PUBLIC MEETING

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Session 1: Extending CHIP: Short-Term Issues
Chris Peterson, Principal Analyst.....4
Ben Finder, Senior Analyst.....20

Session 2: Long-Term Policy Options for Children's Coverage
Chris Peterson, Principal Analyst 39
Joanne Jee, Principal Analyst.....54
Ben Finder, Senior Analyst.....71

Public Comment.....98

Session 3: Update on Medicaid Expansions
Sarah Melecki, Analyst.....99
Martha Heberlein, Principal Analyst.....109

Session 4: Sites of Care Serving Medicaid Enrollees
Anna Sommers, Principal Analyst.....115

Session 5: Review of Medicaid Eligibility and Enrollment Issues
April Grady, Policy Director..... 141

Session 6: Improving Eligibility and Enrollment for The Medicare Savings Program
Katie Weider, Senior Analyst.....175

Session 7: Use of Behavioral Health Services by Medicaid Beneficiaries
Amy Bernstein, Policy Director and Contracting Officer.....190

Session 8: Use of Psychotropic Medications by Medicaid Beneficiaries: Patterns and Policy Issues
Chris Park, Senior Analyst.....219

Session 9: Medicaid Coverage of Dental Services for Adults
Sarah Melecki, Analyst.....241

Public Comment.....260

Adjourn Day 1.....261

P R O C E E D I N G S

[10:12 a.m.]

CHAIR ROWLAND: Good morning, and welcome to this meeting, the Medicaid and CHIP Payment and Access Commission, and we're going to continue our work today at looking at the issues surrounding the Children's Health Insurance Program, both its immediate extension and the options that are being pursued by the Congress to look forward to the next few months of taking some potential action on at least continuing CHIP during a transition period and then, after this discussion, turn to looking at some of the longer term issues.

But we're going to start with Ben and Chris to discuss short term, CHIP in the short term.

Session 1: EXTENDING CHIP: SHORT-TERM ISSUES

* MR. PETERSON: Thank you, Diane.

Last June, the Commission recommended that Congress extend CHIP funding by two years. We noted that if CHIP ends, as under current law, many children would become uninsured, and the cost of receiving care even for those obtaining other coverage would often be prohibitively high compared to CHIP.

As you know, our March report this year will provide even more evidence of these and other effects. The Commission has made clear that it is urgent to extend CHIP as soon as possