak Spanish, and 15.7 percent have no English-speaking adult in the

household; many of whom are living at or below the poverty line; 35 percent of whom are between the ages of 35 and 54; 38 percent are between 138 percent and 400 percent of the federal poverty level, meaning they make between $26,000 and $78,000 for a family of three; 75 percent of the people who are uninsured have at least one full-time worker in their family.

That is where the Affordable Care Act comes in. It introduces reforms in order to create a fairer and more efficient system. One piece of this is the creation of a health insurance marketplace or an exchange in every state.

Let me start with our goal: to ensure Americans have quality, affordable health insurance. Some of the people need and want insurance, but don't know how to choose it. Others feel invulnerable; yet others are uninterested in insurance.

Giving these people access to coverage is a goal we are working toward across the administration. The White House, the Department of Health and Human Services, and people across the administration are committed to it.

So I'm going to start with some of the basics. A cornerstone of the Affordable Care Act are the marketplaces. They're for individuals and small businesses to directly compare certain competitive private health insurance options, known as qualified health plans, on the basis of price, quality, and other factors. The marketplaces, which will become fully operational by January 1, 2014, will help enhance competition in the health insurance marketplace, improve choice of affordable health insurance, and give small businesses similar options as large businesses.

The Congressional Budget Office estimates that more than 14 million Americans will gain access to

health care through private coverage options in the marketplace by 2015 and up to 22 million in 2016.

Qualified health plans in the new marketplace will be sold and run by private companies, and every qualified health plan will cover a core set of benefits called essential health benefits. You will be able to compare your options based on price, benefits, quality, and other important features.

The marketplace can help people consider their coverage choices and answer questions. Help will be available through a website, a call center, and community groups or individuals specifically designated as navigators to help consumers. Depending on the state, insurance brokers and agents may also help consumers and small employers find coverage options in the marketplace.

That is a high-level overview of the vision of the marketplace, so let me turn to the implementation and tell you a little bit more about where things stand.

Given our close working relationships with the States in the implementation of ACA, I want to give just a brief overview of where we are in terms of the state landscape.

We have 24 conditionally approved states as well as the District of Columbia to partially or fully run their own marketplace. A federally facilitated marketplace will operate in the other states, and states continue to play their traditional regulatory role in reviewing health plans sold in their state.

In 2015 and annually, states will continue to have the option to apply to operate their own marketplace or partner with us. We will continue to work closely with all states to build these new marketplaces. And as I mentioned, we are actively building a federally facilitated marketplace that will be scalable in order to operate in any state without its own approved state-based marketplace.

Again, our goal is to ensure that residents of every state have access to affordable health insurance in

2014.

Let me give you a sense of the progress we are making on the marketplace bill that CMS and what the rest of the year will look like.

We are very much focused on operations. We have completed the vast majority of the policy work and our regulations and guidance. Last month, we accepted applications for qualified health plans to be offered through the marketplace. We have been working hand in glove with the issuers to provide them with the technical assistance they need.

Now that applications are submitted, the state or HHS will review the submission, including rates, to determine whether all the required data has been provided, all rates are justified, and cost-sharing reduction advanced estimates are reasonable.

The state or HHS will also review the products to determine whether the QHP meets the state benchmark for essential health benefits and actuarial value standard, satisfies network adequacy requirements, and does not have a discriminatory benefit design. Later in the summer, issuers in the federally facilitated marketplace will hear final certification determinations and sign the qualified health plan agreement.

Since there will only be one application for coverage, no matter what way a person chooses to enroll, whether online, in person, or with a paper application, there will be no wrongdoer. Depending on their eligibility, the single application will get them to Medicaid, CHIP, or qualified health plans and help them to enroll, and it will determine if they are eligible for a tax credit.

We learned through consumer testing what terms and instructions were best understood by the consumer. In the end, the application tested very well. It integrates electronic verification sources, and it

will provide income verification and other information in near real time.

Let me describe it a little to give you an idea. It is dynamic. The questions are grouped into topics in a way that makes sense for consumers. Consumers are presented with the next question based on how they answered the first, so they don't need to scroll through questions not relevant to them.

On both the online and the paper applications, consumers are asked to supply family and household information, personal information such as social security numbers, special circumstances, including if any family members have a disability or are an American Indian or Alaska Native, because they would be eligible for special benefits, as well as income information, including for the upcoming year unless applying for Medicaid or CHIP.

Consumers would then have the opportunity to review their applications, sign, and submit. If they are submitting online, in many instances they will receive their eligibility results almost immediately, including the amount of their premium tax credit they can expect to receive for a qualified health plan or learn if they qualify for Medicaid and CHIP.

In June 2013, the call center will be launched. The health care insurance marketplace call center will go live by the end of June. We will have a single 1-800 number for the call center and a single TTY number for hearing-impaired callers. Service representatives will be available 24/7 via telephone and online web chat. Customer service representatives will speak English and Spanish, and a language line will assist callers in over 150 additional languages.

Service representatives will respond to general inquiries regarding the health insurance marketplace. The call center will go live in conjunction with a re-launch of the consumer website healthcare.gov.

Healthcare.gov will have a new look and feel and a strong focus on getting consumers ready to enroll in new coverage. The new content will focus on educational information.

We are working hard to make sure that consumers can get the help they need to apply for and choose the new insurance options. These resources will include navigators, in-person assistance personnel, certified application counselors, and agents and brokers.

In particular, navigators will have a vital role in helping consumers prepare electronic and paper applications to establish eligibility and to enroll in coverage through a marketplace and will be available in every state.

In late March, CMS published a proposed rule about the navigator program, defining training, certification, and recertification, conflict of interest, and meaningful access standards for navigators. The comment period for the navigator program just closed this week.

Navigators will be required to go through a training and certification program. States may impose navigators' specific licensing certification requirements so long as those requirements do not impede a navigator's ability to carry out their work. For example, requiring a producer's license would not be permitted.

Last month, we published a funding announcement of $54 million to fund navigators in federally facilitated or state partnership states. Every marketplace must have at least two types of entities serving as navigators, and at least one will need to be a community- and consumer-focused nonprofit organization.

Applicants should have expertise in eligibility and enrollment rules and procedures, the range of qualified health plan options, and insurance affordability programs, including Medicaid and CHIP, and privacy

and security standards.

Applications for the FOA are due 1:00 Eastern on June 7th. We are encouraging organizations that serve minority populations and community groups to apply to help ensure that the needs of the population are adequately met.

On October 1st of 2013, healthcare.gov will start accepting applications for enrollment. At that time the online application will be accessible, and specific plan will be available. Individuals, families, and small business owners will be able to go to the site and apply for eligibility, compare plans in their area, and select a qualified health plan.

Starting on or after January 1st of 2014, individuals, small businesses, and their employees will have access to a range of standard plan options with comprehensive coverage. We have issued a number of regulations in the last year to setting out the parameters for insurance coverage in the new market. For example, we finalized regulations on essential health benefits, market reforms, and the payment notice this winter.

The Affordable Care Act changes the status quo by requiring all issuers in the individual and small group markets to use the following set of pricing factors: age within a 3:1 limit for adults, tobacco use within a 1.5:1 limit, with certain wellness program requirements, geography, and family size.

No longer will individuals and employees and businesses be penalized because of health status or gender. Health insurance will not vary based on what type of business it is or who is employed at the firm. Cost-sharing limits will protect employees against catastrophic costs and ensure cost-effective care. And, also, the benefit package will be similar as the benefit package typically offered by small businesses today.

The new rules ensure that individuals and employers in every state have a minimum set of protections. It is very important that these market reforms are enforced. This is essential to minimizing opportunities for adverse selection and preserving a stable market in and outside of marketplaces.

And so before I close, I would be remiss not to mention some of the ways in which we are coordinating with Medicaid and CHIP programs and how they will interact with the marketplace. I mentioned a few, but, of course, state Medicaid and CHIP programs will accept the single streamlined application from consumers, as I previously mentioned. They will make eligibility determinations for certain populations using modified adjusted gross income based, or MAGI, methodologies, coordinate eligibility decisions with the marketplace. They will connect to the data services hub which is one way that all the states can connect to the Federal data sources; claim enhanced FMAP for newly eligible populations; and provide alternative benefit plans to newly eligible populations through contract changes with plans and providers.

Implementing the marketplace, ensuring that it is open for business on day one, is an exciting opportunity to make a difference in the lives of individuals throughout the country. We have the regulations and the infrastructure in place, and we are working to get the word out. Stakeholder outreach efforts are underway in all states. We look forward to hearing your voice in this conversation to getting employer feedback from all sorts of stakeholders.

I always like to make sure we mention where you can find more information. You can check out the CCIIO website at cciio.cms.gov. There is a place to learn more about CMS policies and operations for the marketplace. And our colleagues in the Office of Communications and the Office of Public Engagement also recently launched a new website that consolidates much of the consumer and partner information. To

see this, go to marketplace.cms.gov where you will find official resources, research, news events, along with publications and articles.

With that overview, I am happy to take any questions that you all might have. Thank you.

CHAIR ROWLAND: Thank you.

VICE CHAIR SUNDWALL: Well, thank you for your presentation. It was very informative, and I am sure you feel like these are daunting challenges. You have these deadlines to meet. It is an amazing change in policy.

My question is related to Utah's health insurance exchange, which we were just granted some flexibility to continue our online exchange for small businesses. I guess the question I have is: In the event a small business in Utah chooses to do what we call a defined benefit contribution, not a defined benefit but I mean a contribution to their policy, will that still apply to the federal exchange if they choose not to go with our state-run plan but go with the federal plan, which we have conceded will do individual ineligibility for the tax subsidy? Will they still be able to use that subsidy to purchase insurance through the federal exchange?

MS. BROOKS-LASURE: I'm not sure that I'm fully understanding your question, but if your question is a small business in Utah, whether they would use the federally facilitate --

VICE CHAIR SUNDWALL: Well, if they choose -- say if individuals in a company, a small business, their company decides to give them a defined contribution, not a defined benefit but a contribution to purchase insurance, I am assuming they will just have the flexibility to say, well, I'm not going to go through the company's plans for the Utah exchange, I'll go to the federal one, and I'll use that subsidy to buy insurance, does that make sense to you they could do that?

MS. BROOKS-LASURE: I don't want to answer fully without knowing exactly the details of the proposal. But if an individual was going and applying as an individual, they would be using the federally facilitated marketplace in Utah. If the small business was actually offering the plan, they would be in Avenue H or the UTAH SHOP.

VICE CHAIR SUNDWALL: Are you aware of other states that have had this kind of hybrid system where they're running their own health insurance exchange for a small business but allowing individuals to go to the federal plan?

MS. BROOKS-LASURE: So, as you know, we have had an approval process about the marketplaces, and the opportunity that we announced with Utah is also available to other states this year who applied for a blueprint. And so if a state wanted to -- one of those states wanted to adopt a standard where they were only running the marketplace for the small business, they can do that. States will have this option as well in future years.

VICE CHAIR SUNDWALL: Thank you.

COMMISSIONER ROSENBAUM: Thank you for coming today. A couple of quick questions.

The first one has to do with enrollment assistance. Last week -- I have lost track of time -- HHS announced an enormous investment in enrollment assistance through community health centers, and I wondered when we might expect to see more detailed guidance as to what exactly the responsibilities will be and how the health center enrollment program would work. Most of the uninsured -- most uninsured people today are disproportionately located in medically underserved communities, so this is a great decision, in my view.

MS. BROOKS-LASURE: We throughout the summer will be talking more about our outreach efforts. We have, as you know, several ways that we are looking at implementing outreach, the navigator program, as you mentioned, the work that we -- the money that we've announced for community health centers, in-person assistance personnel. Throughout the summer we will continue to put out more guidance. Some of our guidance is in the rulemaking process. Others we'll be announcing through the summer as well as training programs to make sure that individuals and groups understand how to enroll individuals in a way consistently.

I think we have really been focused on making sure that individuals and small businesses really have a variety of ways that they are reached, and that has really been our focus and why we have really several ways that consumers will have in-person assistance if needed, trying to make sure that we are -- as I was mentioning, you can see that in the marketplaces there's really a diverse group who will be coming in, and as you said, many of the uninsured are in medically underserved areas.

COMMISSIONER ROSENBAUM: Thank you. My second question has to do with, of course, this issue of the Medicaid exchange interaction, which is going to be a huge one. Since subsidized -- folks receiving subsidies in the exchange have about a one in two chance of crossing over during a year, I wonder if you and the Center for Medicaid & State Operations have had any discussion about what I think is maybe the most important aspect of this, which is multi-market plans that share networks -- where you have a common network. So one entity participating in both markets with a common network, so that when people's subsidies change, they don't have to change their physicians. And I'm just wondering where things stand with that, whether this has been a subject in terms of looking at the QHP bids as they come in, what the two

agencies together might be doing to encourage alignment.

MS. BROOKS-LASURE: That is a very important question, and one that we have been talking about really since the beginning of the passage of the ACA, particularly with States. The coordination between the two programs is critical, and I know you are hearing from Cindy Mann later. We, CCIIO, and CMCS have been working very close in working on our guidance and trying to make sure that we are coordinating as well as we can, as well as also coordinating with the States collectively together. So we very much, when we are talking to the states about coordination, whether it is a state-based marketplace or where we are working -- where we are building the marketplace, really talking with the states to ensure coordination.

On your specific question about networks, there are many ways to coordinate, and one of the ways is certainly if there are plans, Medicare managed care plans who then choose to offer in the marketplace or marketplace plans who then choose to enter the Medicaid market, that is something that we have certainly encouraged plans to consider and have tried to really certainly from our perspective encourage those types of partnerships. Sometimes it's the same entity. Sometimes it's coordinating two -- different companies coordinating. Obviously, it's still voluntary whether a qualified health plan enters the marketplace, but that's certainly something we have been looking at and encouraging. There have been other proposals that states have talked about in trying to think about how to ensure coordination.

COMMISSIONER RILEY: Well, I now look at this issue in a very different way, because I am one of those people who has several part-time jobs and buys her health insurance in the private market from a state that is not going to do an exchange. So I will be online on October 1st, and I'll let you know how it goes.

But to that end, I'd like to hear you talk a little bit -- one of the promises of the ACA is more

competition in the profoundly broken individual market and fixing that. And I think we are well on our way, and you are all doing incredible work. I wonder if you could speak a little bit about how that looks today. Will there be more competition? What is happening with the multistate plan?

And since Sara asked two, I'm going to ask two. Secondly, I've always been intrigued. I think one of the best parts of the Affordable Care Act was suggesting that Members of Congress have to buy their health care through the exchange, through the marketplaces, and I wonder where you are with that.

MS. BROOKS-LASURE: Actually, can you remind of your first question?

COMMISSIONER RILEY: Competition, especially in consolidated markets.

MS. BROOKS-LASURE: So, yes, I mean, the marketplaces really, as we are talking about, are bringing a new level of competition. And it's really an exciting time, and it's a changing time. Insurance, as we know, has been built on a very different system. It will take time, and the marketplaces really provide new opportunities for insurers to not have to worry about selecting only the healthy. We have several important features -- the risk adjustment, reinsurance, and risk corridors -- which will help reduce risk so that people will have -- will stabilize the market. We also obviously have the individual premium tax credits that very much make coverage more affordable for people who will be shopping in the marketplace.

We are certainly still in the process of reviewing applications, and we'll certainly be moving forward. But we have to recognize certainly that some of this change will take time. But we're very pleased with how things are going thus far and feel like we're making excellent progress.

Remind me of your second question?

COMMISSIONER ROSENBAUM: [off microphone] Members of Congress.

MS. BROOKS-LASURE: Oh, yes. Right. So the multistate plans are, as you know, run by OPM. We are coordinating closely, but OPM would need to speak about the multistate plans. And Members of Congress, yes, they are, as you know, slated to enter the marketplaces, and there will certainly be more guidance forthcoming on that.

CHAIR ROWLAND: Denise, and then Judy, and then Burt.

COMMISSIONER MOORE: Thanks, Chiquita, for coming. It's really good to get this update, since there are so many potential interactions. And I'm wondering if the problems between exchanges and Medicaid will be so different based on the decision making of the States as to run their own exchange, whether to expand the Medicaid program, and so forth. And I have been concerned from the very beginning about administering and managing these two programs in a State and whether we're going to end up with more silos and more duplication in some places and I'd like for you to review the incentives that might be in place or that you would anticipate you could put in place for States to work together on -- regardless of their other decisions as to whether they're running an exchange or expanding a Medicaid program -- if there are incentives and what incentives you might see to having States produce the smoothest possible interaction that will renown to the benefit of the newly-covered folks.

MS. BROOKS-LaSURE: Certainly. There -- and, of course, Cindy can speak more to this later, but significant dollars on the table on the Medicaid side for systems. We've certainly made a huge priority of making sure that States have the dollars that they need to implement the changes. So both on the Medicaid side, where there's been enhanced funding for IT systems, and then on the marketplace side, where States are running the exchange or entering in partnership with us, there are 1311 establishment grants which are

available to States which we've encouraged States to use to build their systems and encourage coordination. There obviously are differences. In some States, it's State to State, where it's the State marketplace and the State Medicaid, and in other States, it's us and the State Medicaid office. So coordination, obviously, is an important piece.

Again, we've really focused our rules on trying to make very clear that coordination is required regardless of what type of model a State has decided to adopt, so there are certainly Medicaid requirements for the Medicaid agency to interact with the exchange, whether it's us or with a State.

CHAIR ROWLAND: Okay. Burt.

COMMISSIONER EDELSTEIN: I, too, wish to thank you for the clear presentation and the update. The Commission has recently addressed for the first time dental issues and oral health coverage and notes that although biologically it's an essential set of services, that the Medicaid law leaves oral health as sort of an orphan. And this seems to be perpetuated, especially subsequent to the EHB regulations, where dental care for kids, although listed as an essential service, is the only service that is, in fact, optional for consumers in the exchanges.

Could you comment on that and address if there is any option other than what Rhode Island did, which is to require -- to go beyond the Federal requirement and require consumers to purchase both a medical and a dental plan at checkout from the exchange.

MS. BROOKS-LaSURE: As you mentioned, dental coverage is, obviously, it's one of the -- dental coverage for children is one of the ten essential health benefits. The statute, the Affordable Care Act, makes clear that stand-alone dental plans are permissible, and if stand-alone dental is offered in the marketplace, that

the other qualified health plans are not required to offer dental coverage in the qualified health plan.

Something we're certainly very focused on. There are cost sharing reductions that will be available to individuals when they enroll in stand-alone dental for their pediatric services and we're very focused on making sure that individuals have access to all the ten essential health benefits. There are, of course, limitations under the statute, but as you mentioned, States have options to go beyond what we're able to do.

CHAIR ROWLAND: And, Patty, last word.

COMMISSIONER GABOW: Again, thank you for coming, and most of all, thank you for your group's hard work on this incredibly large and complex project.

I have two questions. The first is, in a State which is using the Federal exchange, given the "no wrong door" approach, what actually happens to someone who comes into the Federal exchange who's eligible for CHIP or Medicaid? So can they enroll through the Federal exchange at that point into those programs, or is there some different path? That's the first question.

And the second question --

CHAIR ROWLAND: Let her answer the first one first.

COMMISSIONER GABOW: Okay.

MS. BROOKS-LaSURE: Thank you. So we certainly -- we're coordinating with all of the States, and if someone comes and they are eligible for Medicaid or CHIP, we're doing an assessment based on the State-specific rules about whether a person is tax credit eligible or Medicaid or CHIP eligible. If they end up being Medicaid and CHIP eligible, we will have a handoff to the State so that the State actually enrolls them into coverage, because that's the State Medicaid agency's function. We have a series of rules and procedures

to make sure that that handoff works well, that the consumer isn't dropped, and that they're able to get coverage in a timely way, and that will certainly be something that we'll all be very focused on as the marketplaces get up and running.

COMMISSIONER GABOW: Given what we know about the incidence of behavioral health issues in low-income populations, in the population in general but maybe disproportionately in this group, what are the efforts around seeing that behavioral health and physical health are integrated in a meaningful way in the options that are offered?

MS. BROOKS-LaSURE: So behavioral health is one of the ten essential health benefits that plans are required to cover, consistent with the benchmark as well as the other rules that we have regarding essential health benefits. These will, of course, be an important part as we're looking at plans, moving forward, as we look to improve the health care system and delivery system reform, which I didn't focus so much in my remarks, but is also, obviously, an important part of improving our health care system and trying to make sure that individuals get access to not only certain services, but ones that are well coordinated.

CHAIR ROWLAND: Okay. I know your time is limited, but I think we have one more question from Sharon and then we'll let you go.

COMMISSIONER CARTE: Just a real quick one. Earlier, you talked about the certification of the navigators, but could you speak just a little bit to training requirements for the in person assisters?

MS. BROOKS-LaSURE: Certainly. So, as I mentioned, this summer, we will have trainings and a series of trainings for different types of entities. That's something that we'll be providing more information in the coming months as we get closer to open enrollment. But there will be training for all individuals that are

certified to operate in the federally-facilitated marketplaces and States will run trainings for their marketplaces.

COMMISSIONER CARTE: Great.

CHAIR ROWLAND: Well, clearly, you have a lot to do between now and October 1. Everyone keeps focusing on January, but we know that open enrollment starting on October 1 puts a lot of pressure on you this summer. We know your time is limited, so we thank you for sharing that update with us and we wish you the best of luck as you and your staff move forward to bring these things into full operation by the first of October.

MS. BROOKS-LaSURE: Thank you so much.

CHAIR ROWLAND: Thank you for joining us.

And we're going to turn now to Chris Peterson, who is going to provide us with an update on the premium assistance option under the Medicaid program and its focus as a possibility for the Medicaid expansion in the State of Arkansas. And that's at Tab 2 of your briefing book.

SESSION 2: PREMIUM ASSISTANCE AS A MECHANISM FOR MEDICAID EXPANSION

* MR. PETERSON: Thank you, Diane.

Premium assistance has been around in Medicaid for a long time, but has garnered a lot of recent attention because of Arkansas' proposal. The State is proposing to cover newly eligible individuals in 2014 using Medicaid premium assistance to purchase exchange coverage. While there's been a lot of speculation about what the Arkansas plan might look like, we now have the benefit of real legislative language as enacted into State law just 23 days ago that we can discuss here today.

So, in this presentation, I will go over a definition, the definition of premium assistance, review its history, State use, premium assistance as discussed in recent proposed CMS guidance, and also to provide a background on Arkansas' Medicaid program and provisions in the new Arkansas law, and some issues and considerations to spur your discussion.

Premium assistance is where Medicaid or CHIP pays the enrollee's share of premiums and cost sharing for private coverage. Most premium assistance enrollees are in employer-sponsored coverage. However, many States do have premium assistance for non-group coverage, that is, for private insurance not purchased through an employer but through the individual market. And Medicaid and CHIP often wrap around the private coverage for benefits and cost sharing.

And premium assistance is generally used by States to leverage private funds. So, for example, a State will use premium assistance when an enrollee is eligible for employer-sponsored coverage and the Medicaid program essentially says, let's use the employer contributions, leverage that by just providing that marginal cost of the enrollee's share of premiums and wrapping around.

There's a provision in the original Medicaid law that permits premium assistance. It is quoted here in full, which is just a little snippet from the statute, that Federal Medicaid funds are available, quote, "for other insurance premiums, for medical care, or any other type of remedial care, or the cost thereof," end quote.

So that provision now lives in 1905(a), where medical assistance is defined. So in 1905(a), it says a Medicaid program can cover inpatient hospitalization, it can cover prescription drugs, and at the very end of that list is a big paragraph and in that is this little snippet, point being that there isn't a lot of specificity in the statute for this particular type of premium assistance in 1905(a).

However, the more commonly used authorities for premium assistance are in other provisions, 1906, which was enacted, I believe, in 1990, 1906A, premium assistance for children, which was enacted in 2009. These two Medicaid provisions are only intended for employer coverage and they require cost effectiveness, that is to say, what the Medicaid program pays in terms of the enrollee's share as well as wrapping around for cost sharing and necessary benefits, plus administrative costs, must not be more than what the Medicaid program would have spent on those individuals for direct Medicaid coverage.

CHIP also has a couple authorities that are primarily focused on employer-sponsored coverage and they, too, require cost effectiveness.

There's a very useful GAO report from 2010 that reached out, contacted States. Thirty-nine States have premium assistance programs in Medicaid or CHIP and there can be multiple programs in a State going between Medicaid -- one for Medicaid and one for CHIP and for other purposes.

But the point also is that spending is relatively small on premium assistance within Medicaid, representing only 0.06 percent of Medicaid benefit spending in 2009. So while a lot of States have this, not a lot of Medicaid spending on it, not a lot of enrollment, as you see here.

Of the 45 programs GAO analyzed, all of them covered coverage in the employer market, and 21 permitted enrollment in the non-group market. It's probably worth describing conditions where a State would be interested in doing premium assistance in the non-group market. We had talked to a State and they have a premium assistance program in the non-group market and their description was, we use it when, let's say, a person comes into the hospital. They're not enrolled in Medicaid. They are already enrolled in non-group coverage and paying premiums. They find out when they're in the hospital they're eligible for

Medicaid. It is in the Medicaid program's interest, therefore, to continue to pay those premiums so that that coverage is the primary payer and then Medicaid can wrap around as appropriate.

Thirty-eight of these 45 programs are required to be cost effective. The other seven are operating under 1115 waivers, so there is a budget neutrality requirement for the 1115 writ large, so one could say that all of these are subject to some sort of budget requirement.

The authorities that GAO cited, 29 programs use 1906, 16 use 1115, and six use 1905(a), and there are others that are also listed in their report.

CMS published regulations, proposed regulations. I should note that prior to the ACA, there had been very little guidance on premium assistance for non-group coverage. However, with the creation of exchanges in the ACA, CMS proposed a new section of the Federal regulations to address Medicaid-funded premium assistance in the individual market. It was one of the numerous provisions in the January 22 proposed rule that we had looked at.

It is important to note that this proposed rule was published before the Arkansas plan emerged, so the proposed rule conveys a more limited role for premium assistance than we're currently talking about. The proposed rule wanted to address what we've called split family coverage. I think, Sara, what you just alluded to, kind of along the same lines, multi-market coverage.

And what the proposed rule said was that they wanted to, quote, "provide an option for States to assist families who wish to enroll in the same health plan when some family members are eligible for either Medicaid or CHIP while other family members obtain coverage on the exchange with advanced payments of the premium tax credit. Premium assistance provides an opportunity for State Medicaid and CHIP programs to

offer coverage to such families through the same coverage source, even if supported by different payers," end quote.

So, what the proposed rule said is that this authority is under 1905(a) and there will still be some requirements in the proposed regulation. Medicaid must cover State plan benefits not covered in the individual health plan. Enrollee cost sharing cannot be higher than what's permitted in the State plan. There's a cost effectiveness test, and the State cannot require individuals to enroll in premium assistance as a condition of their eligibility. And the preamble notes that cost effectiveness, although it is not required in 1905(a), CMS included it in the proposed regulation to be consistent with other ACA changes regarding premium assistance.

Once Arkansas's plan was announced, CMS provided a two-page FAQ in response. They wanted to clarify that Arkansas is not seeking a partial expansion, which had been kind of talked about before, where maybe a State will only expand Medicaid up to 100 percent of poverty, and then from 100 to 138 percent of poverty, they'll let the exchange take that, and CMS said, no, that's not what they're doing. If a State is going to get that 100 percent newly eligible FMAP, they have to go all the way to 138 percent of poverty to get that.

Premium assistance, CMS wanted to note, is possible without a waiver. CMS, however, will consider a limited number of premium assistance demonstrations under 1115, but there are still requirements that they wanted to make clear up front, and some flexibilities, as well, that budget neutrality could include new factors, such as reduced churning; that enrollees must have a choice of at least two plans; that there will be necessary wrap-around for benefits and cost sharing; that those who are enrolled in the premium assistance must have a similar risk profile to exchange enrollees; and that the State would have the flexibility to target certain groups;

but that the premium assistance as envisioned here would have to end by December 31, 2016.

So now just a little bit of background on the Arkansas Medicaid program before we turn to the legislative language and some of the highlights from that. In Arkansas's regular Medicaid program, there is no coverage of non-disabled childless adults under age 65, typical in that regard to other States. It has the lowest eligibility level in the U.S. for working parents, 16 percent of poverty for a family of three, which is $3,125 in annual income.

I should note, they do have a waiver program that GAO did not consider it to be premium assistance for a couple of reasons. It doesn't require employer contribution. It's a State-created kind of plan. And it does go away after 2013, so it's not a critical thing here, but I just wanted to make you aware that, currently in Medicaid in Arkansas, there are other options.

It's also important to note that there is currently no comprehensive risk-based Medicaid managed care in Arkansas. But if you look at some of the broader definitions of whether managed care is in a State, they include in that definition whether there are limited benefit plans, and Arkansas does have one limited benefit plan that covers non-emergency medical transportation. And 60 percent of enrollees are in primary care case management.

So with that background, let's talk about the new State law. The new State law would permit premium assistance in exchange coverage for low-risk new adult group enrollees, and then there would be regular Medicaid available for those with exceptional medical needs. There is some additional language in the State law around that. Eligible individuals are those 19 to 64 who are not eligible for Medicaid on January 1, 2013, up to 138 percent of poverty.

The State law has a provision that if the Federal Government decides to reduce the newly eligible FMAP -- so that newly eligible FMAP is 100 percent for 2014, 2015, and 2016, then it drops down until it is 90 percent for 2020 and beyond -- if the Federal Government decides to change this FMAP, then the program would end.

With respect to cost sharing, the State law says that it must be comparable to private insurance market for individuals with the same income, that individuals must enroll in the Silver plan. On the other hand, it also says that the cost sharing must be within Medicaid limits.

I want to note for Commissioners and audience members that this last bullet has changed slightly. Unfortunately, explaining Medicaid always takes more words than you might want. So the State will seek approval for 2015 for high-deductible health plans accompanied by what they call an independence account with funds that may be rolled over from year to year, similar to what Indiana has in their Healthy Indiana plan, which I believe has a deductible of $1,100 and then an account that has $1,100.

To continue with some of the provisions, and somewhat in line with the requirements that CMS had mentioned in the FAQ, the State law says that two insurance plans must be available in every county. Also, insurers in the exchange must participate, they must all participate in the Medicaid premium assistance, and they would be subject to the medical loss ratio and participate in a State multi-payer initiative that Arkansas has.

It's also worth noting the stated goals of the legislation include promoting individually owned health insurance, attracting insurance carriers and enhancing competition in Arkansas's exchange and their marketplace, also, to reduce the size of the State-administered Medicaid program.

So some issues and considerations. What are the implications for enrollees? How might benefits and cost sharing differ for those in premium assistance versus regular Medicaid? How might access to providers differ? What is the effect on churning and on split family coverage? When we're talking about Federal spending, will Federal spending increase? Should the cost effectiveness test apply in premium assistance like this? So one could say, well, the authority is under 1905(a). Why should there really even be a cost effectiveness test if it's not associated with 1905(a)? But if you are going to have it, is comparable, the word used in the proposed regulation, is comparable cost the right standard?

Then what are the implications for plans? So what are the possible effects if exchange-based Medicaid premium assistance increases enrollment in exchange plans? Will premium prices drop? What are going to be the effects? How do you handle risk of those who would be newly eligible under premium assistance?

And then what are the implications for States? If Arkansas is approved, what might other States do? Does the statute prohibit requiring enrollment under 1905(a), and should the regulations prohibit such a requirement? Would the standardization that exists in exchange plans make it easier to administer premium assistance?

So these are some tough questions, a complicated issue. And with that, I look forward to your discussion.

CHAIR ROWLAND: Chris, having just heard from Chiquita, could you go a little bit into what the nature of the exchange is in Arkansas and what the implications of moving large numbers of Medicaid patients in or out might be.

MR. PETERSON: My recollection is that they will do a partnership exchange, and from what I have seen, and we had a brief conversation with Andy Allison, that they expect the Medicaid enrollment through premium assistance to more than double their exchange enrollment. So there would be a big effect in terms of enrollment and on the market, and that that was intentional. They sought to enhance their enrollment in exchange coverage in that way.

CHAIR ROWLAND: Okay. Thank you. Mark.

COMMISSIONER HOYT: You made a few comments about cost sharing. I wondered if you could just explain that a little more for me, going all the way back to maybe Slide 6. I just didn't quite follow how those requirements are set and how they're going to be monitored going through this.

MR. PETERSON: So, the statute says that you can only have certain levels of cost sharing for various enrollees, that for premium assistance, the State plan must -- the State must ensure that those enrolled under premium assistance are subject to those same cost sharing protections.

So the State will have to find a way to wrap around the exchange coverage. From what I see in the State legislation, that would occur by the State directly paying the qualified health plans in which those individuals are enrolled to ensure that their cost sharing is no more than what they would pay -- would face regular Medicaid.

CHAIR ROWLAND: Chris, I think it's important to make one clarification here, that the Arkansas legislature passed this law and the Governor signed it, but they have not yet submitted, if I understand it, a request to CMS for a waiver or for the ability to do this, nor has CMS obviously made any statement about approving it. So what we're talking about here is what Arkansas would like to do as opposed to what has been

proposed or approved by the Federal Government.

MR. PETERSON: That's right, and so there's a lot of specificity that still remains to be seen in terms of how this is implemented.

CHAIR ROWLAND: And many of those points would be things that would be clearly negotiated in trying to decide what was approved and not approved.

I have Judy, and then David.

COMMISSIONER MOORE: Thanks, Chris. My understanding from some folks in Arkansas who have spoken about this is that a key piece of this you addressed in your list of provisions in the new law has to do with the Payment Improvement Initiative that they have built into this. Because, I think, the State folks would suggest that this Payment Improvement Initiative will, in fact, hold down costs and will provide a more level playing field for all insurance coverage in the State.

Can you say a little bit more about that? Is that described in any more detail in the legislation, or am I correct that that's kind of a key part of the proposal from Arkansas that doesn't necessarily specifically relate to the premium assistance part, which we're kind of zeroing in on here?

MR. PETERSON: Yeah, and other Commissioners may know about this and can speak to it more than I can. I'm a little bit familiar with it, and I think you're right that it is a big initiative. They have it ongoing now for payers. And so this is just building on that. It's not a new thing per se that is cooked into the State legislation. It's just building on what's already there, and I think they're trying to clarify that this continues.

CHAIR ROWLAND: David.

VICE CHAIR SUNDWALL: Thank you, Chris. As always, you dazzle me with your knowledge of the details. This is complicated. But I can't -- it's hard to overestimate the impact that this has had. I mean, you have a State like Utah, where we've yet to decide to expand Medicaid but have put in place a very comprehensive, deliberative process to determine what we're going to do, and the Governor will probably decide in September. They talk about the Arkansas thing all the time as though it were a done deal. I really appreciate your clarification that the waiver has not been submitted nor approved. But it is, in fact, that Secretary Heckler has -- I mean, Heckler, my gosh. It shows you my age.

[Laughter.]

VICE CHAIR SUNDWALL: Sebelius. It shows you my age. My goodness. Well, she was Secretary when I was head of HRSA a few years ago.

But, anyway, that she has indicated some support for the concept. Is that your sense, that, in fact, they're willing to be that flexible and to give this sort of premium subsidy some purchase? Because in Utah, I can tell you, the whole concept of lower rolls on the public program, lower costs, is very appealing, and they're looking at it carefully.

MR. PETERSON: Yes, CMS has expressed their support conceptually to this model and I think that's why they put out the FAQ that said these are the conditions that must be met just so folks could be clear on what one could permit and what requirements would have to be in an 1115, or if one chose to use a State plan option.

CHAIR ROWLAND: You know, let me ask just a follow-up on David's point, though, on the lower rolls. If the people in the expansion are receiving their care and their coverage through the exchange but

they're still going to be claiming federal match, they will still actually be Medicaid beneficiaries. They just will be -- so they'll still be in many ways on the rolls. They'll just be getting their delivery system picked through the exchange, and the financing will run that way.

So I think there's a lot of trickiness to actually the mechanics of this versus the hype. Okay.

MR. PETERSON: Right, and I think just to further illustrate that point is that if Arkansas goes ahead with this and is approved, these individuals in Arkansas who are getting premium assistance would be counted as Medicaid enrollees in our MACStats, for example. And I think --

VICE CHAIR SUNDWALL: They would [off microphone].

MR. PETERSON: Yes. Yes, absolutely, because they're getting federal Medicaid funding for this. And that's why I think the way that they said it in the state legislation that this would -- they're striving to reduce the number of people in state-administered Medicaid programs. That is the distinction I think they're trying to draw.

COMMISSIONER RILEY: It's hard -- I know premium assistance in its former life. It's hard to sort of get your arms around how this works and how the financing works. But I'm intrigued by the level of thought that has gone on in Arkansas.

I guess where I'm struggling is what do they mean -- do we know anything more about what they mean by a low-risk individual? How does eligibility work? And what happens when that low-risk -- as we know, people at low income don't necessarily stay low risk forever. What happens when that low-risk person becomes high-risk? They don't have a Medicaid expansion for the traditional Medicaid program. Have they given any thought to how that works?

MR. PETERSON: And I think -- let me try to kill two birds with one stone with that, because I think one of the other questions that comes up has to do with benefits. So if the premium assistance must provide regular Medicaid benefits and wrap around, how does that work?

From our conversations with Andy and the way that you read this legislation is that --

CHAIR ROWLAND: Andy Allison [off microphone]?

MR. PETERSON: Andy Allison, the Arkansas State Medicaid Director, yes. -- is that if a person needs those services because of a health condition, then they go out of premium assistance, and they go into regular Medicaid. And that's somewhat similar to how alternative benefits for the newly eligible group apply anyway. That is to say, you are entitled to be in the new adult group, and as part of that you would receive an alternative benefit package that's based on the benchmark, et cetera, unless you are medically frail or meet certain other criteria, which then would give you benefits you would not otherwise have access to necessarily through that alternative benefits package. And so this mirrors that kind of approach.

COMMISSIONER RILEY: And would the exchange, because it's a partnership exchange, make the determination about low risk, or would the Medicaid agency?

MR. PETERSON: I think that remains to be seen. I'm not sure.

COMMISSIONER CARTE: Chris, excuse me if I missed this detail on your last slide, but where you have the second bullet, be subject to a medical loss ratio, does that mean Arkansas will propose a different one other than the ACA? So it is the --

MR. PETERSON: Yeah, that was a provision that just applies writ large to the exchange plans.

COMMISSIONER CARTE: Okay.

COMMISSIONER COHEN: Hi, Chris. I wanted to just dig in a little bit to I think what is sort of like one of the key issues here or kind of further work and further consideration. So, you know, fundamentally the concept of providing subsidies to an individual market to cover people, if the coverage is the same or can be wrapped around, you know, to be the same, the coverage issues -- you know, you could probably create a product that looks from a coverage perspective, you know, awfully similar to what's in Medicaid.-- But, you know, one really key and core difference that coverage doesn't address is sort of what are the -- who is the regulator and what are the terms of the regulation of the product that's being provided?

So in Arkansas, since there isn't a comprehensive risk-based -- you know, there's not an existing plan structure in Medicaid, you can't do a comparison of what does the contract for the Medicaid plans kind of look like as compared to what are the exchange rules for those same plans and do sort of a cross-walk, because that doesn't exist. But I do think that that is sort of like a key area for us to really sort of look at. What does it mean that the plan is going to be regulated by, you know, a different entity? So it's sort of the who question. And is that relevant? And how is it relevant? And then what's in the contract or what are the regulatory requirements?

So I guess I'm saying we don't have in Arkansas a really sort of easy cross-walk to do, but I'd be curious to think about some proxies for that, some typical Medicaid managed care contracts from other states or other things. I just think it would be -- you know, we can all sort of -- we can theorize about what some of those differences might be, and some of them might be quite plain. But I think it would be, you know, to sort of dig deeper and see if, you know, there are areas of concern or really maybe there are really not, and what is theoretical, what is up to the state to sort of, you know, have as a difference, I think those are all sort of really

important questions going forward, because again, we can sort of like abstractly theorize, but the really concrete empirical differences between what one contract really looks like or can look like and the other kind of gets to the heart of like how important is it that it's in one program or another. So for future work, we'd like to see if you can do some --

MR. PETERSON: Yeah, you're right because the Medicaid statute has many requirements on Medicaid managed care organizations. And that would not then apply in the condition where you're just doing premium assistance and paying premiums for these individuals. So that does raise some issues.

COMMISSIONER COHEN: Sort of really digging into the what of that specifically, and what is up to a state versus what's just -- you know, what's sort of a minimum mandated by the Federal Government.

COMMISSIONER ROSENBAUM: Thanks, Chris. I think Andy's point is really important, but I want to come back to the issue that actually bedeviled the program since its beginning, although sort of hit this group of people, meaning lower-income people, with the advent of Medicaid managed care, which is this question of when does Medicaid play a supplemental insurer role versus the primary insurer. So if you think about Medicaid managed care, you buy a contract, and many states omit either entire classes of benefits from the contract or pieces. They, you know, say you cover this benefit up to this level, and then we step in with the rest. Or we'll pay for certain services in certain settings. And, of course, the same issue, as you point out, comes up in the context of alternative benefit plans, and now potentially comes up in the context of premium assistance. And there is this quality of Groundhog Day here that we keep thinking this is a new problem. It has, of course, been a long, long issue in the world of dual enrollees in Medicare and Medicaid.

And so I think because there's going to be increasing interest in having Medicaid play the role of a

supplemental insurer -- I mean, if you stop and think about it for a moment, there's no reason why a medically frail person cannot have a standard insurance plan with supplemental coverage for things that standard insurance doesn't cover. There's nothing wrong with that. And there is a great concern that we can't do coordination of benefits in Medicaid. It was an issue in 2009 when Congress considered the Affordable Care Act. And I think quite honestly it's one of those concerns that doesn't have a lot of practical information behind it. And because the premium support example in Arkansas is just the latest in a long line of examples to bring this issue to the forefront again, I would recommend strongly that we think about devoting considerable MACPAC resources to essentially fleshing out the issues as you have begun to do, because I think it's an area that allows us to think more clearly about what Medicaid brings to the table that no payer brings to the table except Medicaid, and what issues Medicaid brings to the table that quite honestly might be replicated in another way. And it also will bring to the table the issues that Andy has pointed to, which is, depending on the subject matter in front of us, you know, who ought to be the primary regulator, and what does that say about exchange and health insurance department and Medicaid interactions.

And I think this is one of the areas that we are just beginning to grow under the Affordable Care Act and know little about, so there's a lot of work to be done here. And I think your presentation was incredibly clear, and we should be clear in what we're writing, that this is the fifth time, you know, in 50 years that we sort of keep confronting the same question, and it really deserves our attention.

MR. PETERSON: And the same issues are true with CHIP as well, and that's something that is going to have to be considered.

To your point on the supplemental coverage, when you say that, what you're referring to is the extent

to which an individual may be covered for their kind of regular medical stuff, and then Medicaid's role to provide those benefits that are not otherwise included in --

COMMISSIONER ROSENBAUM: I think a crucial example of this -- and I meant to ask Chiquita a question and just didn't -- is going to be around things like habilitative services, so you have a family with a child who has mild to moderate autism spectrum disorder, whose qualified health plan may offer 20 therapies, and the child is otherwise perfectly healthy but is going to need more intensive autism spectrum disorder treatments than the plan is going to cover. There's nothing in the Affordable Care Act, as long as you don't violate parity, that's going to prevent therapeutic limits. And it's an obvious role for Medicaid to play, to come in as a supplemental insurer. There's no reason for the child not to be in a standard benefit plan. But there's every reason from a clinical point of view to offer greater intervention than perhaps state law or CCIIO in its negotiation with the plan because of the room that they're giving plans around habilitative services to offer. And I think we're going to confront this more and more and more because plans, in an effort to hold down costs, are going to obviously have tighter networks, higher cost sharing, therapeutic limits, and you can be someone with a serious and chronic condition and still be in really basically fine health, no reason not to be in a standard benefit plan, but you need more.

And from a risk management point of view, it makes sense. From a Medicaid -- this is exactly why we have Medicaid, because it's flexible, it can do things like this. And so there are -- I mean, both strict limits, facial limits, medical necessity definitions, as I said, location setting, service settings, a lot of places where this will come up.

MR. PETERSON: The only point that I would make with respect to Arkansas in particular is that

one of their purposes was to make sure that those Medicaid individuals they are moving to exchange coverage are very low risk. So to the extent that those people who need those supplemental services are also at the same time needing more of the regular services and, therefore, bring higher risk, that's one of the reasons why they wanted to partition --

COMMISSIONER ROSENBAUM: Right. But going back to Trish's point, we won't always know this. You could have two nice healthy parents who happen to have a child with autism. Do we tell the parents, "Because your child has autism and needs some additional habilitative therapies, you must disenroll the child from the plan"? I mean, it is its own version of pre-existing condition exclusions once we start doing that. And if we're -- if health reform is in part about risk solidarity, then this ability to draw bright lines and to essentially rebuild in disability discrimination is really going to have to give way to broader considerations. And one is that you use Medicaid precisely to cushion what otherwise would be a benefit plan that's more limited than we might care to make it.

CHAIR ROWLAND: Okay. Trish has a follow-up to that. Then Denise had her hand up as well.

COMMISSIONER RILEY: Thank you, Denise. I'm intrigued by this, because I do think this is where we're headed with this sort of Medicaid as a supplemental plan, the wrap becomes a supplemental. But it does strike me, it's intriguing and it has great possibilities and can do a lot for family coverage, but it can also challenge continuity of coverage.

So what I'm intrigued by for the Commission is we can inform this work from our work on dual eligibles because we have potential here to create a new dual-eligible problem with two payers, without the continuity of coverage, without clear lines of authority.

So it seems to me we should take the lessons we've learned from dual eligibles and apply them to this new model of Medicaid before the horse is completely out of the barn and we lose our opportunity to sort of learn the lessons of the past and afford the opportunity to do this wrap coverage in a thoughtful way.

COMMISSIONER HENNING: And that's exactly what I was going to say.

CHAIR ROWLAND: I also think that we really need to look at how the pieces fit here, which is what Sara and Trish and everyone have been saying, and especially since, as I recall, the premiums in the exchange will have smoking as one of the factors that can substantially raise your premiums. And we know that in a very low income population that can be quite a prevalent condition. So how that kind of interaction will play out, and also when we were talking about no wrong door in enrollment and the enrollment in the exchange is from October 1st through March, yet Medicaid enrollment is open throughout the year. So I think there's a lot of other issues that, as we try and figure out how this would play out or how the department decides to proceed with this, are worth investigating and how those two entities mesh together.

COMMISSIONER GABOW: Given that cost is an issue for the country as a whole in health care, and given that we know that Medicaid is a very cost efficient program, I think one of the questions that we should look at as we continue is: Does this premium subsidy into private insurance cost more, as has been suggested it will? Or is it actually lowering the cost since these are low-risk, quote, individuals who are going into this? I think that's going to be an important question.

And then, again, to always perseverate on my issue of simplification of our complex health care system, I think as we look at this going forward, we have to decide is this actually creating more complexity, both for the patients and for the providers, as well as the state trying to manage this, especially when you get

into the issue that when they are no longer simple, they need to -- or low risk, they need to move. And one could see that adding to the churn, which we worry about.

So I think keeping an eye on really does this save money or not and does this add more complexity across the board are two important issues I think we need to think about.

CHAIR ROWLAND: And I do think it's critical because of the very low income eligibility levels for parents in Arkansas. We're not really talking about this applying primarily to a group of new Medicaid entitlees who are adults without dependent children. We are talking about it for very low income parents of children who are already enrolled in Medicaid. So what does that mean for putting family coverage together? And also is there an income -- I mean, I think in the FAQ that the -- or the FQA -- the federal government put out, they talked about this may be a strategy more appropriate for individuals above the poverty level and going up to 138, who do have transition ability in the exchange, whereas the Arkansas proposal goes to very, very, very low income individuals, which may be part of why the risk language is there, because we know the poorer population can have substantial health care needs compared to higher-income individuals.

MR. PETERSON: And indeed the Arkansas state law said that they would evaluate whether they could do it for all their parent populations in 2015, and perhaps kids as well.

And then back to the cost question, there was a paper by Manatt, and they went through some of the savings that could result, and they ticked off some. For example, we've already discussed additional savings from price competition by moving these individuals into exchanges, but also whether Medicaid would otherwise be required to increase their provider rates. So if Medicaid would have to increase those rates to get adequate access, now that becomes a comparison that you need to take into consideration to increase provider

capacity. Savings related to having to administer the alternative benefits, if you did your own thing in regular Medicaid, now you don't have to worry about that, so there might be savings that they could count by just using the exchange plans. Savings related to a decrease in beneficiary churning, which CMS had also mentioned.

CHAIR ROWLAND: Is another concern that the size of the exchange population without Medicaid is a fairly small risk pool?

MR. PETERSON: Yes, I think that's part of the issue, just trying to get the biggest risk pool possible. I'm not sure if it's --

CHAIR ROWLAND: Because so many of the individuals in Arkansas who are uninsured are very low income.

Other questions? Obviously, this has been very informative and will be something we'll continue to assess and review.

VICE CHAIR SUNDWALL: One last question, and this was something I wanted to ask Chiquita and didn't get a chance to, so you're the kind of follow-up act here.

I was intrigued when she said that rates had to be reviewed and approved by the federal government for the plans participating in the exchange, and I guess not only do they have to reviewed and approved, but heretofore that has been pretty much a state function, right? I mean, state review of insurance plans.

MR. PETERSON: That's correct.

VICE CHAIR SUNDWALL: This is a real big change with the federal government having that final say. And if, in fact, they're going to review and approve the rates that can be charged, how does that facilitate

the market working in these exchanges? I mean, there must be just a narrower way of maybe they market on quality or some other way. But if the rates -- does this amount to rate setting or just rate approval? I'm kind of perplexed about how they're going to market forces with this kind of federal review of an approval of insurance rates.

MR. PETERSON: When I was at CRS, I did the exchange stuff, but that was a long time ago now, and I've brain dumped all that now for Medicaid.

[Laughter.]

MR. PETERSON: So, Sara, feel free to --

COMMISSIONER ROSENBAUM: I would just note I think it's rate review and question, and so the law really doesn't give the Secretary the authority to disapprove a rate, but, clearly, it brings her to the table to make sure that there's an appropriate evidence base for a rate and raise issues around rate. But I think that, in fact, state insurance departments remain very much in the driver's seat. So it's not like we have federal rate setting.

CHAIR ROWLAND: But there also is the medical loss ratio and the review of the 80/20 provision and any substantial increase -- the increases in the rates are subject to review by HHS under the ACA, and that's already in place.

COMMISSIONER RILEY: But, actually, the Arkansas thing raises the issue of the three R's, because when you think about a Medicaid population and an exchange, the cost of risk adjustment and reinsurance will take on sort of new -- it will be really important to sort of look at the costs there and how they'll handle that.

CHAIR ROWLAND: Mark, did you have a comment?

COMMISSIONER ROSENBAUM: I think this question was [off microphone].

COMMISSIONER HOYT: I think there's some fear factor around them. You know, right now, with the managed care rates for Medicaid, they have this huge oversight role and a checklist and all of that. And now there's no requirement around actuarial soundness for the premium rates themselves that are out there. I think they just feel kind of like they're flying blind and there's always new moving parts. You have higher income levels. I didn't ask a very good question before about the cost sharing, but this idea of trying to -- I'm sure whether it's formalized or not, they're going to want to know whether this is cost-effective or else what's it costing them and what do I get, and I think they're just trying to have some kind of protection possibly to be able to garner some more data to look at this, even though they can't really express very well how to do that. I think there's some fear that they're losing control, or at least the sense of control that they have now inside Medicaid with the managed care rate-setting process that's in place.

CHAIR ROWLAND: Okay. Chris, thank you very much. We will all look forward to continuing to hear from you.

With that, we're going to adjourn for lunch, and we'll reconvene at 1 o'clock to discuss waivers. Thank you.

[Whereupon, at 11:57 a.m., the meeting was recessed, to reconvene at 1:00 p.m., this same day.]

AFTERNOON SESSION [1:05 P.M.]

CHAIR ROWLAND: Okay. If we could please reconvene, if the Commission members could take their seats.

We're going to turn now to an area that the Commission has been very interested in looking at, which is the degree of flexibility within the Medicaid program and the use of waivers as part of the Medicaid experience as well as in the CHIP program and have obviously convened two panels today, the first to provide the Federal perspective on the use of waivers and the second to look at some of the State experience with regard to various types of waivers.

This follows up a discussion we had at our previous meeting around really trying to do a descriptive piece on the nature and the use of waivers, and we're very pleased for this session and any minute to see Cindy Mann walk through the door to open our discussion about the Federal Government's oversight of waiver authority and the Federal Government's use of waivers. And she is being accompanied by Jennifer Ryan. And then following that, we've asked Katherine Iritani from the Government Accountability Office to provide a perspective of some of the work that they have done on waivers and the nature of waivers.

And here is Cindy Mann.

VICE CHAIR SUNDWALL: Well, you know how to make an entrance.

[Laughter.]

CHAIR ROWLAND: So, Cindy, if you would just really provide us with really your insight and your oversight of the waiver process. This is not intended to be a specific discussion of any one waiver or one State's waiver. It is really intended to be an overall review of the use of waivers within the Medicaid program,

the authority for waivers, and how they've been used in the past and how some of the procedures are changing.

But it would also be very helpful if within your discussion -- the Commission has been concerned about when does it make sense for a State to have a State plan amendment change versus a waiver and how do waivers evolve over time from waivers to options in the statute.

So the floor is yours.

SESSION 3: PANEL ON MEDICAID WAIVERS: FEDERAL PERSPECTIVES

* MS. MANN: Thank you. So thank you. Thank you, Diane, David, and all members of the Commission. So, it's great to be back here with you again. It's been a while. But I watch your work and read your work avidly, so thank you for all that you do to bring sunshine and information about the Medicaid program and all its complexities to the world as well as to those of us working at the State and the Federal level to implement it. So we really appreciate it.

I have some prepared remarks to try and address some of the issues that Diane just outlined, and then, of course, I assume we'll have some time for a significant amount of back-and-forth.

So just to set the ground, just to have a level playing field, there's lots of different waivers in the Medicaid program, as people may or may not realize. In general, a waiver is a way for the Secretary of HHS -- sometimes that authority is delegated to CMS -- to allow a State to receive Federal dollars for an expenditure, a Federal Medicaid dollar for an expenditure that otherwise wouldn't qualify for the funds, okay. So we need to start with that. It is a divergence from the statutory construct and saying, well, in certain circumstances, the Secretary should have the authority to say, notwithstanding the law, we're going to spend funds in a different way.

So under the statute, we have various waiver authorities. The broadest and the one I think that gets talked about the most is pursuant to Section 1115 of the Social Security Act. It's not a Medicaid-specific authority. It is actually a broader waiver authority which applies to the Medicaid program as well as some other Federal programs. And it allows the Secretary to waive certain provisions of the law, designate certain sections of the law that are subject to that authority -- and this is a close to quote of the statute -- in the case of any experimental pilot or demonstration project which, in her judgment, is likely to assist in promoting the objectives of the program.

So, we additionally -- and I'm going to talk about the other waiver authorities, too -- so, additionally, we have some more narrow waiver authorities that are just inside the Medicaid program as opposed to sitting outside in the Social Security Act that have some applicability to the Medicaid program. And probably the most prevalent ones are 1915(b) waivers, which are one of several options open to States that allow States to do mandatory managed care in the Medicaid program. I'm going to come back and talk about that in a minute, because we have other authorities, as well, for managed care, and sometimes States use the 1115 waiver authority to do managed care initiatives.

We also have 1915(c), another targeted waiver authority for the Medicaid program, and that is specifically designed to allow States to provide certain kinds of long-term services and supports to individuals in home and community-based settings, or for individuals who have those needs.

So, currently, we have 65 active 1115 waivers and 34 are what we call comprehensive waivers, although I'm going to get back to them in a minute. Seventeen are family planning only waivers. States have used the 1115 authority to provide family planning services to people who otherwise would not qualify for Medicaid.

Five are exclusively children's health insurance program waivers, because the 1115 authority applies to CHIP as well as to Medicaid. Nine of those waivers are targeted waivers, meaning they apply to a certain group of people or a certain locale or a certain set of services as opposed to sort of more broad, comprehensive waivers.

We have 57 -- obviously, many States have more than one -- 57 active 1915(b) waivers and 320 1915(c) waivers, although we're working with States right now to consolidate those. Those are the home and community-based waivers, and what has happened over the years is States have used, you know, developed one waiver for one population group that needs these kinds of home and community-based services and another for another population group, so some States have multiple (c) waivers and we're providing some new flexibility for States to consolidate those to, I think, provide both better services as well as, obviously, reduce administrative burdens.

So, I did want to point out on the issue of what is a comprehensive waiver. Sometimes, you'll see the amount of dollars that are attributed to 1115 waivers and it looks like a vast amount of dollars in the Medicaid program are under 1115 waivers and some of those waivers will be under the rubric of comprehensive waivers. And you can't really tell just from that analysis, because what we have for some comprehensive waivers are States -- New York is one of them, not a small State -- that it has a comprehensive 1115 waiver and it largely was to do managed care.

Now, there are other things over the years that have been added to that waiver, and New York has some other 1115 waivers. But the vast majority of the way in which New York operates its program -- so if you put all the Medicaid managed care expenditures under a waiver in a State that's doing managed care wall-to-wall, it looks like the entire New York State program is under an 1115 waiver when, in fact, the waiver

authority that's really operative is to do managed care and everything underneath that, or virtually everything underneath that, runs according to State law and Federal law, okay. They haven't changed eligibility. They haven't changed benefits. They haven't changed cost sharing. But because the managed care delivery system covers virtually the entire program -- not the entire program -- it appears that all of these dollars are under waiver authority. They are, but you need to look underneath that waiver authority to see exactly what's being changed and what the scope of those changes are.

So it's just a caution when you think about comprehensive waivers and what's being waived. You really need to look beyond the identification of the State and the dollars to look at -- which I'm sure you probably do late at night -- the detailed terms and conditions that are outlined in the waivers.

So waivers play an obviously very important role in the Medicaid program, and the need and interest in waivers ebbs and flows over time, and it depends on what States are interested in doing at any given point in time, what's happening in the marketplace, what interests them. In the mid-1990s, managed care was just coming into the Medicaid program. It was really coming into the commercial market. So that's where the energy was in terms of 1115 waivers. Now, we're moving into a different era, and we'll talk about some of the waivers that States are interested in doing right now.

It also depends, frankly, on what any given administration is interested in approving, and some administrations have, over a period of their tenure, areas where they wanted to focus and they will encourage States, come in for this kind of waiver or we're going to approve this kind of waiver. We're not going to approve this other kind of waiver, because it's obviously, particularly in 1115, quite a bit of discretion lies with the Secretary.

And then, of course, and this goes back to Diane's point, waivers ebb and flow depending also on what authorities States have to do the things that they're interested in doing without going to a waiver. And so it is always important to think about waivers in the context of an evolving statutory framework, and it's changed quite a bit. Over the years, many of the reasons why States have sought waivers have been addressed by the statute, and there, at least theoretically, the need for waivers have lessened. Let me give you a couple of examples.

Managed care, which I talked about before. Until 1997, and if you think about it in terms of marketplace developments, that will ring true to you, a State had to go to a waiver in order to do mandatory managed care, in order to say, let's say, for its parents and children population, which was the first group that States were interested in doing managed care. If they said, we want to mandatorily enroll. You have a choice of plans, but we're not going to let you -- we don't want to deliver services in a fee-for-service setting anymore. We want you to get care through managed care. At that point, until 1997, you had to have an 1115 waiver in order to do that, or some kind of waiver in order to do that.

Congress changed the law in the Balanced Budget Act of 1997 and provided a State plan option. So States can come in. They can ask to do mandatory managed care. There are certain rules of the game that Congress laid out, of course, as to under what circumstances they can do that, but it's pretty broad-based authority to do capitated managed care models through the State plan option, and we have 36 States that use this Section 1932 authority.

Family planning is another good example. I mentioned before that we have 17 family planning waivers. Up until the Affordable Care Act, it was the only way you could say, well, for people -- sometimes

it's women, sometimes it's women and men that States decide to extend family planning services to -- if I want to give family planning services to people who aren't otherwise eligible for Medicaid, just that package of service, they had to do a waiver. The Affordable Care Act included a new State option, and we have about a dozen States right now that are either using the State plan option or have State plan amendments before us under review. So that's moving forward in terms of State activity.

Home and community-based services. I mentioned before that we have a specific waiver authority, 1915(c), that is about doing home and community-based services. But over the last, really, five, eight years, we've seen a number of different ways in which Congress has added State plan authority, which means authority for States to do home and community-based services without a waiver, and there's various different mechanisms to do that.

And again, in the Affordable Care Act, we have two additional routes for home and community-based services that are State plan options for States. One is the Balancing Incentive Program. The other is the Community First Choice Program. And also in the Affordable Care Act, we have Money Follows the Person, which is another initiative that States can draw down dollars in order to do home and community-based services, and particularly in the case of Money Follows the Person, to transition people from institutional care to home and community-based settings.

We've also seen in the area of benefits statutory changes. So in 1996 -- I'm sorry -- yes, 2006, in the Deficit Reduction Act of 2005, enacted in 2006, but we won't go there -- there was a new benchmark benefit option that was advanced as an option for States. So that meant that they could -- a State can change its benefit package, really benchmark to commercial plans, without, again, going through a waiver. Only a

handful of States have used that authority, but as you probably realize, that is the platform, actually, that Congress used to provide the benefit, set of benefit rules for the States moving ahead on the new adult coverage, the Medicaid expansion will be using benchmarks. So we'll be seeing lots more benchmark benefit plans for adults -- it's particularly for adults -- as we move forward.

A lot more flexibility. You can benchmark to a commercial plan. There's a Secretarial-approved option. You can design your own plan. There's obviously -- it's not without some constraints, but certainly gives States a different route in terms of establishing a benefit package than they've had before and a different route than going through a waiver.

And then perhaps most significantly, or at least very significantly, is in the area of eligibility. You know, for the first three, four decades of the Medicaid program, a State could not cover a parent unless that parent was receiving cash assistance. The Congress extended eligibility for children, let States cover children who were not eligible for cash assistance and then ultimately set minimum standards for children that were well above the cash assistance standards, but for parents, you had to be a cash assistance beneficiary.

In 1996, with the repeal of the AFDC program and the advent of the TANF program, Medicaid eligibility for parents was de-linked from cash assistance and States had the ability to expand Medicaid eligibility for parents in the same way that they had the flexibility for children. And so here in the District of Columbia, they've been covering parents up to 200 percent of poverty for some time. Under that statutory authority, no waiver is required.

And then, of course, more recently, in the Affordable Care Act, the final big eligibility gap in the Medicaid program was filled and States that previously could only cover so-called childless adults -- I say

"so-called," because many of them have children, but their children may be over 18 or not living at home -- until the Affordable Care Act, the State could not cover childless adults except through a waiver. We had a handful of States, a couple handfuls of States that did that. But now, of course, with the Affordable Care Act, that becomes an option that States can move forward on through the State plan and not through proceeding through a waiver.

Beyond these statutory changes, we in the administration have been looking at ways of expanding flexibility through the State plan. We've been looking at our statute, looking at our regulations in light of changes in the marketplace, in light of the interest that States have to do certain things, and saying, well, wait a minute. Fifteen years ago, ten years ago, five years ago, we may have interpreted a statute or looked at the regulation this way, but the marketplace is changing.

So we issued in August, for example, a State Medicaid Directors letter around integrated care delivery models that are in fee-for-service settings but allow States to construct coordinated integrated care delivery models, again, without asking for a waiver. They can do that with a State plan amendment. They can incorporate shared savings, quality components. We have a series of guidance coming out on that model. And we are already open for business and approving State plans under that.

And, similarly, in this past January, we issued regulations that identified additional flexibility for States around cost sharing, particularly to improve the use of appropriate care at the appropriate time so it focused in on preferred drugs, differential cost sharing for preferred versus non-preferred drugs, and for the non-emergency use of the emergency room.

So the program is one that is a living, breathing program. It's always changing. Congress is making

changes. We're making changes. And, of course, much of this is at the instigation and the creativity of States and the changes in the marketplace, saying, wait a minute. We should be doing things a little bit differently.

So, in many ways, these expansions of State plan authority lessen the need for waivers as we go forward, but, of course, we still have quite a bit of interest in waivers, so you might ask why.

One is, I will say, and this is more of a statement of the various details of the Medicaid program, there's little appreciation sometimes of the flexibilities that are available. We have Medicaid Directors that are changing and moving through the system very quickly. The law keeps changing. It's hard to keep up. It is a large program with lots of different pieces to it. And so you often just don't have a full appreciation of what can be done without a waiver.

Secondly, I think it's fair to say that, in some circles, waivers become synonymous with reform. If you want to do something that sounds like reform, you must do it through a waiver, and that feels like that's really different, whereas if I just do something that the program allows, maybe I'm not doing anything really significant. And again, that's coupled with, I think, a lack of full appreciation of the opportunities that are available through the State plan authorities.

And, of course, there's new initiatives that States are interested in doing. So you're never totally caught up to either Congress or regulations to what makes sense, and so the purpose, really, of 1115 waivers is to try something new, is to test a new idea, is to pilot something, have a demonstration. And so there's also a need for waivers because there's always new things to try and new things to test, or things that really, legitimate purposes for a State to do but you just can't accomplish it through a State plan. So let me give you a couple of examples of waivers approved recently that fall into that bucket.

Texas -- Texas did Statewide managed care and it had been providing supplemental payments to hospitals. You can't provide supplemental payments to hospitals when you're not doing any fee-for-service. That's under the statute. And so we worked with Texas and did an 1115 waiver that really diverted, turned those supplemental payments into transitional improvement pools, payments for their hospitals, but more than that, their hospital systems to really try and -- not just put supplemental payments out to hospitals for this or for that, but to really say, what changes do we want to accomplish in our delivery system? And so Texas and in a very locally grounded way came up with a way to use those dollars and really to focus them not just on payments to hospitals, but payments to hospitals for transforming care in a way that made sense to Texas.

We have some initiatives that are sub-State. You can't do that, generally, without a waiver. For example, we've approved a waiver for California for different counties to come in and do early adoptions of the expansions. You couldn't do that except through a waiver. We've approved some sub-State waivers like in St. Louis or in Cook County that, again, are system transformation focused, but they weren't going to be taken up on a Statewide basis.

We have an increasing number of waivers that are looking at doing mandatory managed care where you can't use State plan authority, particularly for populations excluded from the State plan authority, which are including dual eligibles, and particularly for some services that might not be possible to include in managed care, like some of the home and community-based services. So we have a number of States -- Texas and Rhode Island were really the first two, but we have a number of States that have since done this -- where they moved into capitated managed care arrangements and had a broader group of beneficiaries and a broader group of services.

And then we have simplification and enhancement of enrollment and eligibility. For example, we are putting out -- well, we've approved a waiver for doing continuous eligibility for parents. The statute says you can do it for kids. Some States said, well, wait a minute. We want to do it for the family. So we needed a waiver to do continuous eligibility for the family unit, not just for the child. The same thing with express lane eligibility as a way to move people through the process by using data available through other programs. The option was for kids. As States are increasingly looking at family-based coverage, they want to use those options for the parents, as well.

So, recognizing the importance that waivers have played and the importance of the tools that they have available for States, we have been adopting several waiver initiatives that are aimed at increasing transparency, simplifying the waiver application process, and increasing our focus on quality and on evaluation.

So on transparency, the waiver has long been criticized as being this inner workings and deal that's cut between the Federal Government and the executive body at the State level and nobody knows exactly what's in it until one day a waiver is approved and announced and there it is. And it can have very significant implications for plans, for providers, and certainly for beneficiaries.

And so Congress in the Affordable Care Act adopted a waiver transparency set of rules and we have implemented those transparency rules. They require that the State put forth its proposal at the State level before it submits to the Federal Government, gets at least a 30-day comment period, have some public hearings on that proposal before it sends that proposal into the Federal Government. When it sends a proposal into the Federal Government, we check for completeness. Is it enough to then do public comment at our level, at the Federal level? So then we post it on our website and we have at least a 30-day public

comment period. We gather public comments and we move forward from there.

So it is a big change. All of those documents are now on the website. They're available. I hope you look at our Medicaid.gov waiver transparency website. We're constantly trying to improve it.

We have also, I think, gone beyond what the transparency requirements were by also really trying to simplify the process. There was, until recently, no waiver application for an 1115. So States that have done it before, States that hired consultants, they didn't have a problem. But States that were new at waivers or were guessing what the Federal Government wanted to see in a waiver, we didn't want them guessing. We didn't want them having to waste time thinking about what it is that was on our mind as to what would be a complete application. So we did an application, a waiver application template. We did actually a couple of ones for States to use, and States have been using them regularly.

We are also moving to an online system of doing waivers, so just not we post documents online, but the actual transaction between us and the State will be online, and there will be basically an online database for States and the public to access so that you can run queries and figure out what waivers have been approved, what waivers are pending. You can do that now, but it'll be much more simplified.

And we're also working hard to streamline the process. So there are areas where waivers are very complicated, and I know the question always asked is why does it take so long? Sometimes it's just a lot of nitty gritty in a waiver. Sometimes, though, they're simpler, and sometimes one is similar to another. And so what we're trying to do is in those ones that are simpler, in those ones that are similar to another, is create modules and to be able to say, we've done this before. Here's our standard terms and conditions for that. It may have to be tweaked a little, given the State's circumstances, but how can we move the process along in the

area of a waiver where we're confident that it moves forward.

We're also moving aggressively forward on areas around quality and really trying to make sure that there's more focus on quality in our waivers. Sometimes, there would be by the States' efforts. We were really less focused on it at the CMS level. We are trying to do these quality initiatives very much in ways that are consistent with the National Quality Strategy, in ways that are consistent with what's going on in the Medicare program, with measures that are consistently used in the private sector, as well, because, obviously, if we're going to try and move quality forward, we can do it in a much better way if we're not just operating in the silo of the Medicaid program but more broadly in the marketplace.

Connected to the quality initiatives are initiatives around better evaluation. Over the years, there's been more or less time spent and effort spent on evaluation of waivers. We want to be very consistent about evaluations and make sure that at least on the big ones, at least where there's a lot of dollars, a lot of lives on the line underneath the waiver, that we've really been asking the right questions, that the State really has a sound evaluation plan. And we've been certainly working closely with ASPE at the Federal Government as well as, of course, the Centers for Medicare and Medicaid Innovation.

So we can think about how to, again, approach evaluation similarly across initiatives, and also really think about real-time evaluation, rapid learning cycle, so it's not just what happened five years later when everybody's moved on, but so that we can get some real-life indications of what might need to be changed along the way.

So there's a number of ways in which we're moving forward and we are, very much going back to Diane's point, and I'm just going to wrap up, looking at waivers in the context of what do States want to do?

What makes sense to do? We encourage States to come to us with their ideas on what they want to accomplish, not necessarily coming to us saying, I think I need this authority and I think I need this authority. Come to us with, here's what I'd like to do, and then what we do is assemble a team and say, well, okay, you could do it through this way or this way, or this is the only way you can do it, and we try and put together the authority so that a State doesn't have to be a master of all those specific 1915(i)s and (e)s and (o)s, but can really think about trying to move its program forward, and we can think about what authorities do we have to support that program and that initiative for moving forward.

So, we really appreciate MACPAC's interest in this area. Our goal is really to ensure that through waivers as well as through the other mechanisms, that beneficiaries receive high quality affordable care, that States have the flexibility that they need to evolve and to innovate, and also -- and this is an important point when you think about what waivers do in terms of spending money outside of the statutory context -- to make sure that there is accountability for the dollars that are spent under waivers.

So, thank you. We appreciate your time and your effort into this. We hope that you think about the waivers together with us. Give us your ideas, give us your suggestions, but in the context of the broader context and mission of the Medicaid program.

CHAIR ROWLAND: Thank you, Cindy.

And turning to accountability, Katherine.

* MS. IRITANI: Okay. And how do the slides work?

Well, I have bad news and good news. The bad news is I'm on west coast time, and I don't talk nearly as fast as Cindy.

[Laughter.]

MS. IRITANI: The good news is that, wow, that was impressive. She covered a lot of really good background, and so I can skip through many of my slides and points, and hopefully --

PARTICIPANT: And you can talk slower.

[Laughter.]

MS. IRITANI: So I'm Katherine Iritani with the U.S. Government Accountability Office. Thank you very much for this invitation. I very much appreciate the good work of the Commission and the Commission staff. Your work is very much a resource to us and I know many others.

So today I'm going to speak to selected GAO findings from reviews that we've done of the review and approval of Medicaid 1115 demonstrations, and I am going to skip over the GAO role. But the one thing that I want to say about what I'm speaking to today is that we've done a number of different reports on the review and approval of these demonstrations, starting with the mid-1990s and most recently 2008. So those are the reports that I'll be speaking to today.

Going to the background on the Section 1115, I think Cindy covered that very well. One thing I do want to note that is different about the 1115 authority as compared to other waiver authorities is the Secretary's authority to approve costs not otherwise matchable. I think Cindy did mention that. But that is unique to the 1115.

So our reviews in terms of scope and methods, we have typically been asked by our congressional clients to look at federal oversight and answer questions like: Is there sufficient opportunity for public input at the federal level? Are demonstration approvals within the Secretary's authority under 1115? Did HHS

adequately ensure that the approved demonstrations were likely to be budget neutral prior to approving them?- So that's the gist of what we've basically studied in these different reports.

I am going to skip over my slide on the process. States submit applications. I do want to note that, you know, the budget neutrality policy for the 1115s is basically the policy suggests that spending under these demonstrations should be no greater than continuing the state's regular Medicaid program. And I think that this policy is important from the standpoint of recognizing that if states are given additional flexibility, that shouldn't be accompanied with additional budgetary resources, that the federal government shouldn't be picking up more costs under these demonstrations.

Under the budget neutrality policy, spending limits are developed -- I'm on Slide 6. Spending limits are developed based on the projected costs of continuing the state's existing Medicaid program.

Oh, I'm sorry. Do I need to do that? Okay.

So the budget neutrality process, HHS' policy for budget neutrality states that the spending limits that are developed under the demonstrations will be calculated from two components: a spending base, which is the spending from a recently completed fiscal year, and growth rates that establish the projected growth for the course of the demonstration. And in assessing a state's spending limit, HHS' policy calls for using estimates that are the lower of the state's historical growth for Medicaid in recent years or Medicaid growth rates projected for the nation. So this is how states would project the cost of their program without the waiver for purposes of figuring out what their Medicaid program would have cost. We reference the lower growth rate as benchmark rates.

So this is a schematic of the general process, starting with establishing a spending base, looking at a

recent year for how much was being spent on a per person basis for people covered under the demonstration, then figuring out the historical growth in the states' programs, and then comparing that to the CMS actuary's estimates of growth for the nation as a whole. And so to figure out what the program is likely to cost, the states should be applying the lower of those two growth rates to come up with an estimated spending for the costs of their program without the demonstration.

So now to some of the things that we have reported in our reports. Some of the key findings in our reports have included that some of the demonstrations that we've reviewed have raised different kinds of concerns, including that the Secretary has approved demonstrations without adequate public input. We found in reports in the early 2000s that HHS was not following its policy to provide for a federal public input process and was approving demonstrations that could significantly impact beneficiaries without a public input at the federal level. And you've since heard of the good work that CMS is doing in establishing a public input process.

We've also found in some reports that the Secretary has approved demonstrations that were inconsistent with 1115 authority. For example, in the early 2000s, we had a series of reports that reported on the use of the 1115 waiver to use CHIP funds to expand coverage in some states to childless adults, and we reported that as inconsistent with the authority which provides for waiver of the funds only if it's consistent with the purposes of the program. And in this case, it was CHIP, and so -- but since then, the Affordable Care Act -- or, actually, since then, legislation and CMS have clarified the appropriate uses for CHIP funds in 1115 demonstrations.

The third point is what I'm going to focus my comments on for the remainder of this, is our findings

related to demonstrations being approved that are not likely to be budget neutral, and without adequate assurance that the demonstrations will not raise federal costs.

A couple overarching observations in our work is that HHS' basis for approving the spending limits as budget neutral has not always been clear, and that the negotiations with states and the rationale for the reviewed demonstrations' spending limits was not always documented.

Some of the specific types of concerns that we found with the approved spending limits include states including impermissible and hypothetical costs in the baseline in the spending limits. For example, we've reported that HHS approved spending limits for some demonstrations that allowed the state to roll over unused funds from a prior demonstration into the baseline for the new demonstration. Another example is allowing the state to include in its spending limit the hypothetical costs for covering a new population that was not being covered in their existing program but was an optional population that could be covered. So essentially allowing hypothetical costs that the states may not have ever covered, I think it was questionable to us that the states would have covered them without the waiver.

And the last point was allowing impermissible costs such as a state being allowed to include UPL payments that legislation had slated to decrease in its spending limit.

One of the key findings that we've also raised related to the approval of spending limits was that HHS had approved spending limits that exceeded its benchmarks in terms of the growth rates that were used to project the spending without the waiver. So this slide demonstrates from one of our reports what HHS approved in the first column in terms of the spending limit for the course of the demonstration and what we estimated the spending limit would have been if they had used the lower of the states' historical growth rates or

the CMS actuary's projection for spending in Medicaid nationwide. And so the dollar difference there is about $3 billion.

So HHS' policy does allow for negotiations around states' proposals, and deviations from these benchmarks are allowed when evidence supports them, but in many cases we asked for the rationale and the evidence supporting the deviations, and that's where we examined what the rationale was, and the evidence, and often didn't find good documentation or transparency around that.

Another concern related to budget neutrality is that HHS had approved some demonstrations that in our view didn't maintain the fiscal integrity of the program. For example, in 2008, we reported concerns with HHS allowing one state to create a state-operated managed care organization within which all Medicaid beneficiaries would be enrolled, establish a relatively high payment rate to that state-operated managed care organization, and then use the excess revenues from that arrangement to fund state programs. And some of these state programs were things like a grant to the medical school and other types of previously -- physician training, other types of state health programs.

Another example was when HHS allowed a state to continue a problematic supplemental payment arrangement. An HHS financial management review had identified in this supplemental payment arrangement that the payments were inflated and that the financing sources were inappropriate, and the waiver that was approved allowed the state to continue that arrangement and also increase the dollars that were paid out of it and the providers that were -- the types of providers that were paid.

We have made a number of recommendations, some of which Cindy has mentioned and I have mentioned that have been responded to in terms of public input, et cetera. We do have some

recommendations that we've made that have not yet been acted upon, and we have raised these to the Congress as matters for their consideration. We have suggested that the Congress consider requiring increased attention to fiscal responsibility and approval of the Section 1115 demonstrations. For example, by ensuring the Secretary clarifies the criteria for reviewing and approving states' demonstration spending limits, better ensuring that valid methods are used to demonstrate budget neutrality, and documenting and making public material explaining the basis for approvals.

I wanted to mention we do have ongoing GAO work on this topic, and we expect to have a report that would be issued next month.

And just a few observations I'd like to close with for the Commission. Medicaid demonstration waiver authority provides a way for the Secretary to allow states to innovate outside of many Medicaid's otherwise applicable requirements, and has been used in important ways to test out new ways to deliver services. Medicaid demonstrations can also set precedents that are often adopted by other states and essentially recalibrate the standards set by Congress. As such, there are tradeoffs and tensions between state flexibility and federal Medicaid requirements.

One challenge in overseeing the waivers has been how to allow for innovation and evaluation without increasing federal costs. And given the significant federal expenditures governed by these demonstrations, there is a need for improved accountability and transparency in HHS' review and approval process around the spending limits.

Thank you.

CHAIR ROWLAND: Thank you, Katherine. And since Cindy is sitting next to you, I just want to

clarify that many of the results that you were talking about are for waivers that were approved in the past and that what we're dealing with now is what the waiver policy is today.

MS. IRITANI: Yes.

CHAIR ROWLAND: And could you explain the authority for the budget neutrality? Is that a statutory authority, or how does that operate?

MS. IRITANI: It is by policy. It's a policy that the administration has had since the 1980s. It is not in statute.

CHAIR ROWLAND: Okay.

COMMISSIONER ROSENBAUM: It has been great to have the two of you testifying side by side, and I thank you for this. And it made me start to think about this whole area in a way that I really hadn't thought about before, and it actually keys off of Diane's observation that this is a policy issue and not a statutory issue.

So Cindy makes a very good point that the underlying dynamic really is what can states do to mold their Medicaid programs as a matter of state flexibility. And the 1115 authority really ought to be interstitial to that.

Originally, when 1115 was enacted, although there's a very limited history -- and Judy knows this better than anybody -- it really in its origins -- I remember hearing old discussions with Wilbur Cohen on this, and taped interviews -- was supposed to be like the CMMI. It was supposed to be an affirmative grant of authority to the Secretary to test things out. It sort of has wandered around in the desert for 50-some-odd years now, playing this other role, and we've kind of backed ourselves into this weird corner where it feels like

almost the Medicaid program is running by waiver, and I think CMS is very correctly now trying to go back to the origins of Medicaid as a more flexible statute and then filling in with 1115.

And I'm wondering whether it might not be worth our thinking about as MACPAC a very different model for 1115 going forward; that is, going back to the roots of 1115 as an affirmative grant to HHS to test new models in Medicaid and CHIP, with a budget, very much the way CMMI has a budget, so that actually we can make some investments, and that really becomes the driving issue around 1115.

For example, the idea of continuous enrollment, this is something that probably in the short run -- and David made this observation earlier -- will cost a little bit of money. It costs money to keep people continuously connected to their source of care.

So why shouldn't CMS be able to do five-state, you know, five-year continuous enrollment demos where we actually really do spend some money, we do a careful evaluation to see what the effects are, you report back to Congress, and maybe out of that comes a new recommendation for a change in the statute?

I'm just wondering whether we went down a pathway of using 1115 as a reactive measure to accommodate state frustration. That then backed us into corners around, you know, budgets and spending and budget neutrality. And now we're sort of living in this cramped world with 1115, and whether we ought not to just decide to cut this Gordian knot and go someplace else entirely if, in fact, CMS is putting a lot of effort into simply having the state be able to administer its Medicaid program without all of this demonstration authority.

So I'd be interested in knowing whether -- realizing, of course, the GAO's job is to, you know, look at activities under current policies, whether you have given any thought to whether there is a different way to

thinking about 1115, whether CMS has sort of thought from the work you are doing now about a different way to think about 1115 entirely, to move out of these boxes.

MS. IRITANI: Well, I think you're right that we haven't gone there because we've been operating within the construct of the current program. But I think that we are -- our recommendation is consistent with the thought that there needs to be more budgetary certainty in these approvals. And from that standpoint, I think that makes sense.

MS. MANN: I won't comment on administration policy, but, you know, certainly the idea is one that I think has been considered over time, and I think that you make some really important points. If you read the statute itself, it does talk about a pilot, a demonstration project, and it is sometimes hard to think about investing in that without -- when you don't know exactly whether or not it's going to be a cost saver or not. But that may be the issue you want to test.

And, also, frankly, both for the state and for the federal government, to do a deep evaluation you need some investment in order to do that.

So I think those are all important areas to think through as to, you know, what are the most valuable purposes of the 1115 authority. As Diane and Katherine point out, the budget neutrality is longstanding policy. It is not statute, it is not regulation. You know, there is certainly concern about implications to the federal treasury. But there are definitely different ways to be looking at it, and I think in light of -- you know, the tradeoff of having also Congress in the statute having over the years allowed for additional flexibility.

CHAIR ROWLAND: Does the budget neutrality provision apply if 1115 waivers are used in other programs under the Social Security Act? Were they used in the welfare reform 1115?

MS. IRITANI: I am not aware of that. I know that the 1980s policy is specific to Medicaid.

MS. MANN: And let me just say, since I didn't affirmatively address budget neutrality in my remarks, but obviously Katherine did, and the GAO has looked at this, and we've carefully looked at their recommendations over the years. It is a policy. It is a longstanding policy. It is our policy, and we take it quite seriously. And I think if you talk to any state about going through a waiver process, they will acknowledge, sometimes painfully, that we take it quite seriously.

But at the same time, you know, we live in the real world, and we want to make sure we are accommodating real-world situations. So, for example, when you look at that the general policy is to use the lesser of state trend rates over the recent period of time versus the projected trend rates from the President's budget for the Medicaid program, you know, as sort of a judgment as to what would have been spent without the waiver and what would have been spent with the waiver, we've had the instance, you can imagine, in recent years where a state's recent trend rates are lower than the President's budget because they did a lot of recession-driven reductions. That was not necessarily their choice. It's not necessarily where they wanted to be hereafter. And what we've seen, of course, in the Medicaid program is states sometimes do cuts in the program prompted by economic pressures, and then they may restore. They cut dental benefits, they add dental benefits. They cut provider payment rates, they then relieve those provider payment rates and bring them back up to a certain level.

If we lock in a state just at a point of coming out of a recessionary period into the trend rate that they've had during that recession, then we're basically saying that for the purposes of the demonstration we'll assume that trend rate going forward.

So it's guidance. We take it quite seriously. We work really hard at it. But we also try and operate in the real world and try and figure out what makes sense in light of actual circumstances.

CHAIR ROWLAND: Okay.

COMMISSIONER RILEY: I appreciate the tough balancing act with the federal budget and the state budgets, but I always worry -- I can never take my state hat off completely -- about the notion that hypothetical costs should be disregarded. States learn from each other, so I'm a state that hasn't done X, Y, and Z. I look at your state that has done it, but I don't like the way you did it, and I think, ooh, there's a better way. So I apply for a waiver so that I can do it in a different way.

I could have gone ahead and done it Jennifer's way and spent all that money, but I want to spend it in a different way. So I always get nervous when we disallow hypothetical costs. Certainly it can be abused, but I think to draw a line in the sand that says no to hypothetical costs really impinges on states' ability to be creative and take different routes and test new ideas.

COMMISSIONER MOORE: In addition to Sara's interesting ideas, would you go through, Cindy -- and I honestly can't remember; I should -- what we anticipate under ACA in the next three to five years in terms of changes in policy and statute? There are some ways that states are able to look at different ways of Medicaid and health reform in the statute, but I don't remember the specifics, and I'd just like to be reminded at this point.

CHAIR ROWLAND: You mean like health homes and --

COMMISSIONER MOORE: Well, no. I was actually thinking of the -- is it 2017 authority to allow additional experimentation?

MS. MANN: You mean what does the ACA allow specifically in terms of waiver authority --

COMMISSIONER MOORE: Yes, yes.

MS. MANN: -- as opposed to state plan authority?

COMMISSIONER MOORE: Right, right. I'm sorry. That was very inarticulate of me.

MS. MANN: That's okay. There is a provision in the law that actually applies largely to the exchange, and it allows states beginning in 2017 to come and apply for a waiver from the Secretary to deliver care in different ways, and there are certain conditions that benefits have to be at least as comprehensive, out-of-pocket costs for beneficiaries can't be greater, overall costs to the federal government can't be greater. So within those confines, it says come to us if you have -- after having the experience of running the marketplaces or having seen marketplaces being run for a period of time if you have a different proposal as to how to deliver care, you can deliver care.

It contemplates that a state may come in with that kind of waiver, with a Medicaid waiver connected to it, because a state that's thinking about that is probably not thinking about it in the silo of just the population that might be eligible to purchase coverage on an exchange, but would be thinking about it more broadly, certainly for their programs that they already run.

And so the statute actually says that the Secretary shall consider, as we think about those waivers, how to integrate the consideration, if a state should have an 1115 proposal, with that 1115 proposal.

COMMISSIONER GABOW: Well, first of all, thank you both. And Cindy, that was a fast and brilliant review of it, and I think answered one of our questions about how do you move from something that's a waiver to something that is now in statute or in a state plan. I think we've been talking about that.

My question is, I always worry about the disparity that happens geographically in the program. And while waivers give states flexibility, they also create differences across the country in uniformity. If you could just talk a little bit about that, is one question.

The other is what is the role of CMS regarding these waivers, when you see something that is really brilliant in a state, about reaching out proactively to other states to say you know, we've seen this really work and improve quality and lower cost, et cetera. And we would like to see more of you do this. And if you would do this, we would have an expedited way to let you adopt something that appears to be quite useful, either in cost-savings, quality, or access, in any of those domains?

So those are my two questions.

MS. MANN: Well, both very good ones. Thank you, Patty.

On the issue of uniformity, I think that's one of the fundamental tensions, as well. We've identified several fundamental tensions, I think. And they are healthy tensions to think about, in terms of do you have -- how far should flexibility go versus assuring some level of uniformity? And really more beneficiary access to care at a certain level.

We have had -- and this has really been applied across administrations -- a policy of not waiving requirements to cover mandatory populations. So for example, children have to be covered up to at least 100 percent of poverty for kids six and older, younger kids up to 133 percent of poverty. That is going to move all to 133 percent of poverty in January of 2014. We have not waived that provision.

So there is a uniformity in terms -- that was clear, Congress said all poor children, no matter whether they are in one state or another state, should have access to medical care through the Medicaid program.

So I think that there has been some limits applied by policy, not by statute, in terms of waiver authority. I think we continue and I think everybody who observes the world of waivers and the statute itself continue to struggle with what is the right balance on assuring some level of access across the country versus flexibility.

I will say, where there is very, very broad flexibility in the statute and where we are very interested in additional flexibility, if needed, through a waiver is around delivery system and payments. And that I don't think anyone has yet found that perfect silver bullet on exactly the way to deliver care and exactly the way to pay for care. I think people have lots of ideas and testing different ideas. That is exactly where the laboratories of innovation bloom. And we have lots of flexibility on the Federal statute and the state plan for that. And where we don't, we've been offering up that flexibility.

So that's an area where I think it's not that hard to think about, well, you don't really necessarily at this point want uniformity around delivery system and payment reform. We want to learn. We want to experiment. We also want to reflect local markets.

On the issue of reaching out, I think we are doing more of that, actually. But I would say that, for the most part, we are reaching out along the lines of what I described which is here are some policies you, the state, may think about that State X, Y, and Z have tried and looks very promising. And here are the different authorities that you might end up putting together to make that work in your state.

So for example, when we did the integrated care delivery model guidance, we said here's the basic model. You can do it, and you can do it in a state plan. You might, state, want to couple it with a mandatory -- bringing in some -- reducing freedom of choice in terms of providers. You might want to couple it with

also bringing in long-term services and supports. If you want to do that, we might want to combine the state plan authority with these two different waiver authorities.

We are going to be coming out soon with a guidance about targeted enrollment strategies that we've seen over the years adopt to simplify enrollment and to bring in eligible people with less administrative burden. And we are inviting states to come in, do these options. Some they can do under state plan. Some they are going to be able to do under waiver. We're simplifying the waiver process to do that.

So I do think we are very much in the business of looking at what has worked over the years in states and trying to get states to be interested in those and aware of them. But we don't approach it so much by authority as opposed to by idea.

COMMISSIONER CARTE: Cindy, maybe going a little bit further from what you just said in the are of home and community-based services, where we are so often dealing with more challenging populations for serious mental illness or intellectual disability.

Does CMS see, or do you see trending out, where you could give states more flexibility? Especially where we are looking for that flexibility to provide environmental supports and things separate from clinical or other interventions? Is there anything trending that way?

Also, I want to say, we are missing a couple of our commissioners and they have particular interests in long-term care and could probably ask you better questions. But I'm still curious about that.

MS. MANN: Well, that's a good question.

We are, actually, always looking for ways to support the ability to provide long-term services and supports to people in the home and community-based setting. And sometimes, as you noted, it is not just

medical care that people need in order to be able to flourish in the community.

Some of that actually can be done through our Section 1915(c) waivers. There is quite an array of different kinds of services that have not otherwise been allowable under the Medicaid state plan, understanding that array of services and supports that are needed for somebody to be able to live in the community despite high medical needs and needs for assistance with daily living.

We are also continuing to explore ways that the Money Follows the Person Program can be used in those ways. We are learning all the time from states and local initiatives around that. We were just discussing yesterday a new way in which we think we can encourage states to use Money Follows the Person to be able to provide some bridge and transition services that are really outside of the traditional Medical world.

So I think a lot of that actually goes on right now in a very regular way under 1915(c) waivers and I think we're constantly looking at additional ways in which we can do that.

That being said, it's the Medicaid program. We can't fund everything people need for every -- you know, one of the big issues for home and community-based services, people need housing. When they are in a nursing home, we pay for the housing because it's part of a nursing home care. We don't pay for housing in home and community-based services. We pay for the services and support around them -- not just medical care, but not for the housing.

And so that's really been a roadblock, I think, in terms of efforts to move forward. And we're working very closely with HUD and with local communities and states to really try and think about how to broaden the reach in our collective thinking about how to make that work well for people.

COMMISSIONER HOYT: I had a couple of questions for Katherine.

Could you say a little bit more about what GAO concerns are around transparency and a lack of public input on the waivers? Is it implied that that is leading to increased costs for the Federal Government?

MS. IRITANI: Well, there's a couple concerns around transparency. One was the lack of Federal input -- or lack of input at the Federal level. And that has since been addressed.

That was a finding -- HHS' policy from years ago was to require states to have the public input process, but also to have one at the Federal level, as well, because many of these waivers go beyond the borders of a single state in setting precedents. And so our early work in the 2000s had found that HHS had not been providing that Federal input process. That has since been addressed.

But we still have a transparency concern around the basis of approvals for the spending limits. And again, around the deviations from the benchmark growth rates, for example, that have been allowed and the basis for those deviations. We collect the documentation around these approvals and the spreadsheets for the spending limits and the calculations and assess them and apply the benchmarks ourselves and ask for explanations when there are deviations.

And that's where we would like to see more documentation and explanation, just with regard to the basis for deviations and for the approvals.

I think part of the concern is just making sure that states are treated consistently, in just in terms of how the spending limits are set.

COMMISSIONER SMITH: I just wanted to make a comment because my son -- we adopted our foster child. As a foster child he went into a very unique program that South Carolina was able to put together, the Medically Fragile Children's Program, partnered with the Medical University Hospital, Children's

Hospital, the Department of Social Services -- primarily foster children -- and Medicaid partnered together and had a fantastic program.

This child had never even put anything in his mouth until he was almost four years old. But because they were able to, in this unique way, come together in one building and give him what he needed, which was four days a week of therapy rather than the one 40-minute session a week. Within a few months, he was eating, chewing, swallowing. By the time he was four, we were able to get rid of the G-tube.

He had cognitive issues, short bowel syndrome. They were able to potty-train him, which took away the diapers and all of the other medical -- I mean, down the road -- it might have cost more up front but down the road he's not on any medication now except for supplements. And he was on a lot of medication. And he's not using a pump. He doesn't go to the surgeon. We see very few specialists now. He didn't have one ER visit in the three years we were with the program. He had been a frequent flyer before that.

So I just wanted to say that sometimes spending the money up front, if it's done right, may save a lot of money down the road.

MS. MANN: I think that's a wonderful tale and a wonderful outcome and it really evidences, I think, some of the struggles that we all have in thinking about what it means to do an investment in the Medicaid program or in health care generally, and even within the confines of a policy of budget neutrality what does that mean? And we have waivers that are approved generally for five years, three years. Do you expect to see a -- and we have a policy that it doesn't have to be budget neutral in year one, it's over the course of the waiver. But is five years the right time? Is three years the right time? Is 10 years the right window?

And then also, some of the things are difficult to quantify in terms of just changes in quality of life and

opportunities that otherwise wouldn't be available.

CHAIR ROWLAND: Well, I think Robin's comment is a great one to end on. I want to thank both of you for coming -- and you, too, Jennifer -- and to say that this is very helpful to our ability to really try to better understand the role of waivers, to better understand how to improve the process, and to inform our work.

So thank you for coming.

We are going to now hear from some of the states that have used waivers, about their experience, and that will help really to inform our ongoing work in the chapters that we are planning to prepare.

Thank you.

[Pause.]

CHAIR ROWLAND: Okay. Waivers, Phase 2. I want to welcome Valerie Harr from the State of New Jersey, the Director there of Medical Assistance and Health Services; Tom Betlach from the Arizona Health Care Cost Containment System and the Arizona model, which is maybe the longest-standing comprehensive 1115 waiver which we've just heard about; and Robin Cooper, the Director of Technical Assistance for the National Association of State Directors of Developmental Disabilities Services.

I think the order that you are planning to go in is as you are seated, so I will welcome Valerie to start the discussion.

SESSION 4: PANEL ON MEDICAID WAIVERS: STATE PERSPECTIVES

* MS. HARR: Great. Thank you. Thanks for the opportunity to be here today to share New Jersey's most recent comprehensive waiver experience.

Again, I'm Valerie Harr. I'm the director of the Medicaid and CHIP program in New Jersey. I've been the director for over two years, but started out my Medicaid career at the Center for Health Care Strategies about 16 years ago and have spent many years in state government prior to becoming the director.

Just to give you a little context, New Jersey covers 1.3 million Medicaid recipients in the state. About one in six New Jersey residents are covered by Medicaid. We have a long history of managed Medicaid going back to the mid-1990s, and we have a very broad package of services and are probably one of the only states that we do not have any cost sharing under our Medicaid program.

Prior to our comprehensive waiver, we already had two 1115 demonstration waivers, and one, I just want to comment with respect to the speaker from the GAO, we were one of the states that used CHIP funding to cover parents, and I have strong evidence that by covering parents, we were able to get more children enrolled and keep them covered. So it was very beneficial for the children of New Jersey.

We had two 1915(b) waivers, and you'll see we had many home and community-based waivers that targeted specific populations. We also had what's called a 1915(j) program, cash and counseling. New Jersey was one of the first states with funding from the Robert Wood Johnson Foundation that started that cash and counseling program.

So, again, I would say prior to our submitting our comprehensive waiver, we had a lot to be proud of in our Medicaid program in New Jersey. We were doing a good job of controlling costs, having an organized delivery system for acute-care services, but we did find there were areas of opportunity, improved opportunity. And, in particular, in February of 2011, Governor Christie, in preparation for his budget address, we had to go and brief him and let him know that we were losing over $1 billion in Medicaid stimulus funding. And with

the maintenance-of-effort requirements, there wasn't a whole lot that we were going to be able to do.

So he really called for us to do a broad canvass of the entire Medicaid program, and Medicaid in New Jersey crosses multiple divisions and multiple departments. So this was an unprecedented opportunity for anybody that had a role in Medicaid, we came together, so it was our Division of Developmental Disabilities, Division of Mental Health and Addiction Services, Department of Children and Families, Department of Health and Senior Services, and all came together and said, How can we build upon the success but really build a program that is going to be sustainable over the long run?

So that's what we did, and our timeline is we did have a concept paper. We went and met with Cindy Mann and her staff. It was the weekend before Memorial Day. I won't forget that long train ride home. And we shared our concept paper with Cindy and her staff to make sure we were on the right page with what we had determined, again, enterprise-wide what we wanted to do to really develop a blueprint and a strategy for the Medicaid program over the next five years.

After that, we came back and we had -- and I'll go into that. We had a public input process, and then in September 2011, we submitted the formal application to CMS, and we received approval in October 2012.

So what we were striving for -- and I won't go over all of these, but we were looking for administrative simplification for our Medicaid program. I think the biggest item that we wanted to do, where we saw the most opportunity, was to move to managed long-term services and supports. We also wanted to move to a managed behavioral health system, expand home and community-based services. We wanted to build on the Texas model, and we did design a delivery system reform incentive payment program for hospital subsidy payments. And we had a number of pilot programs that we wanted to try, especially for children with either

a dual diagnosis of mental illness and intellectual or developmental disability or pilot programs for children with pervasive developmental disabilities.

Our public process, we undertook our public vetting process or public input process prior to the transparency regs being finalized. We had 11-plus individual stakeholders meetings, so specific interested groups we met with independently. We had six legislative hearings, four public medical advisory council meetings that -- we have our committee, and then it is open to the public. We briefed our congressional delegation. We had a public notice in our newspaper, and our concept paper we did put online and took written comments on the concept paper and the proposal.

So in terms of the authorities, I think this is pretty common in what you would see in a lot of 1115 waiver authorities, that we received -- we're waiving certain sections of 1902 of the Social Security Act really to allow us to -- the first one, to move to managed long-term services and supports, to implement these pilot programs, to have mandatory managed care, and to have a self-directed program for certain home and community-based services.

We also sought expenditure authority, received expenditure authority in both our Title 19 Medicaid program and our Title 21 CHIP program for costs not otherwise matchable, and then expenditure authority, which I'll go into a little bit.

So, for example, the costs not otherwise matchable, we identified medical programs the state had been paying for with all state dollars. And without those programs, those individuals would likely have their health deteriorate and they would become Medicaid eligible. So in discussion with CMS, CMS concurred, and basically this is saying CMS, the federal government, would contribute to the cost of those programs because

it did delay or prevent people from needing full Medicaid or institutional care.

We found in certain instances there was definitely an institutional bias that without the CNOM authority, the only option for somebody to have Medicaid coverage is they would need to go -- a child, for example, to a residential treatment center or someone would need to go into a nursing home. So as a result, we got authority through this waiver process to allow us to have federal Medicaid matching funds in order to continue to sustain the Medicaid program and keep people in the home and community and not -- so they wouldn't have to go into an institutional type setting.

Again, these are all just CNOMs. Each bullet is very specific. I'm happy to answer or clarify any of these, but it's the same concept. These are typically state-funded programs. We received federal matching funds to continue. The same thing with -- I mentioned the delivery system reform incentive payment program, subsidy payments to hospitals. Without the waiver and the CNOM authority, we would not be able to continue those payments to hospitals.

This is a little backwards. It's confusing to see the Title 19 requirements not applicable. But really what this did is in a previous waiver, 1115 waiver that carried through -- we rolled it into the comprehensive waiver -- we expanded Medicaid to childless adults at a very low income level, 24 percent of poverty, but we did not -- we waived, we sought to not do retroactive, the three-month retroactive period for that specific part of the demonstration. So that first row is what gives us the authority to not have retroactive coverage for that expansion population.

The second one really allows us to have waiting lists if necessary for our home and community-based programs.

This CNOM gives us the ability to have federal matching funds to support our parents. Again, it was a continuation of the previous --

CHAIR ROWLAND: The Commission members want to know what a CNOM is.

MS. HARR: Costs not otherwise matchable. So without this waiver, without the 1115 waiver, there were state-only programs that under state plan authority we would not be able to claim as a Medicaid program and get Medicaid matching funds. So with the waiver, we are able to -- the federal government shares in the costs of these programs.

CHAIR ROWLAND: I think it was just the abbreviation.

MS. HARR: Okay. Sorry about that.

So now, similarly, just like I had the Title 19, moving to Title 21, different rows giving us different flexibility in our coverage of parents as well as some flexibility in how we administer our premium assistance program. We have a premium support program that allows us to assist a family who has access to employer-sponsored coverage, but it's not affordable. We do a cost-effectiveness test. If the child is eligible for our program but the family has access to employer-sponsored coverage, if it's cost-effective for us to assist the family in buying into employer-sponsored coverage and wrapping around anything that the employer doesn't cover, that's what we do. And the waiver in this particular section is what gives us the authority on a particular aspect of that program.

So, again, if you look at the before approval, we were operating -- our authorities are under a Medicaid state plan, a CHIP state plan. We have a community care waiver that provides home and community-based services for people with intellectual and developmental disabilities. And then we had nine discrete waivers

allowing us to do mandatory managed Medicaid, having a demonstration around the dual eligibles, traumatic brain injury, multiple home and community-based waiver programs for discrete populations.

Since the approval of the comprehensive waiver in October 2012, we continue to operate under our Medicaid and CHIP state plans. We did retain the community care waiver, but the other nine waivers have been collapsed, and we're now operating under one 1115 waiver authority.

That helps us in two ways: It gives us administrative simplification. So for all of the nine waivers on the left, there are quarterly reporting requirements, and the cycle of those reports vary. So it's a lot of paperwork, a lot of timing around the submission of those waivers. But it also creates silos. So as we move to the 1115 waiver authority, and especially managed long-term services and supports, it allows us to break down the silos and in particular with managed long-term services and supports, if somebody meets nursing home level of care and their plan of care calls for certain services, like personal care attendant services, home modifications, some of the non-traditional services that you heard Cindy allude to, that gives us the flexibility to do that -- all with the goal of being able to serve our residents who have said they prefer to remain in the home and the community and not have to go to a nursing home or delay going to a nursing home or stay and not need -- you go to a developmental center. New Jersey still has developmental centers. These services allow us to provide the necessary supports to keep people in the home and the community and have their Medicaid coverage delivered that way.

So some of the challenges that we faced, you did discuss budget neutrality. That's definitely a challenge, and it's a very different exercise. It does not match in any way the way a state does their budget. So, you know, it's very time-consuming, and it certainly was a challenge. And, you know, we're still not in full

agreement for the terms that we ultimately agreed to in order to see our waiver approved.

The complexity of the process of -- we did exactly what Cindy said. We took our ideas to CMS, and then it's figuring out all of that detail that I just provided. Well, this section of this part of the Social Security Act needs to be waived, or this doesn't, or you already have authority to do this -- that took a lot of time. And then turnover. So as you can imagine, as this goes over 12 or 18 months, there was turnover at the state level and turnover at the Federal level. Our project officer changed mid-course, and a lot of this is very subjective and open to interpretation. So it certainly set us back in the progress that we had been making.

Again, I think just operational challenges, again, it's still -- there is, I think, a lot of room for interpretation, and I certainly felt -- it sounds like there's been a lot of progress, but with managed long-term services and supports, we were not the first state to do this, yet it felt as though we had not -- it did not feel as though we were benefitting from any of the experience that other states had gone through.

So I think you clearly are asking all the right questions. I've been listening to your sessions today, and I would recommend that you do review opportunities. Mandatory managed care is one where I'm not sure that that needs to be through an 1115 waiver anymore. Managed long-term services and supports I think has proven to be very successful in other states. And from a state's perspective, it's very costly to write and submit one of the 1115 waivers. We did use consultants. We had to hire actuaries, as well as the evaluation is extremely costly. So if we could have avoided that, I think we would have preferred to do that.

I definitely think there are states -- I could name a number of states -- that are trying something that I think is really for the first time, and I think a state, you would always want the opportunity to really have the flexibility to try to do something innovative. And I would never want that door to be closed. But I think

whether it's templates or modules or moving things to a state plan option, I think those are all very much worthy of consideration.

So thank you.

CHAIR ROWLAND: Thank you.

Tom?

* MR. BETLACH: Thank you for the invitation and the opportunity to be here today. I commend you for sitting through at least 90 minutes now on 1115 and other waiver flexibilities, and so we will continue to plow along and talk about the Arizona experience.

I did enjoy the opportunity to put together this presentation and look back over 30 years and try and figure out how to boil 30 years down into 10 minutes and make it meaningful to the Commission to understand some of the history in terms of Arizona and the 1115 process. It is part of the fabric of the Arizona program. It is part of the framework in which we've developed our program and continue to move the program forward in terms of dealing with new flexibilities and new opportunities and innovations, as well as it was also a tool in terms of dealing with some very difficult fiscal times that the state has gone through over the last few years.

So in terms of looking at a little bit of the history, in 1982, Arizona, as I think many people know, was the last state into Medicaid. It came in only through the flexibilities that were established through the 1115 that was approved by HCFA then at that time. It established a program based on competition, choice, and appropriate managed care.

In 1988 to 1990, there were some amendments to expand the program to include the long-term care

services, including SNF services.

In 2001, there was another significant amendment that expanded the program to provide coverage to adults without dependent children, and at that point in time, Arizona also had to start with the budget neutrality process, and I'll talk a little bit more about that in a few minutes.

In 2006, we expanded the budget neutrality to include our long-term care programs, and then in 2011, there was a new waiver authorized that, as I mentioned earlier, allowed us to deal with some very difficult fiscal times in the State of Arizona.

One measure of the waiver process that I found as I looked through it was just the comprehensiveness, and when I went back and looked at the 1982 waiver, it was a whopping three pages in terms of its breadth and depth.

[Laughter.]

MR. BETLACH: And by the time we got out to 2011, it was almost 200 pages, and obviously very comprehensive at that point in time in terms of providing some significant background, program descriptions, a lot of detailed information. I think the main thing this slide tells me is that by 2016, I may want to be doing something different because I'm not sure how big the waiver will be at that point in time when you look at the line and how it projects out.

Some of the longstanding Arizona waivers, freedom of choice, mandatory managed care, freedom of choice around the MCOs being able to able to restrict their network. Just one point of clarification. Mandatory managed care with the exception of American Indians in the State of Arizona.

Freedom of choice, single plan in rural metropolitan statistical areas for the long-term care system.

As we entered into the arena of managed long-term support services, we went with just one plan in terms of each of the geographical areas, and that included Maricopa County, which represents about 60 percent of the state's population, and Pima County, which is about 20 percent of the state's population.

Over time, we have evolved where we've developed choice in those two areas of the state, but there are still other portions of the state in which they are defined metropolitan statistical areas, which is a requirement for choice, but we do have the waiver.

Costs not otherwise matchable, expenditures for HCBS services for long-term care members with incomes up to 300 percent of the SSI income limit.

One of the unique things about the Arizona waiver, in addition to many other factors, is all of our DSH expenditures authority and requirements are laid out in the waiver, and it's actually one of the reasons why the volume has increased significantly over time, is there's a lot of structure as it relates to the protocols around the DSH distribution. Disproportionate share hospital payments. I'm sorry. I'll try not to use any acronyms.

Eligibility adults without dependent children, again, since 2001, and I think the other point worth making, and Cindy touched on this, is when you look at a state -- and Arizona has obviously had a very comprehensive waiver since 1982 -- we still maintain a very voluminous state plan which lays out all of the categorical eligibility, all of the benefits, all of the payment structures. So you still have all of that detail laid out within a state plan document on top of the 200 pages that make up the Arizona 1115 waiver.

Just in terms of some of the details of what exists within the document, you've got just basic background information. Program requirements are really a long list of federal laws that we're subject to and

also handles all of the transition issues in terms of applying for changes in the waiver, termination of the waiver, things like that, eligibility straightforward.

Demonstration programs lays out the various programs that are operated by the access system. Evaluations lays out those specific waivers in which we have to be conducting evaluations of the demonstration. There's a lot around reporting requirements, both financial and operational, that are contained with it. So there's a lot of accountability that's contained within that 200 pages as it relates to reports back out to CMS. And then, of course, monitoring and other requirements as well.

I mentioned earlier in terms of what we went through from a budgetary and just fiscal resource perspective. In Arizona in 2008 and 2009, the state's general fund was reduced by about 33 percent as a result of the recession. At the same point in time, the Medicaid caseloads grew by about 35 percent, and after raising taxes by $1 billion, selling every state asset, including the state Capitol, and doing a number of other things, the state found itself considerably short of resources. And so in 2011, the legislature could not make a decision in terms of what it wanted to do, and so it enacted a budget that reduced the Medicaid program by $1.5 billion, and that withstood every state law, and told the Medicaid director to resolve that situation.

So given that task, what we did was tried to come up with a framework in which we could preserve the core, and when I talk about the core, it was preserving the plans that we have in our system, the providers that we have in our system, providing services to the largest number of members possible, and preserving services. And what we really wanted to do was get through the fiscal challenges that we were facing at that point in time and still preserve the delivery system and the important services that members depend upon for the State of Arizona.

So if you look at each of the quadrants, I'll start with the enrollment freeze. For the adults without dependent children, we received permission as part of a new waiver to institute a freeze on a population of about 230,000 adults without dependent children. There are now about 80,000 adults enrolled in the program as a result of the freeze and the impact over time. So we knew that that would impact the system, the delivery system.

So in Arizona, there's approximately 300,000 American Indians. About 50 percent of the American Indians are enrolled in the Medicaid program. There were about 25,000 childless adults at that point in time. And working with CMS, we came up with a structure in which IHS and 638 facilities -- and there's about 63 of them in the State of Arizona -- were able to receive payments for uncompensated care. It was the first of its kind waiver, and as far as I know of, it's the only waiver to try and provide that type of flexibility. And all of these waivers were time-limited until January 1, 2014. So what we really wanted to try to do was create a bridge to the changes that were being implemented under the Affordable Care Act.

Hospital uncompensated care funding was another pool of funds that was made available to hospitals that could provide a local match, and CMS recently approved a local city of Phoenix assessment that's trying to leverage this pool of funding, and there have been some other examples.

And then the final area was a coverage piece in which we had to institute a freeze in our CHIP program back in 2010, and as a result of using local dollars, we are now providing coverage to about 32,000 children through the Title 21 program.

So creativity, flexibility provided by the 1115 process to really get the State of Arizona through a very difficult time period and transition towards something different and get us as a bridge.

A second area that is a recent waiver approval is around creating a delivery system for members with serious mental illness, and Cindy talked a little bit about their guidance and their flexibility that they're providing for a fee-for-service model. That just doesn't work in a state like Arizona that has predicated its system in a managed care structure, and so after having two years' worth of conversations with stakeholders in the community around what can we do to improve the delivery system in Arizona, because we historically had a carve-out model. We had a stand-alone behavioral health system. It existed before 1982. When Medicaid came in, we basically Medicaid-ized all the expenditures. But it continued to operate as a carve-out. And so what we had is for a member who has serious mental illness -- and typically about 50 percent of that population is dual eligible -- they had to navigate up to four different systems. You had your Medicaid acute plan. You had your Medicaid RHBA, Regional Behavioral Health Authority in Arizona, the carve-out behavioral health services. You had a Medicare Advantage plan or you had Medicare fee-for-service and a Medicare Part D plan.

So we believed, after working with stakeholders, that is not the most ideal delivery system, and we came up with, again, through the waiver process -- in Maricopa County is where we're starting, and then we're looking at opportunities to roll this out statewide. It didn't make sense to start with choice right away, so we wanted a single plan, single MCO to come in and be fully accountable for all the services associated with members with serious mental illness.

So this plan is responsible for the Medicaid behavioral health services, the Medicaid physical health services. They're also a Medicare D-SNP in terms of having the ability to offer the Medicare package for the individuals. And then also we'll have all the funding associated with housing and employment, case

management, and everything else like that.

So we've awarded the contract, and the contractor starts on October 1, 2013, and we're very excited about this opportunity that, again, was established through the flexibilities provided with the waiver process.

Just a brief history on budget neutrality. We started in 2001, of course. The intellectual challenge was with waiver and without waiver. Well, we've always had the with waiver, so what does Arizona look like without the waiver, and I think it stumped a lot of people. So, at the end of the day, we worked it out with CMS and came up with some PMPMs and some trends, and for the first several years, the budget neutrality was something that we had to pay a lot of attention to. It was part of all the conversations that we had when we talked about making changes in the program, whether it was around benefits or other changes, because, as you can see here, from a per member, per month perspective, we were very close.

And this compares actuals that were negotiated as part of the waiver versus what the actual with waiver expenditure trends were, and you can see the jump in 2007 when we added long-term care. In 2012, we added a per member, per month associated with adults without dependent children. You can also see the actuals drop off significantly, starting in 2009, when the State had to implement a lot of the budget changes that I talked about previously.

So, starting in 2009, budget neutrality in the State of Arizona was really no longer an issue. We created a sizeable gap, and so when you look at just the variance, you'll see that by the time you get to 2012, we have $3.5 billion and it grows significantly in overall budget neutrality.

An important aspect of the demonstrations is the valuation aspect, and I thought that this was relevant as part of the approval letter that Carolyne Davis signed back in 1982. "I look forward to personally

following the progress and achievements of the Access Program. The models that Access will be implementing will be of great importance in developing cost containment features for the Title 19 program:" And I think that that was very prophetic as you look at how Medicaid has evolved over the years since this waiver was signed in 1982 and the expansion of managed care, and more recently, managed long-term care support services.

So the research that was done was very comprehensive and it was done by Laguna Research and there were a number of reports issued. The final report was issued in 1996, so we're talking 14 years after the demonstration first started. And it provided, again, a very detailed summary that looked at a number of the different elements. It estimated that the program had saved about $500 million since inception. And it identified less utilization in terms of hospital days, the savings per year, and then the satisfaction levels that were also high.

So when you look at the details, when you look at the testimony -- GAO also did a study -- there was a lot of comprehensive evaluation in terms of the Arizona 1115.

Another aspect in terms of just the results of the program, this is our elderly and physically disabled population and what's transpired as the State has continued to see an increased use in utilization of home and community-based services, and we know that the members are happier being in the community. We know that the costs are less for the overall program. And so these are the type of outcomes that we've seen continue to evolve with our program, even a couple of decades later.

I'll skip that slide.

Waiver process improvement. Path to permanency. Thirty years later, we still get to go through this

process every three to five years, and it's a lot of fun to go back and talk about all of these things that we've been successful at implementing and had documented success. But, of course, that's still subject to negotiation and Federal discretion.

So, just as an example, back in 2006, when we were wanting to retain our waiver flexibilities, there were staff at the Federal level that did not want to see us move forward with our continued option in terms of having a single plan in Metropolitan Statistical Areas for the ALTCS program, and it took Governor Napolitano calling then-Secretary Leavitt and saying, I have got a county that -- for example, Flagstaff, it is larger than the State of Connecticut, and we've got less than 1,000 long-term care members. Do we really have to go in and put choice in that county? And so, again, continued flexibility, but you still are at the discretion of the Federal agency.

So it seems to me that if we're looking at a path to permanency, if a program has very well-documented success over a very long period of time, then it seems to me that authority should continue unless there is specific evidence that would offer up the alternative, that it is not providing appropriate services in a timely fashion and meeting the needs of the members that we serve.

Timeliness, there is no official clock. That has been talked a lot about. And then appropriate time frames for evaluation. So I understand the need in terms of wanting to get information quickly, but I think that we all can also acknowledge, as you implement these types of substantive changes, there needs to be some time elapsed as the delivery system evolves and as you see the changes get implemented into that system.

So, in conclusion, the value of the 1115 waiver, it's been extensive in the State of Arizona. We continue to be a laboratory. We continue to see significant changes in the model, and I think that as we move

forward, we will see even more changes in health care. And so this vehicle provides us with the ability to make those types of changes. And in the end, it's resulted in a more effective program in the State of Arizona for our members and a more cost effective program for our State and our citizens.

CHAIR ROWLAND: Thank you. Robin.

* MS. COOPER: Okay. Thank you, Commissioner Rowland and members of the MACPAC for inviting me today. I feel a little bit like the Reduced Shakespeare Company. We're going to do this as fast as we can. We've been here a while. I'm also from New Jersey, and even though 40 years in Wisconsin, I still talk fast.

We're going to shift gears a little bit and talk a little bit more about the Medicaid Home and Community-Based Services Waiver Program, the 1915(c) program, and we're going to bring in 1915(i), State Plan Home and Community-Based Services, two additional authorities that relate to providing home and community-based services.

I was asked to do a couple things, to just briefly say what are home and community-based services. Basically, home and community-based services are about creating a life, maintaining a life, sustaining a life in the community. As my name twin, Robin, mentioned, those kinds of supports and services are essential to people's lives, to the richness and fullness of everyday life. And we have -- it's been an incredible source. As Director Mann mentioned, we have 320 1915(c) waivers. I think the States kind of like them. We have a good 30-year history with it, a very positive program.

But what's interesting is home and community-based services are very different things to different people. It's not a unitary package of benefits. For a senior living in her own home, it could be some personal

care and chore services. For a family with an adult living at home, an adult, say, with intellectual disabilities, it could be family training or respite. And for the individual, skills training and employment. So the idea of flexible, customized services in home and community-based services is a critical feature and a critical positive feature of the 1915(c) program.

Why does the home and community-based waiver work so well? Well, in looking back over the 32-year history, I guess it is now, we've really come to realize there's some real brilliance in the original statute. It was probably the most flexible benefit at the time that CMS put -- that came through our Congress in 1981 when this program started. It's highly flexible, so you can target the benefit. You can target to specific individuals. So you could write multiple waiver programs in your State for different groups with different sets of benefits, which kind of makes sense. The benefits that might be meaningful to a senior are not meaningful to a 22-year-old looking for employment, a pathway to employment. So targeting those waivers are really important.

You can choose not to operate the program Statewide. You can make it different in different places. So you can kind of customize what you do to the area where you live. You talked about bringing local match, and Missouri used this waiver of Statewide-ness to bring local county match into their program and serve thousands of new people. But they couldn't do it Statewide because not all counties have match. A great piece of flexibility in the program.

You can choose to cover a broad or narrow array of State-defined services. We have waivers that cover two or three services. We have waivers that allow for 20 different types of services, again, to a targeted population.

What else works? Capping the waiver, and there's multiple ways that you can cap. I would suggest that, in talking with our members and our buddies with NASUAD and some of the other associations, the ability for States to peg the number of people they serve to the dollars they have available has been the reason the waivers have expanded so much. In my heart of hearts, I, as an advocate, would love entitlements, okay. I mean, if we could have entitlements to home and community-based services and States had all the money in the world, I'm totally there.

But what the waivers do is as States garner new resources, they can add people. They can say, we have enough money to serve 2,000 people, 3,000 people, 4,000 people, and when we get new resources, we can always add. So the ability to peg the number of people served in a program to the available resources has actually been the reason States have expanded. They added money in when they have money to add, and this has been an incredibly positive feature of the program.

The other thing States can do is cap the individual budget or the individual benefit, meaning, for example, States have created what are called supports waivers that offer a modest benefit, maybe up to $20,000 a year of benefit, but a highly flexible service array, and this has worked very well for families, for people living at home with their families, or people needing modest supports. And States also can, through the supports waivers, sometimes hold back the tide for more costly and more expensive services. By providing a modest benefit to a lot of people, they're able to hold back the tide for an extensive benefit to a few.

Another thing that is a piece of the home and community-based waiver which is both -- some people might see it as a problem, but actually, we see it as a positive -- is there is a renewal process and States can renew their waivers and just get them re-approved without any changes, and that's a pretty easy process. But

that renewal process gives both CMS and the State time to reflect on what's happened in the last -- it's a five-year process -- and see, has our policy that we've actually written down caught up with what we're actually doing? Are there significant changes we need to make to the program? It's a way to refresh and renew the program every five years and also give CMS the opportunity to work with States on areas that might be of concern, as well.

This idea of individual caps is really important. Home and community-based services, as I'm sure you know, are not the same as clinical services. They may include some clinical services, but it's not as if you have a diagnosis that equals a set of services or a set of interventions. As we say, you may have a diagnosis of intellectual and developmental disability, but what does that mean? For one person, it might mean intensive therapies. For another, it might mean a job. For another person, it might be self-advocacy training. So it's very interesting to look at -- it's really about the social supports and the goals and opportunities and the skills that people need and the deficits that they have that put together what makes sense for a person.

What we talk about a lot is individuals' budgets that give people flexibility. So if you can set a cap on an individual budget but give people a wide array of supports and services to choose from, they can really customize. And again, this is a wonderful feature of the home and community-based waiver. I have a resource. It's finite. I understand that. But I have a lot of flexibility with what I'm going to do with it, a really, really positive feature.

Yeah, there's a few things that get in the way, too. It's not -- you know, I was trying to create the perfect world, but yet we're not there. There are some things that get in the way. The fundamental one is to tie the institutional eligibility, something called level of care. To be eligible for a 1915(c) waiver, you must

meet eligibility for institutional care, what's called level of care, and that would relate to people at the nursing facility level of care, the ICF/DD level of care, intermediate care facility for people with intellectual and developmental disabilities, hospital or rehab hospital level of care. You notice there's no mental health in there. We have the Medicaid problem of ages, what is it, 18 to 64 are not in this population. They do not meet level of care unless they may, in some cases, meet a nursing facility level of care. A huge population left out of this.

This program is 32 years old, okay, and when it started, you used to have to close an institutional bed to open up a waiver opportunity or slot. It was this one-for-one relationship because it was tied to institutional level of care. Well, it's still tied to institutional level of care, but we don't have this rule anymore. In, I think it was 1987, the early 1990s, I can't really remember, the "cold bed" rule, the one-for-one rule where you had to close a bed to open a slot went away. So we've left this tied to institutional eligibility that's kind of no longer relevant. It's really not a relevant tie anymore. So that's an issue, okay.

There is a -- Director Mann mentioned there's a change coming in regulation, but right now, you can only serve one level of care within one waiver. So if I wanted to create a children's waiver for children with severe emotional disturbances, kids with autism, kids with developmental disabilities, kids with physical disabilities, and kind of create a children's home, I can't do that. They're at different levels of care. They can't go in the same program. That is a pending regulatory change, so we want it, okay.

Cost neutrality -- this is the area Chris had asked me to talk about. In the waiver, this is not budget neutrality, and I'll make the critical distinction. It's not the 1115 budget neutrality. As long as you have money, you can add people. As long as the State has match, you can add people. It's not budget neutrality.

It's cost neutrality on an individual basis, which says -- actually not individual. The cost of one person on the waiver has to be less than or equal to the cost if they were institutionalized, okay. Does that get it? So it's as if they were still in an institution. That's your cost, your outside outlier of maximum cost on your waiver, on average across everyone served. So there's this cost neutrality requirement.

Well, cost neutrality can be a real problem. In some States, for example, with the populations that are served in nursing facilities, many people coming into a nursing facility may have some private resources, right. They have some of their own funds to put toward the cost of care. It's not that the reimbursement rates to the nursing homes are low. The Medicaid reimbursement rates are low because there's so much private resources.

So what happens, people get stuck because of the cost neutrality. They actually, if they came out, would cost more than what Medicaid is reimbursing in those facilities, and this particularly affects younger people with physical disabilities. So cost neutrality can really get in the way of serving people who otherwise it would make sense to serve.

So, really, the idea of cost neutrality made sense when we were on this one-to-one conversion. It was people coming out of institutions into the community, closing the bed behind them, creating a slot, and the money came with them. That's not the condition anymore. That's just -- our waivers serve millions of people. I think we spent $23 billion on people on the waivers in 2010, and I would suggest not every one of those people came out of an institution. In fact, most people don't. Most people are diverted, right. Okay.

So, let's go on. We'll do this. I'm going as fast as I can.

Okay. Some other things that potentially get in the way. There are some renewal cycles, three years

on new waivers, five years on once you've had a waiver. They don't match up well with other authorities or other home and community-based authorities. Eleven-fifteen is, what, three, or five, and, you know, there's all these disjunctions in the cycle of renewals that don't make sense when you're trying to create a comprehensive home and community-based program. Okay.

The quality management requirements also differ across a whole variety of very similar authorities, and we would suggest that's kind of crazy making, too. Okay.

So, real quick, the last thing I was asked to do here was to propose to you kind of maybe big statutory change. If we were dreaming, what might we do? Well, recently, CMS -- what, it's 2005, 2007, a new regulation came in called 1915(i), State Plan Home and Community-Based Services, fabulous benefit, incredible. It's a State plan option, not a waiver. And what this did is it decoupled institutional eligibility from the same array of supports and services that are available under 1915(c). Fantastic. We finally have the opportunity to keep people from getting sicker, from deteriorating so that they meet level of care and then can get in the program, right. It was really great.

And the other thing is its cross-accessibility. You could bring in people who are visually impaired who will never meet level of care, right. You can bring in people with mental health needs who do not meet level of care. And you have the array of home and community-based services -- supported housing, peer supports, supported employment, all of the supports that we really -- are meaningful to people.

Okay. There are some other features that are nice. Independent eligibility determination and case management being conflict free, some really nice, good features.

But it has a major flaw. It's an entitlement. It cannot be capped. You can't cap the dollar benefit to

the person and you cannot cap the numbers. So States were really excited. This was a change in regulation that came. It started out being allowed to be capped and then there was a regulatory change.

So what happened is people were so excited to decouple this institutional level of care from access to home and community-based services, but now it's an entitlement and States are, understandably, given our recent recession, somewhat leery to open up new entitlements.

So we have about 15 States that have done 1915(i), but what they've done is tightly targeted, very narrow, children with autism between the ages of three and seven, very narrow benefits. We're not seeing that kind of comprehensive view.

We have a few States that have done some great stuff in mental health, but States are reluctant, until they can figure out a way to manage the access to an entitlement. So fabulous. It decouples institutional eligibility. It has some really good features. Problem: Can't cap the numbers. Can't cap the dollars. So you cannot peg your use of the program to the resources and expand it as you have new resources.

So, in my wildest dreams, maybe it's time to look at overarching home and community-based authority, a State plan amendment that allows all the variety of positive features that we have in both programs, and States would be allowed to pick and choose among those. They could cap it, not cap it. Tie it to level of care, not tie it to level of care. Have multiple populations in one authority or serve a targeted group. So we really see that these two programs have very, very positive features and potentially bringing them together can make a very robust and positive program for States.

So in doing that, we'd also want to make sure to bring along other positive features, like the flexibility in services, the self-directed options, a comprehensive look at quality management, the idea of conflict-free

assessment and service planning which came with the 1915(i), and we think the renewal cycle is a legitimate -- maybe a little longer than five years, but it's a real positive feature.

And that's it.

CHAIR ROWLAND: Very well done, all three presentations.

Comments from the Commission members? They're speechless. That doesn't ever happen. There's Trish. Okay.

COMMISSIONER RILEY: It takes me back to my roots. I remember being in Arizona in August doing a site visit, and for a person from Maine, that was tough.

[Laughter.]

COMMISSIONER RILEY: Can I just ask, the level of care delinking is always a struggle for me. Home and community-based care is so different. How would you -- in health services, there's a test of medical necessity, and we know that everybody who's eligible won't use services because some of them are well. In home and community-based services, potentially -- I remember a legislator saying to me once, "I'd like a homemaker."

MS. COOPER: Mm-hmm.

COMMISSIONER RILEY: So if you eliminate the link -- if you delink level of care, what's the medical necessity test? What's the functionability test, and to what end? I mean, what's the goal of the care?

MS. COOPER: In the 1915(i) statute, there is a process to develop that. It's called -- it's needs -- first of all, it's target group, so you could target it to people with certain diagnostic categories. That would be one way to say you have medical necessity. And you could, you know, narrow it.

But there's something called needs-based criteria. It is in the statute for 1915(i), and States have to develop an assessment process to determine, does the person have need for the types of services covered under the benefit? It includes functional assessment. It includes other assessments by clinicians, I mean, a variety of different assessments to ascertain that the person has a need for the covered services.

So you have two ways. You can --

COMMISSIONER RILEY: And that's done independent from service providers.

MS. COOPER: Independent from service provision, a very nice feature. Right. So I just addressed that.

CHAIR ROWLAND: And since we sometimes get confused with this 1915(c) and (i), 1915(i) is actually an optional benefit under Medicaid --

MS. COOPER: State --

CHAIR ROWLAND: -- as opposed to a waiver, like 1915(c).

MS. COOPER: Correct.

CHAIR ROWLAND: Judy.

COMMISSIONER MOORE: A little historical note, if you will indulge me, about Arizona, and I think as an interesting commentary on the 1115 process and statutory authority since I was one of the group of Federal people involved in the review and approval of the original Arizona waiver, which -- and I wanted to make a couple of points.

First of all, it was incredibly controversial in 1982, and 1981 and 1983, and it got off to a very, very rocky start the first year or two with some very major problems which were then addressed. And in the

subsequent 28, 29, whatever years, I think it reflects a wonderful example of the results of a demonstration which have produced an enormous number of innovations in the Medicaid program which a lot of States have adopted, have copied. I know you still have people coming to Arizona to review the kinds of contracts you use, the kind of quality oversight you have developed. But it certainly hasn't happened overnight and you're still refining, as well. So I think it's an interesting and an exceptional case study, but it sure does take a while to get it all going well, so nice job, Tom, and --

MR. BETLACH: The only comment I have is, Judy, when are you going to write the book on the Arizona waiver like you wrote the book on Medicaid?

[Laughter.]

COMMISSIONER MOORE: I'm still working on getting somebody to write the Arizona story, because I think it should be written.

CHAIR ROWLAND: David.

VICE CHAIR SUNDWALL: I appreciate your presentations. We've been all enlightened today on waivers, which are something we've skirted around for some time and I hope we will come up with some good recommendations.

My question is this. I had always thought that waivers were not just about budget neutrality -- you're doing things cheaper and more creatively -- but about lessons learned about how do you sense all these multiple, now hundreds of waivers, have been useful to other States? Why can't they take lessons learned from a State where something has worked and use it instead of starting all over and forever creating new waivers? Aren't we supposed to get a -- kind of distill the lessons learned and best practices and then be able

to implement them elsewhere?

MS. COOPER: I can speak to the field of intellectual and developmental disabilities where there's a huge amount of cross-fertilization among the States and we all rob from each other. People do learn through a lot of publications, through sharing, through reading each other's waivers. I mean, we've -- States replicate each other's stuff all the time. You know, it's like they steal it and it's good.

VICE CHAIR SUNDWALL: But they have to yet apply for a waiver.

MS. COOPER: Yes, they do.

VICE CHAIR SUNDWALL: If something -- there's consensus on best practice, can't that become policy instead of go for another waiver?

MS. COOPER: I'm with you.

[Laughter.]

MR. BETLACH: We'll double that. We'll apply for that, as well.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: Well, along the same lines, I mean, that's why I wanted to ask you the same question I asked the previous panel, which is whether we ought to give some thought to a fundamental rethinking of 1115. That is, that rather than serving as a mechanism for sort of reacting to State efforts to get out from under limitations of the statute, whether we ought to think about changing the Medicaid statute to embrace more variation in especially service organization and delivery as a State plan matter and use 1115 as a mechanism more like CMMI today, that is, with Federal financing attached to it to allow the Secretary to lead efforts in collaboration with States that may actually cost something, which I think

is truer to the original vision of 1115 than where we've kind of fallen into, which is that it's a passive approach to addressing what are perceived limitations in Federal law as long as it's budget neutral, which turns the whole thing into an accounting exercise.

So, I guess my question is whether, all things considered, States would prefer to operate in a -- whether it's 1115 or the other waiver authorities, I mean, because we've got so many of them now -- whether you gain anything from operating this way, whether you'd rather just operate on the State plan basis and do very rare true research and evaluation in partnership with the Federal Government. So it's mostly, you know, you can look at the burdens, but there are probably benefits that come from this, like the ability to cap enrollment, the ability to use a single plan. These things, to me, are all issues that we really ought to be able to work out in the context of the statute itself. I mean, they don't strike me as demonstration-worthy. They strike me as using Medicaid to replicate -- using the waiver process to replicate what one State already has done. So is there anything to be gained from operating and sort of with waiver as the common denominator always?

MR. BETLACH: Well, I guess my response to that is the devil's always in the details in terms of what that statutory structure looks like. But right now, for a State like Arizona, it's an important part of the tool kit that we have in terms of trying to come up with creative delivery system changes that still meet the requirements of Medicaid, but through the 1115 process allows us to do that in a manner that deals with the local market issues that we have.

And so our biggest concern is always that path to permanency, and for those things that we have proven to be successful, how do we make it permanent, because it is subject to discretion of the Secretary and that approval process.

COMMISSIONER ROSENBAUM: But at this point, thinking about the history here, so are we still in 1115 mode in Arizona because of just the historical complexity of getting out of it? What lives on as so important to do as an exception that we shouldn't think about doing it as simply a State flexibility measure in the statute, the one plan rule, the -- I mean, I'm sort of trying to put my --

MR. BETLACH: Yes. If you have the statute that covers those items that I listed, then that would be great.

COMMISSIONER ROSENBAUM: Yeah. So it's a matter of sort of thinking hard about why you're still operating under demonstration authority and which of those elements is so crucial to maintaining as a general statutory matter that we're going to require you to --

MR. BETLACH: Sure. So if, after years of success, you've proven freedom of choice and some of the other ones, then give us a path to permanency through the statute. That would be great.

CHAIR ROWLAND: Tom, when Arizona began this process, the statute for allowing States to enter the Medicaid program had a fixed and final date and you were well after that date, is that not true?

MR. BETLACH: Yeah. I'm not sure about that. I'd have to go back and look more at the history. I don't know. Judy's shaking her head "yes," and I know she wrote a book on Medicaid, so that must be the answer, but --

[Laughter.]

CHAIR ROWLAND: Because I always wondered why one way to permanency wasn't to just change that statutory provision and allow a State to enter after the window closed. But I would note that with the current ACA, at least there's no window that's been put in there, so, hopefully, States will have the choice

going forward.

Are there -- Mark.

COMMISSIONER HOYT: Valerie made a comment about turnover. It's my impression that the lines just -- sort of related to that, but a little broader -- the lines aren't very bright sometimes between what the regional office does and what central office does, and then it seems to be inconsistent sometimes -- maybe this is what you were getting to -- who you're talking to or who you work with in the central office. Why do you think that is, anybody, and what can we do to improve that?

MS. HARR: My observation is that you have units within CMS, and whether it's the region or central office, that have expertise and specialize in certain areas, and there's also -- and so you get a difference of opinion. So if you're talking to somebody -- so as we try to, you know, collapse our 1915(c) waivers and move under 1115 waiver authority, there's definitely, and there continues to be, a significant amount of disagreement within CMS over what that means operationally -- reporting requirements. So there are differences of opinion, I think, within CMS, especially when you look at these different waiver authorities.

I also think that there continues to be the majority of the knowledge base -- and this is just my, again, my observation -- is around fee-for-service, and so there seems to be -- it's hard to find someone who has managed care expertise within CMS to give -- to get good guidance from. So I think it's skill set, cultural change, because many States, you know, we are following and been watching very closely Arizona, Tennessee, New Mexico, and we do learn and we take every opportunity to learn from other States, but I'm not -- it seems like maybe there's -- it's lagging behind from sort of the cultural environment at CMS.

CHAIR ROWLAND: One question I have is as we go forward to look at waivers, obviously, the

1115 waiver structure is quite different from all the other waivers, and perhaps we ought to take care to make the distinctions between those two sets clearer as we go forward.

But I also am looking at the fact that the history of long-term care services and supports is very difficult when you look at the legislative history in terms of it was very institutional-based. There was a history of trying to then move it into home and community-based services. But at the time, of course, you had by then a Budget Committee that wasn't there when you passed the Medicaid statute in 1965 that was trying to do everything in a cost-neutral or budget manner. And maybe we should really look very deeply at how long-term care services themselves are supported and maintained in the program as one area that is kind of beyond waivers. It's really how do we provide and what services should be there under the Medicaid program. I wondered if the panel would think that would be a useful thing for this Commission to pursue.

MR. BETLACH: I think it would be very useful, but it would be a whole long discussion, much longer than what we have time for this afternoon. But, clearly, again, I think there's a long history --

CHAIR ROWLAND: I'm just offering an invitation to --

[Laughter.]

MS. COOPER: I second Tom. I think it's a very rich area for discussion and a growing one. And this whole marriage of the long-term supports, the (c) waivers in 1115, the use of managed care in long-term supports, I mean, all these things are -- we're seeing much more relationship and integration in those kinds of things and the time is pretty ripe for a major discussion.

MR. BETLACH: And I know you've spent a lot of time on the duals, but then, of course, you have to include that into the conversation.

CHAIR ROWLAND: Right. Well, and I know there's a Long-Term Care Commission that's been set up to look at some of these things more broadly, but I think that it would be very useful out of this waiver discussion to also broaden our look at long-term care.

Trish.

COMMISSIONER RILEY: Before we let these excellent presenters go, can you speak a little bit to the administrative issues, because I'm struck that we spend so much time on fraud and abuse and so little on the management of the agency, and when you think about your multiple waivers that you're now smushing into one, does it help administratively to have one waiver versus multiple? I mean, what's the environment? What are the administrative challenges?

And, Tom, I recollect that AHCCCS is like a quasi-governmental agency and you don't have some of the constraints that other States do, and Tennessee, much the same. That may be part of the reason why you have more --

MR. BETLACH: Well, just very briefly, on our authority, we are now a State agency, but we're exempt from some of the procurement laws in the State, so we have a lot more flexibility in terms of the waiver process. Because it's something that we regularly go through, we have a lot of the staff competencies in-house. We have in-house actuaries. We have a staff that's dedicated to the waiver and working on the waiver. So that's something, again, over time, that we've built just because it's such an important part of the program.

MS. HARR: So, we were hopeful that, as Robin said, for each of those nine waivers -- the home and community-based waivers and we have two Freedom of Choice waivers -- we had quarterly reporting, so --

and she said you had the cost effectiveness test. We would have to do a cost effectiveness test quarterly on each of those discrete home and community-based waivers. Now, under 1115, there is one -- it's sort of one quarterly report. It's all rolled up. And it's the majority of our Medicaid spend, and you're looking at budget neutrality across really the span, the entire scope of the program, versus having the different reporting requirements.

So we were optimistic that that would provide some administrative simplification. The issue that we're having right now is that we have not -- we have the waiver approved, October. We have not yet implemented managed long-term services and supports. So this disagreement that we are experiencing is whether we are now moving to one set of reporting requirements under the 1115 or will we have to continue to maintain the reporting under the other -- with the other waivers until such time that we have managed long-term services and supports, and there is a difference of opinion within CMS that we're working with them to resolve.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: Could any of you, since Valerie brought up this quarterly reporting, is there any value to you in quarterly reporting? I mean, it's hard to imagine in programs of this complexity with these populations that there is -- unless this is, like, a one-page form, which I doubt that it is --

[Laughter.]

COMMISSIONER GABOW: -- of what --

CHAIR ROWLAND: This is our champion of simplification.

COMMISSIONER GABOW: What possible benefit is being accrued to either you, the beneficiaries,

or CMS with this? And is that an area that we should explore in terms of recommendations for simplification, about the nature of reporting back?

I mean, I'm a data girl and I love evaluation, but it's hard for me to see what you could possibly be evaluating quarter over quarter in something of this nature. So could you talk about that?

And then you've brought up this issue about getting different messages from different components, and maybe the rest of you could talk about it, and is there clarity on what you are supposed to do when Person A says yes and Person B says no? And would there be some -- I mean, in talking about templates, so that people would -- I mean, it's going to be that way as long as we have human beings with different skill sets in any enterprise. But is there clarity about what you are supposed to do to expedite that kind of mixed message?

MS. HARR: Well, on that, I think it's through experience, and none of the discussions have ever been adversarial in any way. It's always been -- and everybody at CMS has always, through this process, is always trying to be helpful and find an answer. It's no different than if you would ask probably ten people in my agency. You might get ten different answers because -- and so I think that the best thing is, to the extent that there is written guidance, policy that you can turn to and it's not subjective, there's not room for interpretation, would be the preference.

I think protocol. We always start with our region, and if they can't find the answer, they usually will call on somebody and try to get an answer. Or there are times when I know I need to elevate it and go to someone else within the organization. I think it's just through experience that you learn how to sort of work through that process.

With respect to the quarterly reports, I don't -- I can't speak for what CMS does with them or how useful they are. They would not be reports that I find useful. I absolutely believe in -- a strong believer in monitoring quality, oversight, data. We have an incredible amount of encounter data and claims data. We have our shared data warehouse. And I am really trying to move towards having dashboards. So it's not that I would never -- you know, I think that reporting is essential, but the quarterly reports really aren't in the format, or it's not a report that I honestly would actively go to get information about the effectiveness of the program or how the quality of the program is going.

MR. BETLACH: I would just echo all of that, and there's clearly opportunities for administrative simplification and the first place I would start is the CMS-64 that we have to report on with all the various budget neutrality groups, with retro reporting. I mean, our quarterly 64 is overly extensive and I don't know what CMS does with it, but it clearly goes far above and beyond what we would need for our information purposes.

CHAIR ROWLAND: Judy.

COMMISSIONER MOORE: You know, it's actually really interesting for me to reflect on all the things that you three have said. It's been really an excellent panel. And, you know, in the home and community-based waivers, in the Freedom of Choice, with all the waivers that we've just come so far in 30 years.

But, and this goes back to what David said a few minutes ago, can you all reflect on what -- if there is a more structured way to capture the experiences, the learnings, the best practices. While I understand that States learn from one another and always have and will continue to, it's a bit catch-as-catch-can and I am

wondering if you have some ideas that we should consider for a better way to learn in the Medicaid program.

MS. COOPER: I can speak to the population of individuals with intellectual and developmental disabilities. We collect a national data set on the experience of people in the home and community-based waiver called the National Core Indicators. All 50 States will be doing that eventually. There's a project now to bring -- we have, I don't know, 35 -- I can't remember the number -- in, and with a grant, we're bringing in all the States. And this is a core data set that is about system performance around people with intellectual and developmental disabilities.

So we have this national data set, nationalcoreindicators.org, and, you know, I think it's important to look across populations for learning and within populations. So this is a "within population," but it's across the entire country, and there's a lot we've learned. We've learned about medication use. We've learned about the quality of case management. We've looked at turnover. We've looked at people's experience of, do I have choice in where I live? Does my case manager respond? You know, a lot of, lot of good questions.

And we have a national data set and you can look at it and call up indicators. It's published. It's public. And so we're doing that in intellectual and developmental disabilities and we're now partnering with NASUAD to develop the same thing for the populations of seniors and people with physical disabilities, as well. So there's one.

MR. BETLACH: So, from the State perspective, you know, the National Association of Medicaid Directors is working to establish various collaboratives. We held a session in Phoenix in January where we had seven States present to talk about our oversight of managed long-term care and long-term care and managed care in general, and then Tennessee held one also for seven States the next month, and so we're

looking to add another class like that, an opportunity for States to come together and really talk about best practices. So that's something that NAMD is doing.

I know at the Federal level, they had staff and consultants that came to Arizona to look at managed care last year and what we do and spent three days and looked at plans and talked with advocates and members and spent some time with our staff, and then I think some of that work is now forming the direction that they are proposing as it relates to managed long-term care and support services. I don't want to speak for them, but I know that they're working on coming up with some guidelines, I think based upon the experience that New Jersey and some other States went through.

So some of that is occurring. But, again, how do you replicate it in a more streamlined fashion and roll it out as part of these waiver processes or statutory changes? I think that's the bottom line that we would like to try to all get to, right? So there's clearly opportunities there.

CHAIR ROWLAND: Sara.

COMMISSIONER RILEY: I'm wondering, you know, because it takes so long to put all these different pieces together in your head, but given the -- given so much of our Commission's really statutory mission, which is to think about access measures, whether we might not be spending time, particularly with State officials and advocates, on the question of how to measure access in various contexts and how to get better real-time reporting around access, which in turn, I would think, might allow us to at least consider easing up on the narrow range of service delivery arrangements that are allowed in the statute.

You know, we have these very broad measures of access, the Equal Access statute, which is useful up to a point, but not really, because some of these services don't have a counterpart in the private markets.

We're talking about services that are quite unique to Medicaid and is where Medicaid is the most powerful.

But I think in the subject area of access, access measurement, and access accountability, and the ability to do a much better job on real-time measurement may lie the answer to where we might go in the statute that would get us away from what seems to be an administration mode that we've fallen into that doesn't seem to be serving anybody well, so --

MR. BETLACH: So, to that point, we clearly want to engage in that dialogue, at least from the Arizona perspective, because, as I think about it and as I watch how the conversation has evolved through the proposed regulation that CMS issued and other things like that, I think we have a lot of thoughts in terms of what is more real-time. We look at grievance and appeals on a real-time basis. We look at any gaps in coverage for home and community-based services on a very real-time basis. We have very well established standards that our MCOs have to meet in terms of network requirements, and we measure against that on a very real-time basis.

So, to me, all of those factors are much more relevant to access than establishing a cost-to-charge ratio that looks at payment.

COMMISSIONER ROSENBAUM: Right.

MR. BETLACH: And so, you know, those are the types of things in Arizona that we're engaged on in overseeing and monitoring members' access, plan performance in a real-time basis.

MS. COOPER: One comment on the budget neutrality. We have to remember it's an artifact of what 1115 was about. You were going to take the same money and get waivers of regulation in order to do something new and different that was going to spend money more sensibly. So it's interesting to me.

Budget neutrality doesn't exist on the State plan side. The State has the money. You can cover the benefit. You can open up as many new benefits as you want and --

It's very interesting to me that we have this cost neutrality on the home and community-based (c) waiver. We have the budget neutrality on 1115 and the State plan is wide open. Nineteen-fifteen (i) is a wide open benefit. So it's very interesting to me. It seems to me it's time -- it's like an accretion of really good ideas, but it's kind of a big accretion, so --

CHAIR ROWLAND: Okay. Can I ask another question with regard to we've been told, obviously, that program integrity is a very important part of the Medicaid program, and Trish raises, as I often do, the balance between up-front program management having adequate resources to prevent the need for program integrity. But are there program integrity requirements that are more strenuous or different around the waivers, or how do the waiver activities interact with program integrity?

MS. COOPER: [Off microphone.] Eleven-fifteen or --

CHAIR ROWLAND: All of them.

MS. COOPER: Well, (c) does come with an overlay of quality requirements. There's a whole quality management and a quality improvement plan that States must fill out. There's metrics that States have to gather. And, in fact, we're working closely with CMS right now to make those more meaningful. But there's requirements on collecting information about abuse and neglect, about the use of restraints, about medications, about certain compliance areas, as well. So the (c) waivers do come with significant quality reporting and States have to develop and report on those measures.

CHAIR ROWLAND: But if we're looking at efforts -- because of Patty's emphasis on simplification

-- to improve the way program integrity activities work, is there some particular set of things we should look at with regard to that interaction with your waiver activities?

MS. HARR: In New Jersey, our Program Integrity Office is external to the Medicaid agency. It's in the Office of the Comptroller, so they're independent. We have a Memorandum of Agreement between the two, but they're independent of the division. But we work collaboratively. So we make sure -- we always make sure they're aware of the programmatic changes that we're making in the Medicaid agency.

So with respect to our 1115 waiver, especially moving to managed long-term services and supports and the movement to managed care that we've undergone in the past two years, they've evolved. So now they have a much stronger -- they meet with the health plans and the HMOs, investigative units, on a quarterly basis and are much -- and they're engaged independently of us in meeting with our HMOs and have -- and contribute to the contract language around program integrity and lay out the expectations and the requirements of our health plans.

So they -- and they also now audit our HMOs. So they have also evolved and changed the way the Medicaid Fraud Division is doing business to come along with the change in the way the Medicaid agency is delivering services.

CHAIR ROWLAND: Okay.

MR. BETLACH: There's many facets to program integrity, and when you look at it from a comprehensive nature, you've got the oversight of the plans. You've got oversight of providers. You've got member program integrity issues. And I don't know that there's a direct link per se in terms of standard conditions in our waiver, but clearly it's an overarching concern for our program.

And I think one of the challenges that Medicaid faces, and we're just starting our work with CMS around this, is leveraging all of CMS. And when I say all of CMS, I mean bringing Medicare to the table. So they have a lot of data analytics. They have information that they've done in terms of investigations. And so where we're really trying to focus some of our energy is trying to make sure that we're leveraging the full extent of our Federal partners' capabilities.

CHAIR ROWLAND: Great. Thank you. Any other questions?

Well, I want to thank you. It has been a long afternoon of waivers. We have learned a lot. We have a lot more to learn. And we really appreciate your coming here, your sharing your experiences with us, and this won't be the last you've heard from us, so thank you very much.

MS. COOPER: Thank you.

CHAIR ROWLAND: And now we'll take a brief break and come back to talk about express lane eligibility.

[Recess.]

CHAIR ROWLAND: Hi, Moira.

I think we're all set to go forward for a last session of the day, which is not the least, to look at Express Lane Eligibility and is it really one of the vehicles through which program eligibility simplification can occur. So we are looking forward to your presentation even though it's beyond two hours on waivers.

SESSION 5: EXPRESS LANE ELIGIBILITY

* MS. FORBES: I think it will seem very express. It's just me, 20 minutes.

So what we're going to cover today -- so, Express Lane Eligibility, or ELE, is a policy option. Cindy

Mann actually mentioned it earlier today. It's designed to help states streamline enrollment of children into Medicaid and CHIP.

So the purpose of this session is to brief you on the design and implementation of ELE, present some preliminary findings from an evaluation -- an ongoing independent evaluation -- of the program, familiarize you with some of the key policy issues and discuss future steps.

So, in 2009, Congress reauthorized the CHIP program through 2013 and also included a number policy options and financial incentives for states to increase enrollment of children in Medicaid and CHIP.

So ELE is one of eight policy options states were encouraged to adopt in order to receive performance bonuses. States that implemented at least five of these eight strategies and achieved enrollment increases compared to a baseline could receive tens of millions of dollars in bonuses between 2009 and 2013. I think it's over $500 million in bonuses that have actually been paid out.

So, if you remember in 2009, during the recession, states were facing a lot of budget pressure and Congress was concerned that states would try to reduce the rolls. So these incentives were designed to encourage states to maintain expand enrollment but to do so through mechanisms that would help reduce administrative burdens on the states and make things easier for applicants.

It wasn't just do anything. It was here are some specific strategies that we really want to try.

So, Express Lane. It allows states to rely on the findings of other public agencies such as the School Lunch Program, SNAP, TANF and WIC to determine whether a child is eligible for Medicaid or CHIP. And I'll get into more later about that.

The option was originally set to sunset on September 30, 2013, which was the same end date as the

original CHIP reauthorization. The ACA extended CHIP through 2015, and H.R. 8, which was the Fiscal Cliff Bill, extended Express Lane through September 30th of next year, 2014.

The CHIP Reauthorization Act also required the Secretary of Health and Human Services to conduct an evaluation of the impact of Express Lane on enrollment, administrative costs and the accuracy of eligibility determinations. The executive summary of that interim evaluation report was provided in your binders, and we can share the link to the complete report if anyone would like it.

Now the Secretary was supposed to report to Congress by September 30, 2012. ASPE actually submitted the report in December of 2012, and that was an interim report. They will submit a complete evaluation report, they hope, by the end of this year -- hopefully December 2013.

And the reason this is significant for our discussion today is that MACPAC is required to review reports submitted by the Secretary to Congress and submit written comments to the appropriate committees of Congress and the Secretary. So we'll watch for the release of the final evaluation report this winter, and we'll brief you on the findings at the time so that we can discuss whether the Commission has any formal comments or recommendations based on the complete findings.

CHAIR ROWLAND: We are to submit our comments within six months of the submission of the report; is that correct?

MS. FORBES: That's correct, yes. So we'll keep an eye out, but ASPE thinks December.

So today I want to give you some background and information on the preliminary findings so that you can start to get up to speed. And when the final report comes out, we'll circle back.

All right. So like everything in Medicaid, the Express Lane Eligibility option, as designed, gives states

many choices in how they implement it. And when we get a few slides down, you'll see that it has, of course, been implemented in a different way in every state that's chosen to do it.

But some of the key variables are:

The most important one, I think, is which partner agency the state will accept the eligibility information from. The statute gives states the opportunity to use data from a number of programs that serve low income children and families.

One significant thing is Medicaid and CHIP. In states that have separate Medicaid and CHIP program, they can accept a determination by the other program. So it doesn't affect a lot of states, but that's helpful in states where there is a standalone CHIP program.

The others are TANF, child support enforcement, the Supplemental Nutrition Assistance Program, or SNAP -- food stamps -- the National School Lunch Program, the Special Supplemental Nutrition Program for Women, Infants and Children, which is WIC, Head Start and a couple other agencies that administer federal low income programs under the Housing Act, the Child Care Block Grant and things like that.

States can also rely on information from, the statute says, a similar agency. If the state has a general assistance program or something like that, they can use it. And they can also use state tax information.

The other design elements states can choose include whether to use Express Lane for Medicaid, CHIP or both; whether to use it for initial determinations, for redeterminations or both; and, significantly, whether to use it to identify children who may be eligible or to actually enroll them. There's sort of an outreach option, and there's an enrollment option, and states can decide whether or not to use it to substitute for the screen and enroll process for CHIP. The statute gives states a lot of flexibility in how they implement it.

Just to be clear on the last one, the sort of big policy change that is in ELE compared to prior authority that states had is that they can take the information -- the decision made by another program -- and use it to actually enroll a child in Medicaid or CHIP. Even if the rules for that program around how you count income, what the definition of a household is -- all those kinds of things -- are different, it doesn't matter. You're allowed to accept it.

So, if the income threshold for food stamps is 100 percent of federal poverty level and you get information from the food stamp program that a child is eligible but their income is 95 percent and that's below your Medicaid threshold, you can just enroll them.

It's not a matter of using the information to fill out the application and check against the Medicaid rules. You actually just accept it, enroll them and move on. So that's really the big policy change in ELE.

There are a couple limitations in how states can use ELE that certainly affect implementation.

A significant one is that they can't just share data without getting the consent of the people whose data is being shared. There are privacy rules around this. So, before TANF or WIC or School Lunch or whoever can give the information to the Medicaid agency, people have to be notified of that.

So it either requires a sort of affirmative notification process that people have to opt into or opt out of, or it requires maybe including a checkbox on the application, which means other programs have to change their processes. But that is a significant protection in this.

If the state chooses to use ELE information to automatically enroll children, they have to obtain family consent and they have to provide information to the family on how to access services.

And you cannot use ELE information to deny coverage. If you get information -- if a state does a

match and they get all the information from the WIC program and they see that a child has income -- family income -- of 150 percent and that's above the Medicaid limit, Medicaid can't deny that child Medicaid eligibility based on the other agencies' information. They have to, at that point, get information and go through the full Medicaid process before they can deny coverage.

So it's only a way in.

So I used information from the evaluation report for this slide.

As of April 1 last year, CMS had approved 9 states. CHIPRA was passed in early, I think, February -- 2nd or February 4 -- 2009, and New Jersey was the first state to get the state plan amendment paperwork in. A handful of states picked it up in 2010, and a few more in 2011. It turns out 4 more states had also adopted Express Lane -- Massachusetts, New York, Pennsylvania and Utah -- in 2012.

The evaluation began in 2011. So the initial report only includes the states that had implemented Express Lane before 2011. They wanted at least a year's worth of experience. So it's just those first six states.

They will include information on all nine of those states in the final evaluation report. I don't think that would include the states that came in 2012 just because there won't be enough experience.

So this is a table taken from the evaluation report. As you can see, of the first six states to implement Express Lane, there's a lot of variation in which elements they chose to pursue, including which agency they partner with, what they do with the information. And, as you can see, they end up with a lot of variation in how much take-up there actually was as a result of Express Lane.

A lot of the early adopters used Express Lane to identify potentially eligible children and conduct

outreach. They might get information from a partner agency or from the state tax agency, pre-populate the applications, and to the family, say: Looks like you're kid is eligible. Sign this. Send it back. We'll give you a card.

A few states, primarily Louisiana -- and, to a lesser extent, Alabama has been phasing this in -- actually used the information to make a determination of eligibility. And you can see that they had a much greater enrollment up-take because they did the process and had people opt out as opposed to the states that did outreach and counted on families to opt in.

But also, we'll see that the choices that states made here also affected their administrative costs and any potential savings they saw.

This is the evaluation. The Reauthorization Act doesn't just require a formal evaluation, they actually specified what they wanted to see in the evaluation, which includes an assessment of the administrative costs and savings related to using Express Lane, an assessment of whether ELE improves the state's ability to identify and enroll eligible but un-enrolled children, recommendations for legislative and administrative changes that would improve Express Lane as a method to enroll and retain children in coverage, and report on the percentage of children erroneously enrolled in Medicaid and CHIP based on ELE agency findings.

So this interim report really addresses the first bullet. They were able to get some information on enrollment numbers and some information on administrative costs and savings. They'll report on the final three bullets here, and they'll update the first bullet with information from more states in the final report.

They're looking at a lot of different things. They've got information from the states on the cost, the enrollment numbers, utilization. They're looking at information on all states from the CHIP Statistical

Enrollment Data System. They're conducting case studies. They're doing interviews. And they're surveying all states, including those that have implemented it and states that have chosen not to do it to just get a variety of perspectives on it.

So the interim evaluation report found, I would say -- I'll go through these next couple of slides.

They found sort of modestly positive benefits of doing Express Lane. The states that they talked to reported that applicants benefit from ELE in several ways. The applicants could submit fewer documents. They could have fewer interactions with state staff. And their applications were processed more quickly than standard applications.

One good thing here is that there were some positive spillover effects. Specifically, states found that once they developed linkages, particularly to tax data, they could use it to do ex parte verification for non-ELE applications, which meant that they could speed up the processing of some non-child applications. And also the staff time that was not spent processing all these children's applications could be redirected to process other applications, which sped them up.

So the states that implemented this felt that this was overall administratively better or a benefit to their process.

One interesting thing was the administrative savings and enrollment gains were linked more to the data quality and processes and not the type of partner.

So they compared the administrative enrollment impacts to the state-designed decisions, and I think one of the things that they were trying to look at was, out of all of these choices for different agencies, is there one that is right? Should it always be food stamps? Should it always be WIC? Is one of those like the

source for data?

And what they found was, not really. It matters more in that state:

Does the partner agency have good data?

Are you able to establish a good linkage with them?

Can you make that relationship work?

And does that agency have information on kids who are eligible but not enrolled?

Because you could have great data from the TANF program and you could get daily matches and you could be having all these wonderful -- all this information coming in. If 99 percent of the kids getting food stamps are already eligible for Medicaid, it doesn't really get you anything. It's the same kids.

So it's trying to find a data source with good data that also has reached pockets of children that you have not been able to reach through Medicaid.

So that's really the challenge for states -- to figure out what is the agency, what is that data source.

It does look like although only one state used tax data, one comment that they made is that does seem to be a good source. Families that apply for WIC, that apply for SNAP, that apply for TANF often know about Medicaid. They may go to -- their case worker may tell them that they may qualify for Medicaid. So people that come into a lot of these programs that support low income families often do know about Medicaid and are aware of the process.

The tax rolls capture a lot of folks who may not come into the social services system but may be filling out tax -- may be low income but may be applying for low income tax credit or the earned income tax credit, particularly in states where there's also a state earned income tax credit.

So that may actually be -- they didn't have a ton of evidence for this, but there was a sense that that might actually be the best source. But it was not what most states did in this first couple years of ELE.

Comparing enrollment numbers between the states that used ELE to enroll children in Medicaid and CHIP and those that use it just to conduct outreach -- a couple slides back, if we went back -- the states that just used it for outreach. We can see New Jersey, Oregon -- those are much, much smaller numbers than the states that actually did a full determination, like Alabama and Louisiana.

So, the impact. Again, there's not a lot of data. Only six states were reviewed, and most of those only had a year of experience, and the systems are, as always, not often detailed enough for a rigorous assessment of costs and savings.

It appears that ELE has minor impacts on administrative costs. The states that use ELE to identify potentially eligible children and conduct outreach incurred all of the costs of setting up the partnership and getting the data and doing the mailings and, as you saw, may have enrolled like 5,000 kids. So they may not have saved enough on those expedited applications to make up for all of the up-front investment in the short term.

The states, like Louisiana, that literally got the data, did a match and flipped a switch and sent cards out to 10,000 kids in one day, did perceive significant staff savings from implementing Express Lane.

And those states said that they reallocated staff or they found plenty of ways to absorb that staff time. No state reported that they either added or eliminated positions because of ELE.

So the evaluators looked at enrollment gains two ways, both from state-reported data and from trying to model national data. If you look at what the states reported, there's very little evidence that Express Lane

increased the number of covered children or resulted in meaningful differences in retention. The numbers are very small, as reported from the states that implemented in 2009 and 2010.

The evaluators also conducted a multivariate regression analysis. They looked at enrollment trends in Medicaid and CHIP from 2007 onward and compared Medicaid and CHIP enrollment trends between the Express Lane states and non-Express Lane states to try to identify any noticeable spikes in enrollment in the ELE states following the implementation of the policy.

So they looked at all 51 states, and they tried to account for a lot of variables, such as changes in economic conditions, state implementation of other non-ELE policies.

And their initial assessment is that there is a relationship; there is a positive impact, of Express Lane on Medicaid and CHIP enrollment that they consider to be robust evidence for how that ELE expands coverage to children that would otherwise be uninsured. They estimated that Express Lane increased total Medicaid enrollment by 5.5 percent, which is significant.

So, again, that's by modeling it, using national data sources and then sort of trying to match that up against what the states were tracking and reporting themselves. And that will be updated in the final evaluation as well.

So, program integrity. CHIPRA specifically addressed concerns that Express Lane could introduce enrollment errors.

So states were required to implement systems to track Express Lane cases. They had to have a separate code in their system so they could identify those and isolate them in the data so that error rates could be measured.

And states were required to annually conduct a full eligibility review of a sample of these ELE cases to determine whether they were accurate.

They did exclude Express Lane cases from other eligibility reviews, such as payment error rate measurement and Medicaid eligibility quality control so that they wouldn't be double-counted.

And the statute does say that if these annual state measurements reveal error rates of 3 percent or more in the first 2 years states need to identify actions to reduce the error rate and, in theory, the federal government could disallow payments above that 3 percent threshold.

As of November 2012, CMS had not issued guidance to states on how to conduct these audits. And I could not find, nor could the evaluators, any information on any state measurements to date. The interim evaluation report did say that state-level error rates would be put in the final evaluation report, but I don't have any information to share with you now on what findings have been to date.

So, after the CHIP Reauthorization Act was passed in 2009, obviously, the ACA was passed in 2010. It required states to transition to data-based eligibility methods to qualify individuals for Medicaid, CHIP and exchanges, and required states to establish, verify and renew eligibility using reliable data whenever possible.

So there's not necessarily a direct line between Express Lane and the ACA, but there is a sense -- part of what the interim evaluation discussed is that states that have done this -- it's a big -- folks who have worked in states know it's a big cultural shift from a very paper-based, requiring a lot of verifications -- you know, the whole process of getting people -- you know.

To determine eligibility for Medicaid and CHIP has been very detailed and paper-intensive, historically. And the ACA tries to really get away from that and move to ex parte and use automatic data

matches and things like that.

So states that have done Express Lane may have done some of the groundwork in terms of not just establishing linkages but in changing the cultural mind set of case workers -- that you can just rely on data that you're getting out of a computer and rapidly process, in real-time, an application and be satisfied with that. That's been difficult. I think that's been a stumbling block for a lot of states.

The folks who have done ELE so far -- I think they describe some of their comments in the evaluation report. And no one would say, absolutely, this prepares us for ACA, but they said it should help. So it's modestly positive.

One thing that might be helpful -- the statutory authority only allows the enrollment of children through Express Lane, but states can use some of these principles to prequalify or pre-enroll some of the newly eligible persons prior to January 1. Under ACA, estimates vary, but at least 30 million uninsured, non-elderly individuals are expected to become newly eligible for coverage, and states are going to have to do eligibility determinations for all of those folks.

So there are a couple groups -- parents of children who are already in the system, adults who are enrolled in limited benefit programs, low income adults enrolled in SNAP. States can establish some linkages or use the information that they already have to at least do the outreach, to prepopulate applications and do some of those things, which may be another tool that they can use to help deal with the influx that's going to happen between October and January of this year -- January 2014.

So, final evaluation. They're surveying all 51 programs. They're going to, like I said, look at a couple of additional states in depth. They're going to conduct case studies of states that have implemented some of

those other methods that CHIPRA envisioned for simplifying and streamlining enrollment. They'll also look at the benefits and potential costs of various methods compared to Express Lane. They'll address all those remaining evaluation components. And they'll report on the percentage of children recently enrolled.

So, as we said, the Commission can comment on the evaluation after the final full report is released but can consider today whether there are any questions or feedback based on the initial evaluation.

Some of the issues that Congress is going to need to consider and that the Commission could weigh in on are on the screen.

Like I said, we have some of the information. We'll have more information later this year. But I did want to give you an overview of the issues and see if there's anything based on what I've shared to date that we can go back to ASPE with or at least keep on the back burner until this fall.

CHAIR ROWLAND: Sharon.

COMMISSIONER CARTE: Moira, when I reviewed the material, I was struck by the fact that you see the eligibility increase in enrollment but nothing at retention, and I was wondering if you had any information about that, or insight.

I'm wondering, is that just because the processes are set up such that they're expediting more enrollment and it's not happening at renewal periods?

That's kind of odd, and that would be really important, I think, for the value of this, overall.

MS. FORBES: They are looking at that.

So a couple states explicitly decided to use it for renewals and use it extensively.

I think there were some policy questions at first as to whether you had to go ask for permission again

from the applicant to use updated information if you really rely on it again; or if once the person was a Medicaid person, could you continue to use SNAP information, or at that point did you need to follow the Medicaid process. I think it took CMS a little bit of time to hash through some of those policy issues with the states, which may be why at this point there's not a lot of information on the extent to which it was used at renewal.

But Louisiana certainly feels like if we got information from these other programs within a reasonable amount of time, we're going to take it. And they, I think, just basically don't --

COMMISSIONER CARTE: Right. I think they have a stronger ex parte process.

MS. FORBES: They did before, yes.

COMMISSIONER CARTE: So that means that later on we could see that.

MS. FORBES: Yes.

COMMISSIONER CARTE: That, still.

MS. FORBES: Yes. Sure.

COMMISSIONER CARTE: Okay.

CHAIR ROWLAND: Patty and then Judy.

COMMISSIONER GABOW: I have four questions. I'll do them one at a time.

So is there any information about how providers feel about this -- because anything which expedites enrollment, I think, providers like because otherwise a person comes in and they don't know their status, et cetera. Is there any data on that or any attempt to get any data?

MS. FORBES: It wasn't one of the specific questions that the statute asked the evaluation to address.

So they don't address it.

I didn't look for any -- I didn't see anything in my other reading that I did.

I think -- well, there are two things.

Louisiana has very aggressively moved to get people on the program and keep people on the program in an opt-out way -- like they basically send you a card, and if you use the card you're consenting that you are enrolled; you agree that you're enrolled.

They don't have managed care. So it's not like they start writing checks to a managed care plan. The person may or may not even be aware. So that's partly why that works in Louisiana.

I think it's helpful in that sense -- that they're using it for retention, and so they're avoiding the breaks in coverage that I'm sure are problematic for people who may be on, not realize they've lost eligibility, go to the doctor and then they find out.

There are fewer breaks. There's less churn. And so I think from that sense it's probably a lot easier on providers in Louisiana to have these kids just be continuously enrolled and re-upped every year, right on schedule.

COMMISSIONER GABOW: Secondly, it's a very interesting mix of states. So they're not your usual suspects in many ways. And I don't know if you have any thoughts about why this group opted in, why others didn't since it's sort of an unusual array.

MS. FORBES: There's a lot of money on the table. A lot of states earn 10, 20, 30 million dollars in bonuses, and I think given the economic circumstances, to implement this -- I mean you can see New Jersey didn't get a huge bump in kids, but they did a lot of things that together added up to increases in coverage, and

they were able to earn some bonuses. So I think that probably helped.

I think a lot of states had been doing aspects of a lot of these things, and this helped give them the incentive to actually really make the investment to get over the hump and make it happen.

But like many of the states had been -- partly as an effort to decrease state administrative spending -- I mean a lot of these outreach strategies are designed to make it easier for the states and less paperwork for the states.

So, I mean, part of what you're seeing here is it's making already eligible people easier to enroll with less cost to the state, administratively, and so I think that's also perceived as beneficial.

This isn't an eligibility expansion. This is --

CHAIR ROWLAND: But, Patty, some of these states are states that had already been very aggressive. Louisiana was a very aggressive state in terms of implementing CHIP.

COMMISSIONER CARTE: Right, but also I've suggested it has a lot to do with the ability of states, going back to Moira's point about the quality of their data processes.

Early on, when I was CHIP Director, I approached our tax revenue department and for various -- I mean an antiquated system that was not productive. I worked with our national -- the Department of Education School Lunch Program. And they did accommodate -- you know, they were able to accommodate sending CHIP forms and letting parents know that they could enroll. And that was part of our build-up, but it wasn't as timely as it needed to be.

So I still don't see that right now as a potential field to go to, to help.

And, in West Virginia, it wasn't really so much about -- we didn't have to worry about boosting

enrollment because we're really up there quite a bit. So any expansion would be limited.

But it's just really about eliminating gaps and helping providers have more predictability.

CHAIR ROWLAND: So Patty has more questions, and then we have Judy.

COMMISSIONER GABOW: I have two more.

I think we understand, actually from some of the information from the election, that the more sophisticated your algorithm is and the more variables you're able to put in it the more likely you are to identify the targeted person for whatever it is you're targeting.

So are these states using multiple variables?

You mentioned some used tax returns. Some used enrollment into other plans. But you're probably going to be better off if you have three or four variables that you can feed into it. So I wasn't clear if this is a multifactorial algorithm that the states that are doing this are using.

MS. FORBES: I've talked to the folks in Louisiana, and I read a lot about their experience. It's extraordinarily difficult to establish one of these linkages because they're -- especially when they're different state agencies -- the way that a case is described, the field formats; when there were initial matches, like half the records kicked out just because they weren't matchable. And that was a state that really had already done a lot of work.

And so I haven't heard of any states trying to do that because the up-front challenge in doing it is significant.

And I think sort of like everyone managed to get one, and they're seeing how that goes.

Down the road that might be effective, but I don't know that the evaluation has found any state that's

tried that.

COMMISSIONER GABOW: I think there are groups who are trying to do that for the upcoming enrollment that's going to happen with the expansion of the ACA. So it must be feasible because there are entities that are trying to do this.

So it's just something to think about.

Then my last thing relates to the error rate. I mean 3 percent seems like a low error rate to me. How does it compare to the error rate for other programs?

I mean WIC program, Medicaid that's not using this or CHIP that's not using it.

I mean I don't see that, but it seems like it's comparable.

MS. FORBES: The evaluation doesn't include any information on the other programs, but again, I did read that the states -- one of the things they are advised to think about when they're looking for partners is to get that other program's error rate because if you're using WIC data and WIC is reporting an 8 percent error rate, then that's problematic for you to accept their data.

So that is one thing that states are advised to get information on. If another program has a very low error rate, you can feel more confident that when you're relying on their information that you're not setting yourself up for errors.

But I don't know that the evaluation will look at -- I don't know what they're going to end up including on the error rates.

CHAIR ROWLAND: The other problem with error rates is that we only count people who got on wrong, not people who got left off who should have been on.

Judy.

COMMISSIONER MOORE: There is a quality control -- eligibility quality control required, and I want to say that error rates are supposed to be kept 5 percent or 7 percent, or something like that. A lot of states are doing different -- anyway, that may be something you want to look into because it's actually -- I think it's a relevant question. It's a good question.

I'm actually perplexed because I thought I remembered a lot of experience, or at least some experience, with Express Lane Eligibility before this was enacted in CHIPRA that formed the basis for the reason they enacted it in CHIPRA. And I would have said it was in California counties.

MS. FORBES: Yes.

COMMISSIONER MOORE: Big California counties, some of which are bigger than states.

And I don't know if I'm thinking of something that was like a paper exercise that didn't really work because I didn't -- I, frankly, didn't realize this was difficult based on what I have read in the past.

And it's kind of sad when you think about how siloed everything is, that this is so difficult.

But, anyway, I guess I wanted to understand the history of Express Lane Eligibility and how it got to be in CHIPRA because I thought there was some factual basis for having adopted it. That was probably under a waiver, but there were programs that did this before.

MS. FORBES: Sure. I mean the 100% Campaign in California was a strong proponent of Express Lane, and they -- prior to the authority provided in CHIPRA -- and Sara can correct me if I'm wrong, but I think I read this. That information could be used on an ex parte basis. So you could accept the information from other programs, but you still had to conduct the Medicaid -- you had to apply the Medicaid rules.

So you could get the information. You didn't have to go back to the family and ask them for it. But you had to run it. The case worker still needed to put it in a Medicaid application, apply the disallowances, calculate the household the right way and all of that sort of thing.

So it didn't save as much on the caseworker side, and we didn't necessarily have the information from the other programs to do a full -- you know, to always -- because of all of the rules.

So that was -- CHIPRA explicitly allowed you to say if they calculate income under their rules or they have a household defined as this many people under their rules, you can accept that. You don't have to figure out what Medicaid or CHIP would have done in your state.

And so I think that's the big difference between what was tried between 2000 and 2009 in what authority CHIPRA actually provides.

Is that right?

CHAIR ROWLAND: Okay, Norma was next.

COMMISSIONER MARTINEZ ROGERS: Do you happen to know whether or not the states that weren't on here just didn't want to be a part of it, or how did that work?

Are these just states that gave you the information?

MS. FORBES: So now there are 13 states that have done this. There were eight explicit policy options given in CHIPRA, and an enormous amount of states did at least five of the eight in order to qualify for the bonuses. And some of those states may have chosen things that they were already doing or on a path to doing.

So the fact that not every state did this -- they may have done a half a dozen other things, just not this

one. And I think in a lot of cases it's because they were already, like I said, down the path.

The other options were 12-month continuous eligibility, which a lot of states already had, elimination of the assets test, having a joint Medicaid or CHIP application, automatic or administrative renewal, presumptive eligibility, premium assistance and elimination of face-to-face. So, if states were doing some other handful of those things, they could qualify for a bonus without the lift involved in doing this.

CHAIR ROWLAND: Okay, Sara.

COMMISSIONER ROSENBAUM: You touched on the issue that has always confounded me about Express Lane Eligibility, which is that increasingly, except in the rare circumstance like Louisiana, the card is essentially meaningless because the condition of eligibility is that you be enrolled in a plan for the vast majority of beneficiaries in the state and certainly for a lot of children.

So I'm wondering; in the states and looking at the states that used Express Lane really to screen people or to sort of start the process as opposed to completing the process, so in a state like New Jersey or Oregon where there's extensive use of managed care, Maryland. Once they had the prepopulated form, I assume they were doing it just to, obviously, ease the enrollment process. But even if they move to a Louisiana format, there's nothing in this study that suggests what the state would then have to do once the child was technically eligible.

I mean that's the irony in this whole movement, which I think we're going to run into heavily, actually, in health reform and that not a lot of thought has been given to -- which is you go in, you apply, you're determined eligible for essentially the financial support, but that does not necessarily mean that you are positioned to get any coverage.

And so I would assume that this report -- because it's a report that focuses specifically on Express Lane Eligibility -- isn't really grappling with the underlying issue.

But the question is whether, if we comment on this, we should consider making observations about questions that sort of lie beyond the scope of this that would be important downstream questions to ask. You know, it sort of is implicit in this but not really.

And part of knowing whether Express Lane Eligibility makes any sense is whether it ultimately results in the use of care. If a family ends up getting a card in the mail but really can't trigger its utility because 12 other things have to happen, then that tells that this is a partial remedy but not completely.

And that's why I think it's also important to understand why Maryland, New Jersey and Oregon are using this essentially as an assessment device, if I understand this, rather than an enrollment device.

But that's the question.

MS. FORBES: Yeah, the New Jersey mailed out like -- it was -- I had the number. It was like 250,000 of these applications, and that's what they got back.

I mean, they were really disappointed in what they -- in the take-up.

CHAIR ROWLAND: Okay, Mark and then Norma.

COMMISSIONER HOYT: I had a couple questions.

Maybe you said this, and I just missed it. Did they do any measurement of how fast -- since it's express, how much faster -- they got enrolled, that now it's one day instead of three weeks or something like that?

VICE CHAIR SUNDWALL: Express is express.

MS. FORBES: Yes. So Louisiana is the -- they applied for most of this.

CHAIR ROWLAND: Poster child.

MS. FORBES: Like I said, they did their initial match, and they literally -- this is like their number that they like to talk about. They literally determined 10,000 kids eligible like when they did their first assessment match.

They said they had reduced the time -- it's in the report. They got it down to -- they said they could do it in about one week compared to three to four weeks.

So I don't know how much -- I think there was less back and forth. There was less having to actually process things.

And there's -- if you look at the evaluation report, we can find it. They had put some dollars and some time. They actually had some time studies, where the evaluators sort of got some information on how long it takes to process a typical application, how long, and they modeled it all out to see what the total savings were.

But it did add up, and Louisiana said it was 69,000 hours a year.

COMMISSIONER HOYT: Wow! Okay. Thanks.

And the other thing this made me think of was -- well, we used to call it SOBRA, the Sixth Omnibus Budget Reconciliation Act. I think it had the special maternity extension benefit for pregnant women up to 185 percent FOPL. And we had a number of state clients that did -- I don't know if you call it presumptive eligibility.

And this is overly simplified. A woman could come in and say: I'm pregnant and I'm broke. I qualify for the program.

And they'd say: Okay, you're in. Here's a card. You're enrolled in a managed care plan, if the state was doing managed care. You can go get prenatal care as soon as they can see you.

So, if that proved to be wrong, presumably, the reason they would fail eligibility is they are too rich; my income is too high.

I wonder if there's anything corresponding here in what they do. That may not be the only reason, but I was thinking the most common reason then for them to be bounced would be your income is too high; you don't qualify.

For the CHIP program in the state, if they do that, do they have the family pay for whatever services are received? Then it's not so much a program integrity issue, I don't think.

MS. FORBES: It's not presumptive. It's a determination, and you're eligible from the point after which they determine you. So I guess I'm not sure if it's exactly applicable.

I mean, they're doing a determination, and they're determining that you are eligible, and then they are enrolling you in the program.

COMMISSIONER HOYT: So they rule you eligible, and then it turns out later that you're not or that the kid's not. If the child saw somebody and received services, then what happens?

It's a freebie, or they make them pay?

MS. FORBES: If they do an eligibility review of a sample of cases and do a full Medicaid review and determine that the child was not, in fact, eligible, I assume -- again, this is where the guidance from CMS has not been issued. But in other programs they do not recoup from the beneficiary, I think, or even the provider. The state just has to pay back the errors to the feds.

CHAIR ROWLAND: Norma.

COMMISSIONER MARTINEZ ROGERS: I guess I just kind of -- well, it's more of a comment more than anything else, mostly.

Texas has over a million children that are uninsured. Forty percent of the women don't receive prenatal care. And therefore, if they don't get prenatal care, they're not enrolled in any program.

I guess I'm just kind of wondering; did we say we don't want this, or do you know?

MS. FORBES: Texas?

COMMISSIONER MARTINEZ ROGERS: If Texas declined to have this program to enroll people?

MS. FORBES: I don't know which of the options, if any, Texas took up, no. I can find out.

COMMISSIONER MARTINEZ ROGERS: I'm just kind of curious. I can find out also. I was just kind of curious.

The other is that in Texas -- and this is something that concerns me. In Texas, your co-pay can either be $3 to $5 or -- there's no between. It's either $3 to $5 or $25 or $35 for your co-pay.

Well, $3 for some people is a lot of money. That's $3 not having food on the table.

I know it has nothing to do with this. I guess I'm just kind of like saying what happens in Texas.

CHAIR ROWLAND: I think we are always going to check on what's going on in Texas as part of our discussion.

I have Denise next and then Sara.

COMMISSIONER HENNING: Following up on Norma's comment, I think there are certain

states, like those that are shaped like peninsulas, where possibly they may not want to do Express Eligibility because they may not want to have people on their Medicaid rolls just because of the state budget and expenses and because they generally just don't like Medicaid. So I think that has a lot to do with it in my state and in yours.

But then I had a question, and this might be a Sara kind of question. If you did want to do Express Lane Eligibility, can you not do it for the adult population, for like the new adults that are coming through?

You know, it says it only allows enrollment of children through Express Lane.

Like you can't -- so, if this is a great idea and it's like the best thing since sliced bread and everybody ought to do it kind of stuff, there's a law that says you can't do it?

COMMISSIONER ROSENBAUM: This is a specific -- a specific -- amendment having to do with children.

And I think the point that Moira was making, which is one of the really interesting questions, is, does the ACA's automated system sort of supersede all of this anyway?

And, if it doesn't -- I mean it will be years before we know. But, if it doesn't, then the question is, if Express Lane is still adding value, should it be added for adults?

But right now it really is only an option for children.

CHAIR ROWLAND: And it was enacted as part of the CHIPRA legislation, which was the extension of the CHIP program, which created us. But then the ACA broadened our function, and the ACA provisions may well supersede the earlier Express Lane stuff that applied to children as it's implemented through the exchanges.

COMMISSIONER MOORE: Cindy used this as an example just today of something they were testing.

MS. FORBES: Two states got authority through an 1115 waiver to extend it to adults. So there is waiver authority to do that.

And there is something in the ACA. There's a Kaiser Foundation brief actually on this that suggested that it may be possible for persons to do the income assessment under the Modified Adjusted Gross Income, the MAGI if you can't make a match with the IRS to get the information. There may be mechanisms to use something akin to Express Lane to get information for other adults and expansion groups if you can't get it through the preferred mechanism, which is to get it through the IRS.

CHAIR ROWLAND: There was Sara, and then now there's Trish.

COMMISSIONER ROSENBAUM: So I'm looking at the summary again, going back to the earlier discussion, and there is this tantalizing line -- maybe you mentioned it, and I wasn't following the thread -- that Louisiana had this tremendous penetration, but then half of them exited coverage within 12 months. And it says, due to a temporary policy requiring them to use their Medicaid card within 12 months.

So I don't know if what we're to take from that is that you get people in, but the follow-on step -- that people are not associating the enrollment with potentially a use of care, which is sort of indirectly alluded to in this analysis but not really explored further.

I have no idea what this temporary policy is or what the researchers meant, but I think it's worth at least consideration by us when we're commenting -- that given our mission to promote access to care, that the idea that you put insurance in people's hands, but they're not translating that into a greater use of care may

mean not that you don't do everything you can to find people and get the insurance, but that you really need to couple it with follow-on activities.

CHAIR ROWLAND: Trish and then Patty.

COMMISSIONER RILEY: I apologize that I had to step out for some of this.

When I read the material, first of all, it's kind of striking. There's so much hype around Express Lane. Then you read it, and it's like, hm.

And I guess what I keep coming back to is so we now have the streamlined eligibility for some Medicaid but not for all of it, and you've got SNAP and WIC.

I sort of want to flip it on the other side. Eligibility is not enrollment. So states still have enrollment issues with providers.

But to flip it on a federal side, what can we do at the federal level to streamline and standardize eligibility across all these programs and then use the federal hub to get information?

So it seems to me instead of all these Band-Aids, to try to make a far too complicated set of eligibility programs work, why not change the eligibility at the national level and standardize that?

States would still need some discretion, I suppose, but it just seems to beg some federal action.

MS. FORBES: And some TANF and WIC programs have said, can this go the other way? If Medicaid has determined them eligible, can we use that?

And they have no authority to do that.

CHAIR ROWLAND: Okay, Patty.

COMMISSIONER GABOW: To pick up on Sara's comment, I think you said that Louisiana didn't

have managed care. So that is a big difference between fee-for-service and managed care.

If this enrollment, this Express Lane, was linked to assignment to a managed care program, then the rules that you have to reach out to your enrollees within so many weeks and months gets around this issue that someone gets a card and they have no idea who they should go see and what this means. And that's one of the big shortfalls of fee-for-service that I think you get around with managed care.

So you might not see that in a state where the enrollment was linked to assignment.

CHAIR ROWLAND: But you would also see in a state that had managed care that making them eligible and enrolling them would mean a payment goes to the managed care plan, whereas in Louisiana they give them a card and if they show up at a doctor, it gets covered. So the state

COMMISSIONER ROSENBAUM: That's right.

CHAIR ROWLAND: So the state isn't liable for all of them that get enrolled until they actually access services.

COMMISSIONER GABOW: Right. It depends what your goal is.

I mean if your goal is to get people into care, then in a managed care state automatically enrolling them gets them --

CHAIR ROWLAND: But it may be why they're more cautious in a managed care state than in Louisiana.

COMMISSIONER ROSENBAUM: But it also means, ironically, that in a state that doesn't use managed care states are getting bonus payments --

VICE CHAIR SUNDWALL: That's right.

COMMISSIONER ROSENBAUM: -- although nobody is really --

CHAIR ROWLAND: Getting care.

COMMISSIONER ROSENBAUM: But then half of them are disenrolled because they never use their services. So that's a significant issue.

COMMISSIONER HENNING: Do we know that these people ever actually got their cards?

I mean --

COMMISSIONER ROSENBAUM: According to this, we do. According to this, it says that half of all the ELE new enrollees exited coverage -- they were tossed -- within 12 months because they registered no use.

So there's clearly some mental connect that ought to be happening that's not because they had no barrier to the use of their cards because there is no managed care, and yet still, half of these folks exited without -- you know, children exited without ever using any care.

COMMISSIONER HENNING: But my question is if you mail a card to about 50 percent of my patients, it's probably not going to go to them because they're going to have moved.

COMMISSIONER ROSENBAUM: Well, that, plus the other thing that I think is worth noting is that the whole -- I mean, in theory, the beauty of this is that you're picking up people not at the point of service. Right? You're picking them up at some life event just like it used to be that when you applied for welfare you got your Medicaid.

And so it may well be that you wouldn't expect much use because they're not enrolling at the point of care.

On the other hand, if we assume for children that they probably ought to have maybe some encounter during a year -- preventive or acute or whatever -- it's a little disconcerting to see that they're just leaving the program without ever having used their coverage and that there's a bonus attached to it, which is sort of weird.

CHAIR ROWLAND: I think we are probably ready to have you come back and brief us on the final, but I think you've gotten a good indication of some of the issues we might be looking to have addressed in the final report or to raise with the conclusions in the final report. So thank you very much for being the last but, as I said, not the least of our presenters today.

And now we will welcome if anyone from our wonderful audience has a comment or an issue they want to raise for the Commission, to have them come forward. We thank you for being with us for a very long day as well.

PUBLIC COMMENT

* [No response.]

CHAIR ROWLAND: I think everyone would like us to adjourn.

So we will adjourn for the day and reconvene tomorrow morning to go over some of our chapters for the June report as well to discuss the new DSH regulation and to also focus on outpatient drug benefits.

Thank you.

ADJOURN

* COMMISSIONER ROSENBAUM: I just want to say I thought it was a really wonderful meeting today. I think the staff is to be commended for really a rich meeting.

[Whereupon, at 4:55 p.m., the meeting was recessed, to reconvene at 9:30 a.m. on Friday, May 17,

2013.]

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

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

Friday, May 17, 2013
9:42 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
DONNA CHECKETT, MPA, MSW
PATRICIA GABOW, MD
HERMAN GRAY, MD, MBA
DENISE HENNING, CNM, MSN
MARK HOYT, FSA, MAAA
NORMA MARTINEZ ROGERS, PhD, RN, FAAN
JUDITH MOORE
TRISH RILEY, MS
SARA ROSENBAUM, JD
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 [9:42 a.m.]

CHAIR ROWLAND: Good morning, and welcome to this continuation of the MACPAC May Commission meeting. We're pleased to start today with updates on two of our MACPAC chapters for the June report -- one on maternity care and the other on data and MACStats and information. So we're going to ask both Amy and April to take us through some of their changes and data additions to our analysis.

SESSION 6: MACPAC JUNE REPORT CHAPTER UPDATES

* MS. BERNSTEIN: Thank you, Diane.

As you know, we presented the draft maternity chapter at last month's Commission meeting, and we did not have the data tables ready to present to you, so that is what we have given you today in your mailing materials. I believe it's at Tab 6, or it's in Session 6, at any rate.

Let me see if I can do this with no computer. No? I turned it off. What did I do? Matt?

Okay. Again, we are presenting four data tables to you and an appendix table, which I'm going to walk through with you briefly.

The appendix basically describes the data sets that are used for these tables and some issues that you need to consider when you are actually looking at the data. We use two major data systems in the tables that you have in front of you: the Medical Statistical Information System, or MSIS, which is Medicaid administrative claims data for the most part; and also the Health Care Cost and Utilization Project, which is a data set that's collected by the Agency for Health Care Research and Quality, which is hospital discharge data that I'll talk about in a second. And then we compared that just to see how close we were to data that's submitted to the National Governors Association survey on maternal and child health issues just, again, as a

comparison.

You would think that counting the number of births in a given year would be easy and that everybody would have a really good number. It's actually more difficult than you might think.

The MSIS, which is, again, the claims data, we went through our MACPAC analysis to actually identify women who had a delivery claim in a calendar year, which the latest year that we used was 2008. 2009 data are available now but wasn't at the time that we started this analysis. So we went through the millions and millions of claims data and identified first women and then whether they had a delivery, a hospital delivery.

In the HCUP data, which is the data set that I mentioned before, which actually is a survey of hospital discharge abstracts, so what is in the data set is hospital discharges. We don't really know anything about the women other than that they had a hospital discharge. But what we counted there was the actually number of babies born, assuming that there was a delivery associated with each baby -- you would hope that, at least -- and that we were able to identify how the baby was delivered, either through cesarean or through a vaginal delivery. And then the National Governors Association actually asked states to submit data. So however the state defines the number of births that occurred in a calendar year, that's what is collected. And these numbers don't always agree for a state, and some of the reasons that they don't agree is how you identify a delivery. So if you're looking at delivers in the MSIS data, you have to actually go through and find all of the codes -- and there are different coding systems that are actually identified as a delivery, which, again, is not as easy as it seems, and the codes that we actually used are at the bottom of your Appendix A table.

Again, the underlying data source, so is it hospitalizations, is it claims data, is it vital statistics? State knows I think pretty well how many births they have, and they actually collect data on whether Medicaid is a

source of payment, although different states collect it with different accuracy and put different emphasis on it.

When the National Center for Health Statistics, which does vital statistics, collects vital statistics data, they do not collect insurance, so they do not know how many births are Medicaid births.

And then you have issues with underreporting or non-reporting of the data, so, for example, some states submit encounter data to CMS at different levels of completeness, let's say, and in the HCUP data, there are actually individual hospitals that don't report data. So in some states, there's not a total 100 percent count of all hospitalizations that occur during the year. And the states that have the highest level of non-reporting are, again, including in your Appendix A notes.

So when we look at these numbers, we have to realize that there are some minor issues. That said, these are the best numbers that we have, and we do think that they give an indication of what is going on in these areas.

VICE CHAIR SUNDWALL: Amy, could I just ask a question about the -- when you say the NGA, is that kind of a proxy for vital statistics that states keep? Because that's clearly our source of data for live births. I understand you want to make the link with Medicaid, but I think that's fairly good and captures also home births and other things in addition to hospital births.

MS. BERNSTEIN: I'm sorry. NGA is National Governors Association, so they ask --

VICE CHAIR SUNDWALL: I know that, but, I mean, you say --

MS. BERNSTEIN: They ask the state, and the state submits whatever the state chooses. So some states base it on vital statistics. Some states don't. Some states base it on hospital claims. Some states base it on whatever they choose. It just differs by state.

The other thing that's different among these different data sources is how Medicaid is defined, and so we obviously have Medicaid claims data, so we know that that comes from the Medicaid program.

In the Hospital Cost and Utilization Project, it's expected source of payment from the hospital claim, so we don't know if it's Medicaid or CHIP. They don't even try to identify CHIP payments. So in the National Governors Association data, some states include CHIP data, some states don't.

The MSIS data that we have doesn't include separate CHIP programs, so these numbers will also differ based on how the Medicaid/CHIP program is defined in the data.

CHAIR ROWLAND: Amy, not for this chapter, but I think for the future it might be nice to do a piece on how we can't really tell from all these data sources, and could there be some suggestions to improve that? But not for this chapter. This chapter I think sets out those issues, but I think your explanation that you're giving would lend a very important area for us to pursue as we try to say how can we improve the data that we have to know what these programs do and not do, and feeds into the work that April's doing as well.

MS. BERNSTEIN: Absolutely.

CHAIR ROWLAND: Thanks.

MS. BERNSTEIN: That would be great.

I'm sorry. Did you --

COMMISSIONER ROSENBAUM: I did have a technical question. I would assume there's a fair number of times or some times that a woman who is privately insured, indicates private insurance as her source of coverage, and then, of course, it turns out that there is no private insurance for the coverage because of the holes in the Pregnancy Discrimination Act and the limitations of individual coverage. By the time the

data are reported up through these channels, do you know if they're corrected to reflect having the hospital later bill Medicaid -- help the women apply and later bill Medicaid? Or is this, if anything, potentially an undercount?

MS. BERNSTEIN: I would assume it's an undercount.

COMMISSIONER ROSENBAUM: Because it's only the known Medicaid at the time of the birth.

MS. BERNSTEIN: Correct.

COMMISSIONER ROSENBAUM: So those cases where Medicaid is made available after the birth, no one would -- there's probably several thousand cases like that a year, and we wouldn't have it corrected.

MS. BERNSTEIN: I believe that would probably be true.

COMMISSIONER ROSENBAUM: Okay.

MS. BERNSTEIN: And it's probably an undercount for other reasons as well, or in the HCUP data it could be an overcount. We really don't know. They try very hard to match their -- the HCUP tries very hard to weight their data to meet national control totals, but they don't do it for every individual state to the same degree that they do it for the national.

All right. So moving on to the actual data tables, now that we know some of the issues with the underlying data, in 2010 there were about 2 million births. It was 1.8 million births from the HCUP data, but that does not count home deliveries or deliveries in birth centers. So there were 1.8 million HCUP births, which we rounded up to 2 million. This is again from the hospital discharge data. About half of those delivers were paid by the Medicaid program. You saw this table in your last commission meeting, and so that hasn't changed. And state, again, vary in the percentage of total births that were paid by the Medicaid

program from lows in the 20 percent range -- mainly the 30 percent range -- there was only one state that was in the 20 percent range -- to the 50s and higher. We have heard from individual states that their rates after 2008 are even higher than that, but that's not in the data table.

From the MSIS data -- again, we're going to back to the claims data now -- we identifies 1.6 million Medicaid delivers, and then if you look at Table 1, about 70 percent of them were to women who had unrestricted, full Medicaid or Medicaid expansion CHIP coverage. Again, we don't have claims in this analysis from separate CHIP programs. About 11 percent of these 1.6 million women were classified on their claims as having restricted pregnancy-only coverage, and this was primarily true in states that state that they have pregnancy-only-related coverage. And about 19 percent were to women classified as emergency-only coverage due to non-citizenship status, and this includes both women who are in the five-year waiting period and undocumented women.

CHAIR ROWLAND: The 11 percent that have restricted pregnancy-only-related coverage means that they're only covered for 60 days postpartum in most cases. Is that correct?

MS. BERNSTEIN: I'm not sure about that. I don't think so.

COMMISSIONER ROSENBAUM: No, I think it's not an eligibility measure. I had the same reaction. I think it's a scope-of-coverage matter, because 70 percent of women are not always on Medicaid. I think what they're referring to is that they had full Medicaid coverage or coverage that was only for pregnancy-related care. I would assume the majority of women giving birth today on Medicaid are going to be women who are on the program because they are pregnant. It's a very confusing set of bullets.

MS. BERNSTEIN: Well, this is how it's classified in the data.

COMMISSIONER ROSENBAUM: I know.

MS. BERNSTEIN: And I think, based on the data, that the 11 percent that have pregnancy-only coverage are primarily in states that have pregnancy-related coverage only, which are North Carolina and California and a couple other states.

COMMISSIONER ROSENBAUM: Well, what does that mean to have pregnancy-related coverage only? It doesn't make any sense to me.

MS. BERNSTEIN: Well, I mean, that's the statute. Women aren't -- I mean, that's sort of the --

COMMISSIONER ROSENBAUM: No, but there's two things, right? You can be eligible because you're pregnant. But then, separately, you can have benefits that are limited to pregnancy-related benefits.

MS. BERNSTEIN: Correct.

COMMISSIONER ROSENBAUM: So that's what you think it is.

MS. BERNSTEIN: Yes.

COMMISSIONER ROSENBAUM: It's a scope of benefits. That's what I'm saying?

MS. BERNSTEIN: Yes.

COMMISSIONER ROSENBAUM: -- eligibility --

MS. BERNSTEIN: No, it's --

COMMISSIONER ROSENBAUM: Well, there's a lot of confusion at the table, so just so you know. It's not clear that it's an -- whether it's -- whether you're saying that 70 percent of the women giving birth in Medicaid are -- have essentially full eligibility for Medicaid. That's not what you're saying. You're saying that 70 percent have a full scope of coverage.

MS. BERNSTEIN: Yes.

COMMISSIONER ROSENBAUM: 11 percent have coverage that the state has designated as only limited to pregnancy.

MS. BERNSTEIN: Correct. Yeah, that's right.

CHAIR ROWLAND: So if they broke their leg, they're not covered.

COMMISSIONER ROSENBAUM: If they what?

CHAIR ROWLAND: If they break their leg --

COMMISSIONER ROSENBAUM: Exactly.

PARTICIPANT: Maybe.

COMMISSIONER HENNING: Or if I see them for an earache --

COMMISSIONER ROSENBAUM: You don't know [off microphone] not eligibility.

COMMISSIONER HENNING: It's like if I see them for an earache, you know, they have to pay for that visit.

COMMISSIONER ROSENBAUM: Exactly.

COMMISSIONER HENNING: It can't be billed to Medicaid. Whereas, if I see them for prenatal care for something else, but they come in with an earache, I can code that visit separately as an E&M code: I saw this person, she had an earache, I treated her, you know, and that would not be paid by Medicaid under that scenario, that 11 percent scenario.

MS. BERNSTEIN: But you are correct, it is a coverage issue.

CHAIR ROWLAND: Okay. Let's go on.

VICE CHAIR SUNDWALL: I've got one more quick question before you go on. It's 2013. We're the Medicaid Commission. Are we really -- is the best data we have 2008?

MS. BERNSTEIN: It's actually 2009 now.

MS. GRADY: Close to 2010, actually. So at the time we started this analysis a long time ago, 2008 was the most recent, and we acknowledge that there's more recent data in the chapter.

VICE CHAIR SUNDWALL: Okay. It's just embarrassing that we're using such old data.

MS. BERNSTEIN: Yes.

CHAIR ROWLAND: It's embarrassing that that old data is what's available for Medicaid.

MS. BERNSTEIN: Okay. Moving back to the HCUP data, which is deliveries in hospitals, about a third of the deliveries were by cesarean section. Did I go backwards? No. And states again vary. This is Table 2 in your report. New Mexico had a reported rate of 21 percent compared to 36 percent in Florida. And the rates did not differ -- the Medicaid cesarean rates did not differ from the total cesarean rates by more than a few percentage points in any of the reporting states. So there were no states where the Medicaid cesarean rate was significantly higher or lower than the total rate.

Moving on to expenditures, we measured expenditures for the 12 months prior to the delivery and the two months after because we wanted to make sure that we got as many births as we had, so that was the period of eligibility, so to speak, for our sample. And we measured all costs within that period, so these are not maternity costs. We didn't go through every claim and identify it as a maternity claim or not a maternity claim. Our assumption was that most of the care that they would receive while they were pregnant would be for pregnancy. So this would be an overestimate of total expenditures because they could obviously have had

other costs that were not maternity related. But what this is is the total expenditures for women who had a delivery in 2008 for this period, and that was about $11 billion. Per capita it was $7,000 per woman, which actually is fairly similar to other estimates that we've seen.

COMMISSIONER GABOW: Given what we know about the duration of pregnancy and what we know about the rate of first trimester care in this population, was there some reason why you picked 12 months before the birth to look at expenditures? Since that will clearly overestimate the cost of maternity care.

MS. BERNSTEIN: We wanted to make sure that we had as many women as we could, and there's also the issue of --

COMMISSIONER GABOW: I don't understand that answer. "As many women as we could"?

MS. BERNSTEIN: Well, okay. One is identifying who had a birth in 2008. So if you had a birth in 2008, we needed to go back a couple months before 2008 because they could have gotten pregnant and then had the baby in January. All right? So part of it is a sample issue, because if you only took -- if you took a nine-month period and you wanted to get expenditures, you had to go sort of before 2008 and after 2008, because you would have had expenditures before 2008 if you delivered on January 1st in 2008. That's one of the reasons we did it, was we were identifying --

COMMISSIONER GABOW: But you go back 12 months from the birth.

MS. BERNSTEIN: We do, and then we would have to go into 2009.

MS. GRADY: I think you could choose different -- I think we could have chosen a different time period to look back, so we're starting with the birth, and we're looking at the 12 months prior. And your

point is, well, pregnancy doesn't last 12 months, we could have limited it to, you know, nine months or some other time period prior. But, you know, I think we chose 12 months and could have done alternative --

MS. BERNSTEIN: Well, we could have. The other reason that we did it was we wanted to make sure that there was any sort of preconception costs in there. So the reason that we added on the extra three months was in case there were any expenditures for preconception care. It turned out that almost all of the women in the sample had fewer than 12 months of eligibility. The average was I think about six months. So it isn't like -- and the other reason is that they go on and off. So most of the women didn't have a full 12 months of eligibility. So yes, this is an overestimate because it will include the extra three months before, but, again, we wanted to make sure that there were preconception care costs in there, and most of them didn't have that much eligibility anyhow.

CHAIR ROWLAND: So most of them weren't there for 12 months, so you didn't pick up 12 months of expenditures.

MS. BERNSTEIN: Correct. If we were doing it again, maybe we would limit it to nine months, but then we felt that we might lose something, either preconception-wise or, you know, otherwise. It turns out it doesn't make really hardly any difference.

CHAIR ROWLAND: It's more of a sampling issue than a counting issue.

MS. BERNSTEIN: I'm not saying it very articulately. I'm sorry. I will try to find a -- I'm going to think about it and try to --

COMMISSIONER HENNING: I'm just curious. Did you do something to screen out people that delivered twice in that period?

MS. BERNSTEIN: We looked at it. It was a very small number of women, but we did --

COMMISSIONER HENNING: You don't work where I do.

MS. BERNSTEIN: Yeah. It was less than 2 percent of women.

[Inaudible comment/laughter.]

CHAIR ROWLAND: Okay. Go ahead.

MS. BERNSTEIN: Going back to the HCUP data, if you just look at the estimated cost of delivers, it was about $7.1 billion. So, again, you know, that's an extra $3 billion for the non-delivery maternity care, which seems I line with other estimates.

COMMISSIONER ROSENBAUM: Is there any reason to believe that in the states that us restrictive coverage steps they're saving any money by doing that? Do the per capita costs look different or can you not tell?

MS. BERNSTEIN: We can look. We didn't actually look at that specifically. From looking just at the numbers, it didn't really look like it. But we can look at that in more depth.

If you compare against from the HCUP data the cost of a cesarean delivery with no complications, because obviously complications would increase the cost of the delivery, to a vaginal delivery with no complications, the average cost for hospitalization for a cesarean with no complications was $5,000 compared to $3,000 for a vaginal delivery with no complicating additions. This is the total cost to the hospital, the estimated cost to the hospital for the delivery. It's not expenses or claims submitted to the Medicaid program. So this is just for a woman who said that Medicaid was her expected source of payment. This is how much the delivery hospitalization cost. And complications cost obviously more than deliveries without

complications.

And those are the tables, and actually you've raised some interesting questions already, but if you have other comments --

CHAIR ROWLAND: Okay. So we have a follow-up piece that you're going to work on, which is how can we get better measures of births by payer source.

MS. BERNSTEIN: Yes.

CHAIR ROWLAND: And what are some of the limitations in the existing databases?

MS. BERNSTEIN: Yes.

CHAIR ROWLAND: Because we clearly got very confused by the fact that these different databases measure very different things, and are there ways that vital statistics and the NGA survey or other surveys could be really more informative about what's going on.

COMMISSIONER CHECKETT: The earlier discussion we had about the pregnancy-related conditions does, I think, raise another issue for us to look at. And I don't recall in our maternity chapter if we delve into this. But essentially what it is is that the statute allows states to cover women for pregnancy and only for pregnancy-related services. But, you know, that's an endless discussion. I mean, when you're pregnant, in my mind everything is related. But clearly some states have chosen not to. It would be interesting to look at how states have decided to make those decisions, what is included and excluded. Do states have that as their official decision but they actually don't have any system edits in place and any bill you put through will go through?

So I'd just put it out there as something for us to look into, and I, again, don't know that we address it

in the maternity chapter. I don't think we did.

MS. BERNSTEIN: We addressed the fact that there are those differences, but we don't know why. There's actually a sentence that says we don't know what it means to have pregnancy-only-related coverage. We don't know what the implications of that are.

COMMISSIONER HOYT: For what it's worth, we were asked that question in a few states, what would it save them or what would it be worth, and we couldn't find any data to back it up, and we decided like 1 or 2 percent of some really small number.

I had a couple questions, though, about the presentation. A lot has been written about C-section rates and the trends seem to be increasing. At least I know states tried to come up with some payment strategies to possibly mitigate that or scale that back, and I was just wondering if there's any evidence from here, although maybe it would be a stretch to say that proves it out. Do we know anything about how states pay for the maternity care? I'm thinking specifically of case rates and fee-for-service where you just -- some states will just have one payment. Certainly in managed care contracting this has been common for probably 15 years or more now, where under a managed care contract, you know, a plan would just get paid one number, say it would be 6,500 bucks or something, and it wouldn't matter whether it was vaginal, cesarean, multiple births, complications, it would all be rolled into one number, and they would try to eliminate any perverse incentives to load up the billing or to do unnecessary C-sections.

MS. BERNSTEIN: Yes, we didn't actually go into payment in this chapter, but there is a table in the chapter that talks about programs that states have to change their payment rates in order to try to have incentives to have fewer early -- not early, non-medically indicated deliveries. And we mentioned some

examples, like Minnesota has a blended rate, and certain states have just stopped paying for early non-medically indicated deliveries. And so far Louisiana is the main state that has had really positive outcomes from that particular initiative.

COMMISSIONER HOYT: I know Arizona has had that for a long time, and they had a reasonably lower rate, but there's other states I saw there that have done it also where it didn't seem to have any impact.

I had one other question, too. I don't know if I heard you mention this. I don't know if Denise knows. Do we have any data at all about midwives, what percentage of the births were performed by midwives? Does that have any impact on cost or C-section rate or anything else?

MS. BERNSTEIN: The vital statistics has a measure of the percentage of births that were done by midwives, which I think is up to about 7 percent nationally. We don't have Medicaid data, unfortunately, on the percentage of births that were performed by midwives.

COMMISSIONER HENNING: I would just caution you to use vital -- when you're using vital statistics information, when it comes to who actually delivers the baby, oftentimes midwives are underrepresented in that because what happens is in so many hospitals, in fact, probably the majority of hospitals, midwives are on the staff in a way that they're not technically allowed admitting privileges. So the patient is admitted under someone else's name. They are taken care of by midwives. They are delivered by midwives. But when the person that's filling out the birth certificate fills that birth certificate out, they typically will not actually read the delivery not to see who did the delivery, and they'll just go ahead and slap that doctor's name on there.

So the number of births that midwives are performing are likely much higher than the numbers that

you would be getting from vital statistics. And there are a lot of benchmarking data that is being collected by the American College of Nurse Midwives and also by the American Association of Birth Centers as far as the number of cesareans that are done to the patients that they take care of. The birth center cesarean rate is around 5 percent. Most midwifery practices is somewhere between 10 and 20 percent, depending on what kind of population they're taking care of and where they're working.

So I would postulate that when you look at the total number of births that are by cesarean in the 33 percent range, and there are some hospitals like in Miami that have 70 percent C-Section rates, that it's only because we have nurse midwives out there delivering babies that our rates are keeping down as low as they are. Otherwise, they'd probably be a lot more.

MS. BERNSTEIN: I'm sure they are an underestimate. I just haven't been able to locate a national data source that has Medicaid comparisons of midwives versus non-midwives in delivery.

COMMISSIONER HENNING: And I think that might be a failing. We may not keep track of who we deliver that's Medicaid versus who we deliver that's private insurance. That might not be kept as an indicator, and that might be something we would want to add to our benchmarking data, just so that we could be a source for other people.

CHAIR ROWLAND: Okay. I have -- we're running way behind, so I have Patty, Steve, and Norma, and Sara.

COMMISSIONER GABOW: I hope that in the chapter -- I don't think we did this, but maybe we could -- is I think it's very important to point out that when you talk about 46 percent of the deliveries being Medicaid, to underscore that that means almost half the children born in this country are born in poverty and

all the implications that come from that. I think we need to underscore that in the chapter. Just don't stop, 46 percent are Medicaid. I think we need to go to the implication.

For future work, maybe this is not possible, but it would be very interesting to know at what point in the pregnancy the care actually started, because I think one of the big challenges is to get the population into early prenatal care. So I think that would be useful.

And I don't know if there would ever be any feasibility of linking the birth to then an understanding of what was the status of that newborn, NICU care, et cetera, so that we could begin to understand --

CHAIR ROWLAND: The consequences --

COMMISSIONER GABOW: -- care in the pregnancy with the outcome of the child, because that's where Medicaid, I think, runs up a lot of costs that are not captured in the delivery per se. And I don't know the feasibility of that from a data perspective, but it would be -- if it isn't possible, it would be worth pointing out that that actually is worthwhile knowing.

CHAIR ROWLAND: Okay. All right. Steve.

COMMISSIONER WALDREN: Two quick things. First, if you're going to look at different providers, I think you have to look at both the pre- and post-, like the ratio of Caesarian, because I think the populations that they serve are different. So you can't just look at the post- and compare.

The other is that ACOG and the group around vital statistics came together last year and started to put together a set of data definitions. If you go to ACOG.org and look for Revitalize, was the project, and they started to define what live births would be. So starting at that kind of consensus, I think, look for that.

MS. BERNSTEIN: One of our external commenters made us add a sentence about Revitalize, so it's

in the chapter now.

CHAIR ROWLAND: Great. Okay. Norma.

COMMISSIONER MARTINEZ ROGERS: Just a quick question. You may have already said this. Did that include -- the stats you gave, did it include birthing centers?

MS. BERNSTEIN: No.

COMMISSIONER MARTINEZ ROGERS: Okay.

MS. BERNSTEIN: Well, the age cut didn't. The hospitalizations did. As I said, it was any delivery, and we don't know where they were delivered. So it depends on which number you're talking about.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: Just to go back to this question of pregnancy-related and scope of coverage, so the Federal definition of pregnancy-related services, the services necessary for the health of the pregnant woman or fetus or that become necessary as a result of the woman having been pregnant. It is very hard for me to imagine any covered benefit being used by a Medicaid-enrolled pregnant woman that could be excluded as necessary for neither the pregnant woman or the fetus. So I would make a point in this chapter of giving the Federal definition and noting the value of -- an understanding in the States that have introduced a restrictive eligibility coverage standard, what is and is not covered --

CHAIR ROWLAND: Yeah.

COMMISSIONER ROSENBAUM: -- because the definition is just too broad to really be able to argue for leaving anything out.

MS. BERNSTEIN: We include the definition in the chapter and we have struggled with this. So

there's now a sentence that says something to the effect of we don't really know what the implications of this are.

CHAIR ROWLAND: Okay. I think that we have identified a lot of flaws in the way in which statistics on births and maternity care are collected. We're going to pursue that, but Amy, I think you've done a remarkable job of trying to figure out what's going on underneath these various data sources, so I thank you.

And now, since we're on to data, we'll let April quickly take us through what we know from our MACStats. And, Amy, you know, I'm really looking forward to having you do the ultimate review of what we know and don't know from the data sources so that we can make some real recommendations about how we should be collecting and improving the way in which we can assess the impact of some of these changes, including Patty's. I think they are important comments about knowing what the implications are post-birth, as well.

April.

* MS. GRADY: Thank you, Diane. I know we're running behind, so I'll try to be brief.

I have some invisible bullets on this slide here in the overview, but I just want to tell you I'm going to give you a brief review of the differing content in the March and June MACStats, just to remind you about what's in each of those. I'll quickly walk through the June 2013 MACStats, emphasizing key points in each section.

So, at a very high level, our March MACStats provide a lot of State-specific information, obviously, on Medicaid and CHIP, but we focus on aggregate enrollment, aggregate spending, eligibility levels. So we try to provide a broad overview of what's going on in the Medicaid and CHIP programs, and we also provide some

contextual information on State budgets, national health expenditures. So March is a pretty broad overview.

In June, we try to do two things, to provide some historical information on enrollment and spending, because March is largely a snapshot, and then we also try to provide some more detail on the State-level data, delving into spending per enrollee by eligibility group and service type to supplement the aggregate figures that we present in March. We also have a large section in June that provides information on the health and other characteristics of the Medicaid and CHIP populations.

Here are the sections I'm going to walk you through. Section 1 is on trends in Medicaid enrollment and spending. We have historical data compiled from a number of sources from CMS that you're familiar with at this point. A key point we make here in this section is that growth in Medicaid spending and enrollment has varied over the years, reflecting shifts in Federal and State policy along with economic factors.

Another big point we make here is that enrollees qualifying for Medicaid on the basis of a disability account for a substantial portion of spending growth over the long term, since 1975, about half of real growth in Medicaid spending. Now, of course, this is looking at spending over the program's long history and results are going to differ if you look at more recent time periods, which is something we'd like to do for future editions of MACStats. For example, if you look at the recessionary period in the early and late 2000s, non-disabled children and parents were a large part of the spending growth, so that's something we'll examine in the future.

In Section 2, we look at the health and other characteristics of Medicaid and CHIP enrollees. For example, we break out -- so we look at the characteristics, and obviously, the Medicaid and CHIP population differs substantially in many ways from people with other types of coverage. Medicaid and CHIP enrollees

generally report being in poorer health and using more services. But even within a particular age group for Medicaid and CHIP enrollees, you see that they're a diverse population.

So, for example, we break out children who are enrolled in Medicaid and CHIP into three categories: Those who have disabilities and who are receiving Supplemental Security Income payments; those who are not receiving SSI but still have special health care needs because they have an ongoing health condition that, for example, limits their ability to function or requires specialized therapies; and then we have kids who are in neither of those groups. And what you see is that their health status, their service use and other characteristics vary. So Medicaid and CHIP children are not a uniform group.

One thing I just want to point out briefly here. Our use of the term Medicaid/CHIP is deliberate because we're using survey data and it's very difficult to separate Medicaid and CHIP enrollees in surveys for a variety of reasons, in part because survey respondents don't always know which program they're enrolled in. So it's questionable to pull out CHIP separately in that case.

In Section 3, we talk about Medicaid enrollment and benefit spending. Some of the key points here, Medicaid spending per enrollee is affected by a large number of individuals with limited benefits in some States. And the examples we have of the limited benefit package include family planning only enrollees, who were mentioned by Cindy Mann yesterday in her presentation on waivers. Obviously, we've talked about partial benefit dual eligibles, who receive -- their only Medicaid assistance is a payment of Medicare premiums and cost sharing. And certain non-citizens who only receive emergency services, including the labor and delivery services that Amy has discussed in her chapter on maternity care.

The example I want to give here is California, where adult Medicaid spending per enrollee is about

$1,800. If you look at their entire adult population in Medicaid, that seems low. Let's go find out how they're driving down spending or costs in California. But if you take out the people with limited benefits, a large portion of whom are family planning only enrollees in California, and you look at those with a full benefit package, the per capita is more like $3,200. So, again, how you measure things makes a difference and that's part of the point we make here in MACStats.

Obviously, there's a mix of spending on services that differs by subpopulation, and in particular, long-term care users account for only about six percent of enrollees but almost half of Medicaid costs. So we've got some information on that population.

In Section 4, we provide a little bit more detail on Medicaid managed care when we talk about the different delivery models that may be referred to as managed care. All but three States report using some form of managed care. That includes comprehensive risk-based plans, limited benefit plans that cover things like dental only, transportation, or behavioral health, and primary care case management also is categorized as managed care, depending on which statistics you're looking at. The national percentage of Medicaid enrollees in any form of managed care, in any of those types of plans that I just mentioned, is more than 70 percent. But if you look just at comprehensive plans, the share of people in those plans is about half.

And, obviously, participation in those comprehensive plans varies, depending on the group you're talking about. It's lowest among seniors and persons with disabilities, about 12 percent of people 65 and up and about 29 percent of people who are eligible on the basis of a disability. And it's highest among the non-disabled adults and children, between half and 60 percent at the national level.

Section 5 is our technical guide, where we provide a lot of supplemental information on the data and

the methods that we use in MACStats, so you can get into the gory details if you want to. There are some key issues to consider when you're examining numbers in MACStats tables and figures or in other data sources that could address some of the issues that were raised in the maternity discussion.

One of the examples here is whether your spending data in MSIS has been adjusted to match totals that we know are in the accounting forms that States submit to get their Federal reimbursement. And as you know, inconsistency across Medicaid data sources has been an ongoing issue for CMS and it's one of the things we address in a separate chapter on data in our June 2013 report that you've heard about in previous meetings.

I'm talking very fast. I'm going to go ahead and stop there and I'll be happy to answer any questions you have.

CHAIR ROWLAND: Terrific. Now, Patty.

COMMISSIONER GABOW: One thing that has continued to surprise me in many groups that I speak with is the fact that it is often the total Medicaid spend in a State is lumped as a State expenditure. And I think the more we can make it very clear that only half of that is a State expenditure, because you always hear, no matter what form, oh, this is the biggest part of the State's budget. And I know a number of times when I say, no, that's not the right percent, people will say, oh, no, no, it is. So I think pointing that out.

And it becomes very important after 2014 when we're going to have a significant percentage of the Medicaid with 100 percent paid by the Federal Government. I think this is important at the State legislature level. So the more we can make that clear, either in tables or particularly after 2014, the better it will be, I think.

CHAIR ROWLAND: So to look at Medicaid as a share of State general fund spending as well as a

share of the State budget.

VICE CHAIR SUNDWALL: Yeah.

COMMISSIONER RILEY: That will be interesting on the per enrollee cost issue when we have 100 percent financing. The States -- the per enrollee costs when we have 100 percent financing for newly eligibles, and then there will be States that have no 100 percent financing, so that will skew those results.

But that's actually where I was concerned. So many States and others look and want to compare, and you hear in legislative debates, our per enrollee costs are higher than, and I think the more we can shine a light on that and disaggregate the limited benefit from the full benefit, the more valuable it will be.

And to my point earlier this morning, I think -- I guess it's another chapter, but we really don't want to lose sight of all that work we did early on on encounter data and all the limits to the data because it's so frustrating not to be able to make these comparisons over time and across States, and yet the data often don't let us do it.

VICE CHAIR SUNDWALL: Right.

CHAIR ROWLAND: David.

VICE CHAIR SUNDWALL: One last comment on this, and thank you for these presentations. I always like the MACStats and I think that's a real contribution that our Commission is making. However, just to emphasize what Trish said, I think we need to always be clear that the data is old and limited and the conclusions drawn, we need to be careful.

Patty, I just want to make a cautionary note about your implying that all these births are in poverty. In Utah, for example, we have a third of the births are covered by Medicaid, but they're not poor people.

They're college kids. They're married. At this time of their lives, they're poor. Their parents aren't. They nonetheless take advantage of the fact that they do qualify for Medicaid on paper, but they're temporarily impoverished and very quickly aren't, but they do still cover Medicaid. So I don't know what percentage of the births are to otherwise healthy middle-class kids who, by virtue of their time in life, are poor, but I don't think that you can say that all the kids born covered by Medicaid are to poor families.

CHAIR ROWLAND: Denise.

COMMISSIONER HENNING: Before we leave the subject, I just need to put in a plug for a couple of things.

One is one of the reasons why they're spending the big push for not doing scheduled C-sections and elective inductions before 39 weeks is because of the good work of the March of Dimes and other organizations that have looked into the research and been able to show that those late-term births, those 37- and 38-weekers, don't do nearly as well as babies that get at least 39 weeks inside, and preferably more, in my view.

A lot of that work has been done in the States through perinatal quality care collaboratives, and that is where groups of doctors, midwives, nurses, neonatal specialists, come together and start -- and talk about, how can we do things better, because it used to be we'd have these little silos. I deal with the mom until she delivers and then I hand off that baby and it's somebody else's problem. That's really not the way we need to look at birth. We need to look at birth as a whole, the mom-baby unit. And we need to, I think, support the development of these quality care collaboratives, because they're doing really good work. And that's one of the reasons why that 39-week initiative has really taken hold across the country.

And then the other issue is that I think we need to look at the Strong Start funding grants that CMS has been supporting, because I think that some of the ideas that are coming out of that, in particular the way of doing prenatal care differently. We can't keep doing it the same way and expecting different results. That is the definition of insanity.

So we need to start looking at prenatal care, and how can we provide this better, more efficiently, and in a way that reduces costs to the system. It may not necessarily reduce costs to me as a provider, but if I can provide prenatal care in a way that's been shown to decrease preterm births and we don't as a country have to pay for a preterm baby that's going to be disabled for the rest of its life, how much money do we save system-wide? We need to start looking at it from that angle rather than, you know, well, it's going to cost Medicaid $10 more per visit.

CHAIR ROWLAND: Okay. Robin.

COMMISSIONER SMITH: Just a real quick comment. I'm going to admit that, as a layperson, I don't understand what the point of our chapter on maternity is supposed to be.

EXECUTIVE DIRECTOR SCHWARTZ: The chapter on maternity -- I mean, today, we've only focused on these couple of data tables, but the chapter in general is a foundational chapter that describes the eligibility pathways, coverage of benefits, and really paints a landscape for how Medicaid covers maternity, which is clearly an important part of the program. It's got a lot of different components into it. It does have a discussion, as well, over some of these initiatives States are taking to address early electives, non-medically indicated deliveries. And so that's really the purpose of the chapter.

There are some areas where it's clear that we may be doing additional work, such as the issues around

how the ACA changes some of the eligibility pathways, some potential churning. I think the problem here today is that it's now been a month since you've seen the chapter. Amy's been living and breathing it every day and these data tables were just a small piece of the entire chapter.

CHAIR ROWLAND: Okay. Well, I want to thank both April and Amy and to move on to our discussion of the recent proposal on the disproportionate share hospital payment. So if Jim Teisl would join us, that....

And, Jim, you are not going to talk about any data, right?

MR. TEISL: I hope not.

CHAIR ROWLAND: Although DSH data is always helpful.

SESSION 7: OVERVIEW OF PROPOSED RULE ON STATE DISPROPORTIONATE SHARE HOSPITAL ALLOTMENT REDUCTIONS

* MR. TEISL: Thank you, and good morning, everyone.

VICE CHAIR SUNDWALL: Can you tell us your true life maternity experience?

MR. TEISL: My true life maternity experience or recent maternity experience.

So in this session, we want to provide a very brief review again of the Medicaid disproportionate share hospital payments, which we covered in more detail, you will recall, last January. Then we want to review the statutory requirements for reducing state DSH allotments beginning in fiscal year 2014. We'll talk a little bit about the provisions of the very recently proposed regulation to implement the reductions and then maybe have a little time for discussion of the policy issues associated with the reduction.

This is all review basically of what we did in January, so I'll try to move along very quickly. I'm not

going to go through the history of DSH this time but focus a little bit on what it's about.

DSH payments are statutorily required payments to hospitals that serve low-income patient populations. They're intended to improve the financial stability of the safety net and preserve access to health services for low-income individuals.

Total federal Medicaid DSH allotments are about $11.5 billion, and in fiscal year 2012 total DSH payments, including state and the federal allotment, accounted for over $17 billion in spending.

Again, as a reminder, a hospital must receive DSH payments if it has a particularly high Medicaid utilization level, that being at least one standard deviation above the statewide average, or if low-income utilization exceeds 25 percent. A hospital may receive DSH payments as long as its Medicaid utilization is at least 1 percent. What this means is states have considerable flexibility in deciding which hospitals to make DSH payments to and the methodology for making those DSH payments.

A quick review of the reductions required by the Affordable Care Act. So the reductions were intended to coincide with the declining number of uninsured individuals beginning in fiscal year 2014. They start relatively slow in 2014 and 2015, with reductions in total DSH allotments of approximately half a billion dollars, but then ramp up to account for roughly half of federal DSH allotments by 2019. The reductions have been twice extended since the enactment of the ACA by subsequent legislation, first extending the reduced allotment to 2012, more recently to 2022.

It's worth mentioning that the recently proposed President's budget called for postponing the fiscal year 2014 DSH reductions and distributing that reduction amount over future years and then again extending the reductions another year into the future.

The statute included requirements for a DSH reduction methodology but left it up to the Secretary to determine the details of that methodology. So the Secretary was required to use a methodology that imposed the largest reductions on states that have the lowest percentages of uninsured or that don't target their DSH payments to hospitals with particularly high Medicaid utilization and uncompensated care. The statute required a smaller percentage reduction on low DSH states, and just as a reminder, low DSH states are states whose DSH allotment -- or it really goes back to what they were spending back in fiscal year 2000, but it's those states that were spending less than 3 percent of their total Medicaid expenditures on DSH. So because of that, those states have disproportionately -- excuse my use of that term -- low DSH allotments relative to other states.

The statute also required that the Secretary take into account the extent to which a state's DSH allotment was included in the budget neutrality calculation for an 1115, specifically for a coverage expansion. We talked a little bit yesterday about what that means.

So the proposed regulation was just published this week, and I caution you to be kind because it was published two days ago. So we're going to --

[Laughter.]

CHAIR ROWLAND: And you were here all day yesterday.

MR. TEISL: Exactly. So we want to go over an outline of how the proposed regulation would implement the reductions. The plan is obviously to stay at a little bit higher level as the math obviously gets rather complicated, and we're still working through it, and we'll be happy to discuss some of those finer details as we move forward -- even today if you're dying to start to consider them.

So the DSH health reform methodology proposed by the Secretary, first, and importantly, applies to state allotments annually for fiscal years 2014 and 2015. So this initially proposed methodology would only apply to the first two years of the DSH reductions.

Let's see. It applies a smaller percentage reduction for low DSH states as required by the statute, so the first thing that will happen is states will be divided into the low DSH states, 16 or 17 low DSH states, and the rest of the states. And the proportional amount of the reductions that would go to the low DSH states is reduced by a factor accounting for how much lower their DSH allotments are than the non-low DSH states. And that's actually the term used.

Let's see. CMS indicated that they did this initial methodology for only two years to allow for future assessment of the relative impact of state expansion decisions. So it's important to point out that this initial methodology will not account in any way for whether a state decides to expand their Medicaid program.

Furthermore, they go on to say that the available data for looking at level of uninsurance won't even reflect changes based on state decisions right now. So, again, the proposed method doesn't include a method to account for state expansion decisions at this time, though they clearly leave open the possibility that future methodologies beginning in fiscal year 2016 would take that into consideration.

Next, low DSH states will be broken out, as I mentioned, and their proportional share will be reduced. The share of reductions for the low DSH states -- sorry, for the non-low DSH states will then be increased to compensate for the lower share that's assigned to the low DSH states.

Each state's reduction will then be divided among three statutorily required factors. The three factors that will be considered is the level of uninsured in the state and the extent to which states target their DSH

payments to hospitals with high levels of uncompensated care and hospitals with a high volume of Medicaid inpatients.

So the total amount of reductions that will apply to a particular state group, meaning either the low DSH states or the non-low DSH states, will be divided into third. Then each third will be allocated among the states depending on these factors: uninsured percentage, the extent to which they target hospitals with a high level of uncompensated care, and hospitals with a high volume of Medicaid.

Importantly, the Secretary decided to allocate a third of the required reductions based on uninsurance and then two-thirds on these factors related to targeting. And as you'll recall, this was some of the discussion we had back in January. There was some question as to the extent to which one factor might be weighted more heavily than another. So it's a third uninsured, two-third targeting, and that two-thirds is split between high levels of uncompensated care and high volume of Medicaid inpatients.

The proposed methodology would exclude the DSH allotments included in budget neutrality calculations for an 1115 coverage expansion from those targeting calculations. It does not appear to exclude DSH allotments included in budget neutrality of an 1115 for purposes other than coverage expansion, for example, for the creation of something like a low-income pool.

And I think that's pretty much it. So I don't know if you want to stop for any questions now or you want to just continue through the -- go ahead.

COMMISSIONER CHECKETT: Jim, I just want to make sure I'm understanding this correctly that the percentages that you're outlining, the 33.3, 66.7, that the Secretary has determined those actual numerical values, that the criteria are the criteria that was in the statute, but the actual percentages is the Secretary's

discretion.

MR. TEISL: Correct.

COMMISSIONER CHECKETT: Okay. And then does the regulation point out the specific impact state by state or are the states now running their own analysis? I'm sure the answer to that is yes on the latter, but what is the answer to the former?

MR. TEISL: The answer is both, sort of. The proposed regulation does include some illustrative calculation modeling. They're very cautious to say repeatedly this is for illustrative purposes only. And I know that states and other groups are actively working to sort of work through the methodology to determine the impacts for individual states.

COMMISSIONER CHECKETT: Great. Okay. Thank you.

COMMISSIONER HOYT: My question is about the low DSH measurement. When is that where the states' low DSH -- like in 2010 or is there like a prospective look to take a swing at recalibrating in 2014 where you think the states would be?

MR. TEISL: States were deemed low DSH on the basis of their fiscal year 2000 DSH spending. So they're deemed -- low DSH states were deemed low DSH states well before based on that spending, yes. But if you remember, states' DSH allocations go back to what they used to spend before the allocations were set each year, so states' historical spending was the basis for what their allocations are now going forward.

COMMISSIONER HENNING: Patty, is your comment directly related to Mark's? Okay, because I might need you to help explain this to me.

I'm having trouble understanding what the difference between uninsured percentage factor would be

versus the high level of uncompensated care. Uninsurance versus uncompensated, to me it seems like they're the same thing, but if you could explain the difference, that would help me.

MR. TEISL: Yeah, the level of uninsurance is actually the level of uninsurance in the state, so the proportion of the state population that's uninsured. When they're looking at the extent to which states target hospitals with high levels of uncompensated care, they're going to look at the proportion of DSH payments that go to hospitals that see a higher number of people that are either on Medicaid or uninsured.

COMMISSIONER ROSENBAUM: In other words, you get credit as an uncompensated care measure for the Medicaid business you do.

COMMISSIONER HENNING: All right.

CHAIR ROWLAND: First as a statewide measure, and the second to relate to how the allocations work hospital by hospital.

MR. TEISL: Correct.

COMMISSIONER HENNING: Because technically Medicaid is not uncompensated. It's just not compensated very well.

MR. TEISL: Part of the uncompensated care calculation looks at the difference between what Medicaid pays and what the cost of care was to provide care to Medicaid individuals.

COMMISSIONER GABOW: Do you know what the granularity is regarding what it means by state targeting? Because you can imagine that a state would say, yes, we target the money to those institutions with high uncompensated care or Medicaid, and it's not very much targeting. It's like a percent difference or -- so how robust is the meaning of "targeting" in this?

MR. TEISL: It might help a little bit actually to go on to the next slide and talk about some of the data sources that they're going to use.

So what I did up here was took some of the policy issues that we had for discussion back in January and then tried to include on the right-hand side how the proposed regulation approaches those policy issues. So we talked about the extent to which reductions are based on the level of uninsured versus targeting of payments, and as we just described, the methodology would be a third based on the level of uninsured, two-thirds based on targeting.

We talked a little bit about the availability and timing of data for these different factors, so what the proposed regulation would use is the most recently available and usable data in the American Community Survey from the U.S. Census Bureau relating to the percentage of uninsured in the state, and they intend to use the required DSH audit reporting data for state DSH payments to look at the extent to which states are targeting their payments to hospitals with high levels of uninsured or high levels of uncompensated care.

One thing I would note on that is they are adding to future DSH audit reports a requirement that states report total hospital costs, and one other data element that CMS has mentioned they won't necessarily have from existing DSH audit reports is some additional Medicaid inpatient utilization information specifically the level of statewide -- the mean Medicaid inpatient utilization for all hospitals that receive Medicaid and the value that's one standard deviation.

Other policy issues, we asked whether the reductions would be based on assessments of a single point in time extended into the future or whether CMS might periodically assess levels of uninsurance in targeting. This regulation proposes annual determinations of these reduction factors for each of the first two years of the

required reductions. As far as treatment of states that don't expand Medicaid, this regulation, the same formula applies to all states. As far as 1115 demonstration states, the allotment used for expansion is excluded from the targeting. And clearly the formula is intended to encourage states in the future to better target their DSH payments to hospitals with high levels of Medicaid and uncompensated care.

COMMISSIONER GABOW: I still don't think that answers my question about the robustness of the targeting, because if you have, a hypothetical example, a safety net hospital that does $150 million of unsponsored care and another hospital that does $10 million, and the targeting results in a difference of DSH payments of a couple million dollars, is that targeting? And I actually think the interaction of this percent uninsured at the state level -- because you could imagine a state in which the uninsured numbers go down but the uninsured are now more concentrated at a given safety net, and then if the targeting is not robust enough, you create this very difficult situation for the safety net.

So I think understanding how these -- the robustness of the targeting and the relationship between state uninsured and individual institution level of uninsured is going to be really important in order to for the safety net to survive, I think, in this venue.

COMMISSIONER MOORE: Jim, would you comment on the accuracy of the data in the DSH payment reports from the states and whether all of them are actually reporting or have in the past?

MR. TEISL: I'll try. If you recall, I believe it was a 2008 regulation that implemented the DSH audit reporting, and it requires reports to be submitted -- I want to say three years following the state plan year that the payments were made. And the first five years of DSH audit reporting was supposed to be a trial period. I can't remember the exact terminology, but the point was it was to work on refining the DSH audit both data

collection and reporting prior to any sort of deemed overpayments as a result of the DSH audits themselves.

CMS acknowledges that the fact that some of the first DSH audit data that will be used for this reduction methodology falls within that learning period means that additional work will have to be done to try to make sure that the data is as high a quality as it can possibly be. They also indicate that by the end of this calendar year, they intend to issue some additional guidance on improving the quality of the DSH audit data. But it is an issue for discussion.

COMMISSIONER MOORE: But all states have been submitting it?

MR. TEISL: I believe so.

COMMISSIONER MOORE: Okay.

COMMISSIONER ROSENBAUM: Jut to follow up on Patty's point, I think this issue of the redistribution of the remaining uninsured looms especially great in Massachusetts where the uninsured is what now, 2 percent? Health centers are running about 22 percent, and there are a number of health centers that are running over 50 percent just because of where the remaining uninsured have sort of dealt themselves out. So I think there's a fundamental question of what is the purpose of the recalibration of where the money should go. You know, what are we doing here? Are we bringing down a payment? Are we also thinking about supporting those places that have a high -- continue to have a high volume of heavily uninsured patients? Which might be one area where we want to comment.

Another issue that I just wondered about was whether -- and we talked about this briefly yesterday -- you've been able to see any interaction between this rule and the big Medicare PPS rule that came out. My hat is off to you for doing this rule so fast, and the PPS rule is 315 pages just in the Federal Register. But I'm

wondering whether we ought not to be paying attention as MACPAC to some of the interaction between the Medicare DSH formula changes and these changes.

CHAIR ROWLAND: Actually that was my point. I was going to ask whether this was an area where we also needed to coordinate with MedPAC on really looking at the impact at the delivery level between the Medicare changes and the Medicaid changes. Because as I understand it, some of the DSH cuts on the Medicare side are actually deeper than the DSH cuts on the Medicaid side.

COMMISSIONER GABOW: [off microphone] But the total volume is much smaller.

VICE CHAIR SUNDWALL: Is this for duals?

CHAIR ROWLAND: No.

COMMISSIONER CHECKETT: My understanding of the statute -- but I want confirmation on this -- is that there is no involvement or looking at UPL in any way in the statute. And then I'm wondering -- I think the answer to that is that, yes, there is no looking at UPL. However, I wonder if there is -- if this is going to trigger in some way a re-examination of UPL policies or payments. I'm just wondering if anybody has heard anything along those lines, because some of the calls I've received from some of my friends are, you know, it's like, okay, the first shoe is dropping, but what about the next? So I'm just wondering, Jim or others.

MR. TEISL: No, not off the top of my head, though I think it's an issue we can look at a little bit more to the extent DSH allotments reduce to a point where states might choose to make additional payments outside of the DSH program. I'm sort of thinking out loud. It's something we can look at further, but I don't have anything specific right now.

CHAIR ROWLAND: Jim, when are comments due on this regulation?

MR. TEISL: Comments are due July 12th.

CHAIR ROWLAND: Okay.

MR. TEISL: Which is why we were so interested in bringing to you as quickly as possible the overview.

VICE CHAIR SUNDWALL: You kind of mentioned that there was going to be a lower cut for the disproportionate lower DSH states. Can you just explain that a little bit? Because I do think that the states like Utah that have not been very good at calculating their DSH could be penalized if they don't have some kind of a protection here. How are they going to do that? Or just a different calculation?

MR. TEISL: So those states that are considered low DSH states will be subject to a lower overall percentage of the reduction than they would otherwise.

CHAIR ROWLAND: So they get a little extra help.

VICE CHAIR SUNDWALL: Right.

CHAIR ROWLAND: Okay.

COMMISSIONER HOYT: What's limited to two years?

MR. TEISL: This methodology applies to fiscal years 2014 and 2015.

COMMISSIONER HOYT: On how they're going to allocate or do the reduction?

MR. TEISL: Exactly.

COMMISSIONER HOYT: Then they're going to revisit?

MR. TEISL: Exactly. And I wanted to mention, I flipped to this slide on some discussion points that you might want to consider when we're thinking about whether or not we want to comment. Many of

these we talked about already, but the fact that the reg doesn't account for state decisions regarding Medicaid expansion, for example, weighting of the factors of uninsured versus targeting -- if you recall, in January we heard from a representative of the National Association of Public Hospitals that was urging the methodology, for example, to focus on targeting. And they have also mentioned that they were very interested in a methodology that applied to the first couple of years and allowed for sort of a second look at how the methodology was rolling out and how states decisions ultimately affect the level of uninsurance in the state.

The data sources, we have talked about here a little bit. They chose to use the ACS for level of uninsured and DSH audit data. Their interest was in using data sources that they considered the most complete accessible sources of data that were consistent with the Medicaid program, though acknowledged that the fact that they will be several years sort of behind the current data is an issue.

CHAIR ROWLAND: How does this interact with the President's proposal to postpone the DSH allocation?

MR. TEISL: Well, it's separate. I mean, this is a proposed regulation to implement the statute as it stands.

CHAIR ROWLAND: So if the Congress took on the President's proposal to delay or whatever, they would have to readjust this.

MR. TEISL: Right.

CHAIR ROWLAND: Okay.

COMMISSIONER MOORE: Say a little bit more -- maybe I just don't understand this. If a state decided they really needed to change their targeting features because of this reg, like now, could that be

reflected in their reductions in this year? Or how long -- what's the time period? What do the time periods look like here?

MR. TEISL: So that's a good question. I believe the most recent DSH audit data that is available, at least publicly online, is for 2008. So it would take several years for those changes to be reflected in the DSH audit data.

COMMISSIONER MOORE: So if there were changes made for right now, presumably it would be possibly two or three years before a retargeting could be reflected, a retargeting that I think as a policy matter would hopefully take into consideration some of the things that are being emphasized here.

MR. TEISL: I believe that DSH audit data continue to be the source for the targeting factors beyond 2015. It's at least three years because it's three years before the audit data is required to be submitted, and then it takes time obviously to review the data and to make sure it's consistent, et cetera.

CHAIR ROWLAND: But there's a disconnect here, I think, because the audit data is being used to decide how much the state gets as a DSH allocation, and the state can change which hospitals get it at any time.

MR. TEISL: Yes.

CHAIR ROWLAND: So if a state wanted -- it affects the volume of the DSH allocation, but it doesn't affect how the state chooses in 2014 to implement its DSH allocation. So it can decide to refocus it on safety net hospitals, should it want to.

COMMISSIONER MOORE: But it can't be reflected very quickly in the DSH allocation the next year, say, because it would probably be two or three years. So that in trying to produce incentives for better targeting on, you know, more needy and low-income areas, you have just got a long time --

CHAIR ROWLAND: You've got a long time.

COMMISSIONER MOORE: That's what I was trying to understand.

CHAIR ROWLAND: Okay. Thank you very much, Jim.

MR. TEISL: Thank you.

CHAIR ROWLAND: And now we'll move on to look at payment for outpatient prescription drugs, and Chris Park is going to highlight some of the issues today as he provides an overview of that set of payment policies.

SESSION 8: PAYMENT FOR OUTPATIENT PRESCRIPTION DRUGS

* MR. PARK: Thank you, Diane.

Today's session provides an overview of Medicaid payment and spending for outpatient prescription drugs. In this presentation, I will outline the components used to pay pharmacies, including Federal and State limits on payment, describe the Federal Medicaid Drug Rebate Program and State supplemental rebates, highlight the different payment and rebate policies associated with the 340B program, and present the summary of Medicaid spending over the past several years for and after rebates. I will then highlight some potential issues for consideration and present possible MACPAC analyses and research to shed light on some of those issues.

To begin with, I want to provide a little bit of a background. Outpatient prescription drug coverage is an optional benefit that all Medicaid programs have elected to provide. Outpatient drugs are typically obtained by a prescription and dispensed from a pharmacy. They exclude physician-administered drugs or drugs provided as part of another service, such as an inpatient hospital stay or nursing facility day.

As established in Section 1927 of the Social Security Act, a drug manufacturer must enter into a rebate agreement with Medicaid in order for its products to be covered. The manufacturer pays a statutorily defined rebate to States based on the volume of its drugs dispensed to Medicaid enrollees.

Medicaid spending on outpatient drugs reflects two components. First is the payment to the pharmacy for the product, and then the manufacturer's rebates.

In fiscal year 2010, Medicaid spent about $15.9 billion in fee-for-service after accounting for rebates. This figure does not include any spending for drugs provided by Medicaid managed care organizations because it's difficult to tease out exactly how much of the capitation payment went to pay for drugs.

This presentation will focus primarily on fee-for-service payment structures, but I will briefly discuss payment and rebates in managed care, as well.

On the fee-for-service side, the State's payment consists of two components, an ingredient cost and a dispensing fee. The ingredient cost covers the pharmacy's cost of acquiring a drug from a manufacturer or a wholesaler. Federal regulations state that the ingredient cost payments should reflect the State's best estimate of the price generally paid by providers, also known as estimated acquisition cost.

States have typically based this estimated acquisition cost off of a published benchmark price, such as average wholesale price, which is a list price given by wholesalers at retail pharmacy, or Wholesale Acquisition Cost, or WAC, which is a list price between the manufacturer and a wholesaler. Most States either pay a discount off an AWP, such as AWP minus 15 percent, or a mark-up on WAC, such as WAC plus ten percent.

There have been some issues recently with AWP. Several OIG reports have noted that these published prices are often higher than the actual transition prices. A recent class action lawsuit surrounding

AWP led to one of the major publishers to stop publishing it.

Because of these issues, some States have recently moved to using a different measure called Actual Acquisition Cost, or AAC. These States calculate AAC using a periodic random survey of pharmacies to collect information from the actual paid invoices.

In 2012, CMS released a proposed drug rule that would establish AAC as the basis of payment. Under this proposed rule, States would be required to use AAC and would no longer be able to use the benchmark prices, such as AWP.

In addition to the ingredient cost, States also pay a dispensing fee to cover the pharmacy's cost associated with dispensing the drug, which would also include, like, the professional fees associated with the pharmacist's time. In most States, this dispensing fee is between $3 and $6 per prescription.

So when we're considering the payment to a pharmacy, we need to consider both of these components and how they interact with each other to create the total payment.

In an effort to ensure that Medicaid is a prudent purchaser of drugs, Federal regulations and State policies have instituted upper payment limits on some drugs. These payment limits are generally applied to multiple source drugs, which are drugs available from multiple manufacturers. These would include generic drugs and the brand drugs that now have a generic alternative available.

Federal regulations have established a Federal Upper Limit, or FUL, for certain multiple source drugs. The ACA recently established the FUL as no less than 175 percent of the average manufacturer price. The average manufacturer price was established as part of the drug rebate program and is the price paid to manufacturers by wholesalers for drugs distributed to retail community pharmacies.

States have also implemented their own policies to limit payment called Maximum Allowable Cost, or MAC. Similar to the FUL, the State's MAC establishes an upper payment limit on certain multiple source drugs. States have flexibility in determining which drugs would be on the MAC list and what the MAC prices are. There's typically some overlap between the MAC and the FUL and a State will usually pay the lesser of those two prices.

And because of these limits, the State kind of calculates the price according to several formulas and will pay the lowest of. So first would be -- here's an illustrative example. So, say the State's typical payment formula is AWP minus 15 percent with a $4 dispensing fee. They have this generic drug with an AWP of $5. The calculated FUL is $4. The MAC price is $3.50. And then there's a usual and customary payment or charge from the pharmacy of $10. So the State will go through the calculations. The standard payment of AWP minus 15 with a $4 dispensing fee would be $8.25. The FUL plus the dispensing fee would be $8. The MAC plus the dispensing fee would be $7.50. And the usual and customary charge would be $10. So comparing all of these in this scenario, the State would pay the MAC of $7.50.

As mentioned previously, drug manufacturers must pay a rebate to have their products covered by Medicaid. This rebate is defined in statute and is paid to the State in a separate process from the payment to the pharmacy. This means that every State receives the same rebate amount for a particular drug, regardless of how much they pay the pharmacy.

There are different rebate formulas for brand and generic drugs. For brand drugs, there are two components. First, there's a basic rebate amount calculated as the greater of 23.1 percent of AMP or AMP minus best price. Best price is defined as the lowest price available to any wholesaler, retailer, provider, or

paying entity, excluding certain governmental payers such as the Department of Veterans Affairs and the 340B program.

For a specific subset of drugs, which are certain clotting factor drugs and drugs with an exclusive pediatric indication, the formula is 17.1 percent of AMP instead of 23.1 percent of AMP.

In addition, for brand drugs, there's an inflationary rebate that could be added on should the increase in the drug's AMP exceed the increase in the Consumer Price Index over time.

For generic drugs, the rebate is 13 percent of AMP. There is no best price or inflationary component for generic drugs.

The ACA recently increased the Federal rebates by increasing their minimum rebate percentage on brand drugs from 15.1 percent of AMP to 23.1 percent of AMP, and for generic drugs, it increased it from 11 to 13 percent of AMP. In conjunction with these increases, the ACA requires that the amount attributable to these increases in the rebates above and beyond the old formulas will be remitted to the Federal Government. So the Federal Government will keep the entire amount, both the Federal and non-Federal share, of that increase in the rebate dollars. This could be anywhere from zero to eight percent of AMP for brand drugs, depending on where AMP minus best price falls in relation to 15.1 and 23.1 percent of AMP.

For example, if AMP minus best price were equivalent to 18.1 percent of AMP, the Federal rebate offset would be five percent of AMP, which is the difference between 23.1 and 18.1.

For generic drugs, the offset is two percent because there is no best price interaction.

In addition to the Federal rebates, States can negotiate supplemental rebates with drug manufacturers. These manufacturers will pay supplemental rebates to ensure that their products get placed on a State's

preferred drug list. So this is a rebate to try to move volume to their products.

So I just briefly want to touch on drug payment and rebates under managed care. Medicaid MCOs will typically use a similar payment structure as fee-for-service, where they'll pay an ingredient cost and dispensing fee, but will negotiate these payments with the pharmacies individually, usually through a Pharmacy Benefits Manager, instead of using a single payment formula like the AWP minus 15 percent.

The ACA extends the Federal drug rebates to prescriptions paid for by Medicaid MCOs. Previously, these rebates were only available for drugs purchased directly by the State under the fee-for-service basis. Because of these extensions of the rebates, several carve-out States who had taken the pharmacy benefit out of the Medicaid managed care organizations have recently carved the benefit back in.

MCOs can also negotiate their own rebates with manufacturers for placement on the MCO's formulary. These will be similar to the State supplemental rebates.

This diagram kind of summarizes everything I've talked about previously. So on the right side, you kind of see the flow of the drug through the various entities. It goes -- usually, typically, a wholesaler will purchase the drug from the manufacturer and then sell it to the pharmacy and the pharmacy will eventually dispense it to the enrollee. The State Medicaid agency pays the lower of those four different formulas that I mentioned earlier. And in the separate process on the left side, the drug manufacturer pays the State Medicaid agency directly the Federal rebate and any supplemental rebates that they have agreed to. And the State Medicaid agency will share both the payment to the pharmacy and the rebate dollars to the Federal Government based on their FMAP.

COMMISSIONER ROSENBAUM: I just want to congratulate you for this picture.

MR. PARK: Oh, thank you. This is only like a small subset of the entire pharmacy distribution chain.

[Simultaneous discussion.]

COMMISSIONER GRAY: Are the arrowheads correct on the State and Federal --

MR. PARK: The way I've showed it is, you know, the State initially makes the payment and then the Federal Government will send a match to the State Medicaid agency once they claim it on the CMS-64.

VICE CHAIR SUNDWALL: Just before you leave, you said the rebates go from the pharmacy to the Medicaid program, and then you said they share that money back with the Federal Government?

MR. PARK: No. The rebates go from the manufacturer to the State Medicaid agency. So the agency will submit an invoice to the manufacturers and the manufacturers will pay the agency. When the State claims their expenditures on the CMS-64 form, there's a line that accounts for the rebates. So, essentially, it discounts the total pharmacy spend and --

VICE CHAIR SUNDWALL: So they get the lesser payment from it, then.

MR. PARK: Right, and so -- yeah. By discounting the initial pharmacy spend, the State -- the Federal Government share is in that.

CHAIR ROWLAND: Chris, is there any indication of the extent to which extending the rebates to the managed care organizations resulted in State savings? I recall the representative from Virginia telling us that it was a major savings in their budget.

MR. PARK: Sure. There have been a few studies that have been recently put out. I think there was one for New York where they mentioned they saved a great deal of money. For States that had carved it in, it

should be -- who had previously carved it in before the ACA, it should definitely be a pretty big savings for them because they were not getting the rebates before and now they will be. And currently on the fee-for-service side, rebates, while not perfectly aligned on 64, are about 40 percent of the initial drug spend. So based on their managed care, they might be able to save around 40 percent on the pharmacy spend occurring under managed care.

CHAIR ROWLAND: It would be nice if we could try and gather some of that data from the States --

MR. PARK: Sure.

CHAIR ROWLAND: -- to really see what the indication of that -- what that policy change actually meant in terms of savings.

MR. PARK: Right. This slide, I want to briefly talk about 340B entities. There are a little bit different payment and rebate policies for these entities that purchase drugs through the 340B program. These entities are typically what you might consider safety net providers such as FQHCs.

The 340B program creates a ceiling on the maximum price manufacturers can charge 340B-covered entities. The ceiling price is calculated by subtracting the Federal rebate amount from AMP. 340B-covered entities may negotiate additional discounts with the manufacturers below the ceiling price.

So, essentially, the Medicaid rebate has been built into the 340B price. Because of this, the drugs purchased under the 340B program in Medicaid are not eligible for Federal rebates to prevent the manufacturers from essentially paying a double rebate. So the 340B prescriptions are excluded from the rebate invoice that the State sends to the manufacturers.

On this slide, we show Medicaid drug expenditures before and after rebates over the past several years.

One thing to note is in 2006, with the creation of the Medicare Part D program, you see a big decrease in drug spending due to the spending for the duals moving to the Part D program.

Yes?

CHAIR ROWLAND: [Off microphone.]

MR. PARK: Right.

COMMISSIONER RILEY: Before we go on --

MR. PARK: Sure.

COMMISSIONER RILEY: This whole conversation worries me. You've done a wonderful, wonderful job. I used to do this out of my office and it took, like, a year to understand the language and how it's changing. It's a terrible thing.

But this chart does worry me because it's obviously fee-for-service. It doesn't include the clawback. I assume it doesn't include the State supplemental rebates.

MR. PARK: It does include the fee-for-service supplemental rebates, but it wouldn't include any rebates that the MCOs might have negotiated as part of their process.

COMMISSIONER RILEY: Because I appreciate the footnote, but I just want -- it doesn't tell the whole story --

MR. PARK: Sure, and --

COMMISSIONER RILEY: -- State spending and I wonder if there's a way to do that.

MR. PARK: And one of the problems with putting the clawback payment in there is that it is State dollars, so you would need to change the chart to kind of show the State funds versus total expenditures.

One thing to note on this chart is over the past, you know, from 2007 to 2010, after the Part D drugs had been removed, the spending has been pretty low on the net side after rebates. There, it's been about a two percent annual increase from 2007 to 2010, whereas if you just looked at the gross expenditures that went to the pharmacies, it's been about a seven percent annual increase. This indicates that the rebates have steadily increased over time, and a lot of this is due to the inflationary component on the brand drugs.

And since you brought up the Part D clawback payments, that was about $4.5 billion in 2010, and there is some misalignment with -- because this is on a payment basis versus when the drugs were actually incurred and there's some additional offsets in 2010 due to the ACA increase in FMAP. It was, you know, adjusted kind of at a later date and retroactively paid in 2010, so the 2010 payment got offset a little bit.

So as the Commission moves forward with its work on prescription drugs, here are a few issues for consideration and possible MACPAC analyses to shed light on these issues.

The first is the issue of Average Acquisition Cost. A few States have already switched to Average Acquisition Cost as the basis for ingredient cost payment, and as I mentioned previously, the proposed drug rule in 2012 would establish AAC as the basis of payment for all States. While the States that have already switched to AAC believe it better aligns payment with the pharmacies' actual cost and can reduce spending, AAC may not lead to lower payments in States that have already pursued more aggressive drug pricing. The AAC standard could eliminate some of the flexibility that the States have in determining the payment to the pharmacies, as well as maybe increase administrative burden if they choose to do a State-specific survey on their pharmacies.

In order to assess the impact of AAC, MACPAC could do some case studies on States that have

already implemented AAC to better understand what kind of cost savings or financial impact they might have had as well as any implementation issues that have occurred by switching their basis of payment. In addition, we could try to model the financial impact in States by repricing the States' pharmacy claims with AAC prices from CMS. CMS is doing a national survey to determine Average Acquisition Costs on a national basis and they publish this file, so we could use those numbers to reprice some of the States' payments to see what the impact might be in particular States.

As mentioned previously, the extension of the Federal drug rebates to managed care has created a better incentive for States to put this benefit into the managed care organizations, because now they can receive the rebates where previously they could not. Several States have already switched their carve-in approach immediately after the ACA, such as Ohio, Texas, and New York, which are pretty major States with a lot of drug spending.

Additionally, States are looking to move more enrollees into managed care. So as things change over time, we may see a big shift of pharmacy spending from fee-for-service to managed care. So we need to better understand how managed care can impact utilization, spending, and access to drugs. We could analyze spending in those States that have recently moved to a carve-in approach and also compare the formularies under the MCO versus the State PDL to see where there might be differences in key drug classes to access the particular drugs.

Another issue is with program integrity and fraud, waste, and abuse due to poor care coordination, excessive or unnecessary prescriptions, or drug-seeking behavior. To address some of these issues, some States have implemented policies to reduce fraud, waste, and abuse, such as pharmacy and doctor lock-ins,

where enrollees with prescriptions for narcotics and other controlled substances could only get these drugs from a single pharmacy and a single doctor.

MACPAC could research States' experiences with these policies to assess savings potential and any impact on enrollee access. Additionally, we could analyze the data to identify groups of enrollees with a high number of prescriptions or a high number of therapeutic classes to identify potential areas of concern for the States where they seem to maybe be getting more prescriptions than they would need for a particular condition.

Another issue, and it is an emerging trend in the Part D and commercial sectors, are limited network plans, where copays are lower when an enrollee uses a preferred pharmacy. One example of this is the Humana arrangement with Wal-Mart on the Part D side. This has been a pretty popular plan recently. By limiting the network, plans can negotiate lower payments to the pharmacies to be in part of that preferred network. As these limited network arrangements gain more experience, it is possible that Medicaid programs will begin to consider them, as well, both on the fee-for-service and managed care side.

MACPAC can start to do literature reviews on potential cost savings in these preferred pharmacy networks as well as beneficiary satisfaction of these plans. Also, we can analyze pharmacy networks and utilization patterns that are existing right now to understand where enrollees are getting their prescription drugs and identify potential concerns for the State if they choose to limit a network.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: Thank you. This is a great example of wonderful complexity. I have a series of comments.

One is I would ask the Commissioners to take a look at the most recent Modern Healthcare, which listed the total compensation of various CEOs and look at the number of pharmaceutical companies that are in that list.

CHAIR ROWLAND: Is that also the one that has an article op-ed by you in it?

COMMISSIONER GABOW: Yes.

[Laughter.]

COMMISSIONER GABOW: The second is that there -- I think it was in JAMA, maybe somebody else knows this, on 340B, there was an commentary on the 340B issue. The lock-in, we had a presentation here by someone from one of the States that had done a lock-in and how much not only money savings there was, but live saving from narcotic overdose. So I think we should dig into that a little bit because I think it has the benefit of both helping people and saving money.

I was once accused of running a safety net-like business and it would be good if the government did this with drugs. And, you know, if you were the biggest vendor, like Wal-Mart is, they negotiate price based on volume and wouldn't this be good for the government to do in a global way.

In that regard, I don't know if this is possible, Chris, but a table that would take maybe the top ten drugs that are used by Medicaid, and if we could get the price, the general price paid with the rebate off Medicaid, then the price for the VA, the price for Medicare Part D, the 340B price, and the price in the Euro Zone. I think understanding the tremendous difference in this for the top ten drugs would be extremely useful, because I think that there is still a lot of potential here.

And the issue about some of the newer drugs, including the biologicals, I think we have to touch on

that, because I know that before I left Denver Health, this was becoming a huge issue and I think it's only going to become more. There has been a lot of focus on this in the literature, about the cost of these biologics. I think we should maybe sort that out a little bit, because that's going to break the bank.

COMMISSIONER HENNING: First, Chris, I just want to thank you, because this chapter made this super-complicated subject as understandable as anyone could possibly make it, which I'm still confused about, but it's not for you lack of trying. It's just such a complicated subject that it's just really difficult to get a handle on.

But I was just curious on the Medicaid managed care side. I know that some of the Medicaid managed care companies will pay for over-the-counter drugs. Is that allowed under this whole Medicaid scenario, or is that just something they do to try to cut down on people going to the doctor?

MR. PARK: It is allowed. You know, the Medicaid agency will pay the capitation payment to the plan and the plan may choose, instead of dispensing a prescription drug, to substitute it with a generic -- an over-the-counter alternative. And State Medicaid agencies on the fee-for-service side can also cover certain over-the-counter drugs, as well.

CHAIR ROWLAND: Mark.

COMMISSIONER HOYT: This is a really complicated topic, for sure, so I want to compliment you, as well, on the draft you've got here.

My first question was, where do we see ourselves going on this topic, and more specifically, maybe, what I'm thinking is you might want a chapter that's pretty close to what you've got here that's just kind of educational and lays out in broad strips all these different topics. But it just surfaced for me all kinds of

follow-on topics related to this, but it may be too complicated for one chapter, so you'd have a follow-on chapter later that would deal with things like managed care specifically. I'm wondering -- I was honestly thinking right now, probably, the percentage of scripts filled by managed care contracts exceed 50 percent.

MR. PARK: Sure. I think, especially with New York and Texas and Ohio moving to managed care, you'll see a big shift. And one of the reasons why I kind of cut the spending slide at 2010 is because there will be probably a big drop in spending and a big increase in rebates due to the ACA, so I wanted to kind of keep those effects isolated from what I was showing right now.

COMMISSIONER HOYT: I know from other work that I did when I was at Mercer that we did, there are so many moving parts here, it kind of gets mind-numbing looking at all this. It's really important to focus on the net spend, PMPM, although it's hard to boil it down to that.

This is also -- you reach a point of intersection a lot of times with health care and politics that influence a policy. This is one where -- I was thinking of the filling fees, specifically, or dispensing fee, where States will purposely make choices not to negotiate aggressively because it hurts them, it hurts independent pharmacies. But a managed care contract can go out like Atilla the Hun and negotiate a buck-fifty or two bucks, which would be politically unacceptable for the State to do that. So there are savings there.

It would also be useful if we could get to the percentage of generics being prescribed in any of these buckets, by State or fee-for-service versus managed care.

And then one more, maybe, and then I'll stop. Psychotropics is a huge issue for States, the whole behavioral health side. Who has prescribing responsibility? It's probably primary care in almost all States, still. In Arizona, where I'm from, they did behavioral carve-out and they have the drug responsibility. If

there's other States like that, it would be interesting to try to tease that out. Does that affect the spend there? You could almost devote an entire chapter to psychotropics.

CHAIR ROWLAND: I think as a follow-up to Patty's comment, to really look at what the top ten drugs are by State is really interesting, because you do see the strong influence of the behavioral psychotropic.

MR. PARK: Right, and that would be one of the things we would want to do, is to do some more descriptive statistics on drug spend and utilization in the States, you know, what the generic dispensing rate is, what are the top drug classes and the top ten, 20, 30 drugs, whatever.

CHAIR ROWLAND: Mark, I didn't mean to cut you off?

COMMISSIONER HOYT: That's okay. Just a couple comments real quick to wrap up that I think would apply to almost anything we do. At least recurring themes for me would be what are some best practices here by state and what saves money and still delivers -- you know, meets medically necessary requirements and a decent quality of care? I think that's something we're always going to be asked.

This is really interesting. What saves me money and what are a couple examples of states that do this really well?

CHAIR ROWLAND: Great.

COMMISSIONER ROSENBAUM: This is incredibly useful. I wanted to try and flag a couple of issues that sort of fall outside of where we are now, but that I think are very important for us to get on the table. And those have to do with, in fact, drugs that are dispensed in clinicians' offices. So there are two kinds -- one being, of course, drugs for very, very serious illnesses, like oncology, medical oncology.

Back a few years ago -- I don't know how things are today -- when we were doing a lot of work with

D.C. Medicaid, we had an absolute crisis in D.C. because we had no medical oncology available to Medicaid beneficiaries. And the issue was a battle between the oncologists and D.C. Medicaid over how physician-dispensed drugs were being compensated. So I think that becomes an important, a very important issue.

The other way it shows up -- two other ways. One, because of the three-day emergency rule in Medicaid, and the role particularly in clinics in medically underserved communities, whether they're hospital based or clinic based, clinic dispensaries, doing a three-day dispensing of the drug and being able to get paid for that dispensing, to allow someone the time to get to a pharmacy, I don't think we know enough about the policies, how they're working, whether there are dispensaries that can get paid that normally wouldn't be paid as a pharmacy. And in that thing, the third issue is an issue that I spend a fair amount of time on now because of a large study we did on family planning in which we were able to document in many states the serious absence of more new-generation, longer-lasting contraceptives, which are, of course, implanted or inserted; they dispense a drug. And in many states, the dispensing clinic could not get covered for the drug. It was not clear to me whether if you went to a drug store you could go get the drug filled and bring it back. But, of course, each process step here matters, and because there was no revenue flow, both Title X clinics and community health center or family planning programs reported serious underprovision of the more modern prescribed drugs.

So that led me to think that on certain conditions where we are seeing older-generation and newer-generation drugs, and the newer generation -- I don't know if there's another example like family planning, but where there really are great gains to be made, population health gains from certain drugs,

whether those drugs are being picked up, whether they're covered, they're ostensibly covered, but they're not being positioned in ways that make them accessible to the population, I think those are issues, in addition to the prices that Medicaid programs are paying for the drugs, that we really want to think about because they're sort of the hidden access questions in drug availability.

COMMISSIONER CHECKETT: Well, I'll join my colleagues in saying great work on a complicated issue.

One issue that has always interested me is the 340B program because it is a complement to the accommodations we made for high-volume safety net providers. And as a further area of study for us, it might be worth more time on -- you know, we understand why it exists, but are there lessons to be learned, are there -- can we learn that our people may be getting scripts filled on-site as opposed to walking away with prescriptions that don't get filled elsewhere? Are there system delivery issues? And I'd just like to throw that out there because, you know, my understanding of 340B is it's largely institution based -- not always but largely, whether it's at a hospital, an FQHC, and there might be some practices or learnings for us to take away from how that program affects prescription usage and filling and eventually patient outcomes. So just an idea. Thank you.

COMMISSIONER RILEY: I have a little point. If we look at the preferred pharmacy network approach, I think we do have to balance that against state any-willing-provider laws.

MR. PARK: Sure.

COMMISSIONER RILEY: Because there may be real limits on what states can do. But in a bigger picture, I'm always struck every time we get deep into this about the enormous complexity of it. And then so

you think at the pharmacy level there's complexity to administer this, at the plan level, at the state level, at the federal level, and we're doing the same thing in Medicare in silos.

So it strikes me that we could take these issues for consideration and just keep digging into this complexity that probably will make it more complex. Or what if we pulled back, went with MedPAC, and -- but pharmacy spending is still a teeny part of total spend of this program. And yet when you think of the administrative costs and complexity of it, it's unbalanced, the DUR committees and all the kind of work that goes on in this thing. I wonder if it isn't time -- and Patty alluded to this -- to sort of start to think about a national policy for Medicare and Medicaid that negotiates drug prices or sets them and if that isn't a value added to this debate that we could make. Certainly this kind of work that identifies the complexity is terribly important, but do we want to still -- every time we change something to try to make it better or to look at best practices, it seems we make it more complex. And I wonder if it isn't time to say stop this madness, it's 10 percent of the spend, there's a better way to do this.

COMMISSIONER GABOW: Well, I would echo that. I think the 340B issue and the VA pricing are two issues we should look at in regard to national negotiation, because the VA I think, I believe, pays the lowest price for drugs of any entity, and I think understanding the way that is accomplished is suggesting perhaps it may be time to do this. Of course, the pushback will be enormous, but I can tell you that the savings -- and this is a question about 340B, Donna, that I've never been able to ascertain. The cost, at least for us at the time that I was at Denver Health, if a patient filled their prescriptions at our pharmacy where they would get 340B pricing compared to going outside was a difference of about $13 per prescription. If you --

COMMISSIONER CHECKETT: Lower.

COMMISSIONER GABOW: Lower. Yes, lower. And if you think about what that equals in total over the number of prescriptions, there's a lot of money there.

The other -- and we often said, Why can't the government mandate that if you are getting your care at a 340B provider, you get your drug at a 340B provider? And there are benefits to that --

[Laughter.]

COMMISSIONER GABOW: There are two benefits to that. One obviously is the saving of money. The second is that we've been able at Denver Health to get some incredible results in terms of diabetes, hypertension, because all the data then is available within the data warehouse. So you know if Person A doesn't get their hypertension drug refilled at Time A when it should have been done and you can reach out and say, you know, "Gee, Mrs. Smith, what happened? You're due to get your drug refilled." Whereas, if you don't have all that data in a single database, it's very hard to use your registries in a proactive way to improve care.

And so there is -- I think always our goal is how do we save money and improve care, and the mandating that would do that -- but I've never been able to understand whether the 340B price is better than the rebate.

MR. PARK: Well, yeah, as I mentioned earlier, the 340B price is calculated using the rebate information, so it's essentially kind of baked into the 340B price. So from the state's perspective, it gets more complicated because they won't get the rebate if they -- you know, if it was a 340B prescription. And so at the net level for the state, it might not be very different, because --

COMMISSIONER GABOW: But it's better for the patient if you could get --

MR. PARK: Right, yeah. I'm just speaking from a spending perspective.

COMMISSIONER GABOW: -- also caregiver.

VICE CHAIR SUNDWALL: I just can't resist weighing in here and saying that MACPAC ought to also have some statement about the poor outcomes of polypharmacy. I mean, I don't know how better to say it, but the patients I see take too many medications. I'm always proud that I wean them off, to the extent I can. There are way, way, way too many drugs prescribed. They're not only not effective, they often make you sick. And so while we need to negotiate the best prices possible, we also need to promote best practice of prescribing. And it's an important issue in health. It really is.

MR. PARK: Right.

VICE CHAIR SUNDWALL: Especially with the deaths of opioid misuse.

MR. PARK: Right, that would be part of any of the program integrity work that I mentioned, to look at polypharmacy, opioid use, things like that.

CHAIR ROWLAND: Well, I think we're also talking about looking here at the access issues and the quality issues as well as the price issues.

MR. PARK: Right, right.

CHAIR ROWLAND: We're folding it all together. And I think you've set us on -- you've set out a great background here on the pricing side. I think we've had a great discussion, but I think this just is the tip of the iceberg of what we really want to look at. So thank you, Chris.

MR. PARK: Thank you.

CHAIR ROWLAND: And I would welcome anyone from our public audience who has a comment

at this point to come forward, and I think there's a mic, if someone can get it.

PUBLIC COMMENT

* DR. SUMMERS: Thank you. My name is Lisa Summers, and I'm the Director of Policy and Advocacy at the Centering Healthcare Institute, and Centering Healthcare Institute is a nonprofit whose mission is to improve maternal and child health care by transforming care through groups. So, clearly, my big message is we so much appreciate your attention to maternity care because it's so incredibly important for all the reasons you know.

So, just quickly, Centering Pregnancy is an innovation that moves prenatal care from the traditional one-on-one experience in an exam room into a group space, and it bundles all the components of traditional prenatal care with social support, education, and additional social services. And while it was developed in the 1990s, it really came on the radar screen in 2007 when a randomized controlled trial showed a pretty dramatic 33 percent reduction in pre-term birth among women who were randomized to prenatal care versus traditional care, and actually very interesting, it was a 44 percent reduction in the African American population.

So you can imagine that's why it came to the attention of CMMI, and it has been folded into the Strong Start grant that you all know about.

So what I really wanted you to know -- you've referenced several times the potential for payment reform to drive changes in health care. So what I really wanted you to know is that there are a couple of state Medicaid programs that have developed incentives to encourage the use of centering for prenatal care. In South Carolina, it's a $200 incentive payment for the pregnancy. In Texas, it's $30 per woman per visit. And we are actively engaged in conversations with other state Medicaid offices and many Medicaid MCOs to see

what we can do to set up incentives for enhanced care.

So I would love to provide you more information. We'll send some comments to you through the electronic option on the website, but I also want to say that you have in your midst one of our early adopters, Denise Henning. And actually looking back and talking with Denise about her experience, it really underscores in the day when Denise was an early adopter, the founders sort of thought, well, we can go out and teach people how to do this and they'll do it and we'll change care and it'll work. And, in fact, what we've learned, it requires some pretty impressive system redesign to redesign your system. So it's a great time to be talking about it.

Thank you.

VICE CHAIR SUNDWALL: What's the name of your organization again?

DR. SUMMERS: Centering Healthcare Institute.

VICE CHAIR SUNDWALL: Thank you.

CHAIR ROWLAND: Thank you, and we welcome any submissions you have for our consideration as well.

DR. SUMMERS: Thank you. I've shared some material with your staff, and I'll be glad to do that.

CHAIR ROWLAND: Great. Thank you.

MS. KHANI: Hello. My name is Julie Khani, and I'm with the National Association of Chain Drug Stores. I have so many comments after your discussion this morning. I am going to edit myself, but just a couple quickly.

Really interesting presentation. We're looking at a lot of these issues as well, obviously, so as much as

a resource that we can be, we'd love to partner with you.

I appreciated your comments about comprehensive pharmacy reimbursement. That reimbursement for the drug product as well as the dispensing fee is really important.

What you've seen in half a dozen states that have moved to acquisition costs at this point for brand and generic drugs is that because really true cost is being paid on the drug product side, true cost for the cost to dispense has followed suit. So rather than those $4 or $5 dispensing fees, you're actually seeing a dispensing fee varying, but on average about $10 because that is the cost to the pharmacy. So I'd just encourage you to look at that and think about that.

Secondly, I want to mention drug adherence, and prescription drug cost is a small part of the spend, but it has a tremendous impact on hospitalization medical costs. We've seen some interesting things. The Congressional Budget Office has actually changed their scoring methodology related to Part D recently, that if you can get an increase in prescription drug utilization, they're going to score a corresponding decrease in other costs.

CMS also in Medicare Part D population recently released a study on medication therapy management finding the same things, that when you get pharmacists to sit down and talk to a patient who's taking a lot of medications that get them on the right track that you actually can see some significant reductions.

And then, finally -- and I will stop there -- on the issue of preferred networks, we'd also encourage you, if you do look into that area, recently in the 2014 call letter in Medicare Part D, some concerns were actually expressed about those networks that, in fact, they may actually be costing the Medicare program more money than the broader network. So I'd encourage you to look at that as well.

So thank you so much.

CHAIR ROWLAND: Thank you, and we'd welcome any -- since you had to truncate your remarks, any additional comments, please share them with the staff or send them in directly to us. And if there are states that in your work you can identify as places that we should look for best practices, we're always looking for help in identifying where to go and understand some of the more innovative approaches.

MS. KHANI: We'd be happy to do that. Talking about generic utilization, whether it's fee-for-service or managed care, you've got utilization rates that bounce all over the place, and that's just a real kind of obvious first thing. But thank you. We'd be happy to look into that.

CHAIR ROWLAND: Thank you. We look forward to working with you.

MS. KHANI: Thank you.

ADJOURN

* CHAIR ROWLAND: And with that, we stand adjourned until -- I guess until the fall for our next formal meeting.

[Whereupon, at 11:46 p.m., the meeting was adjourned.]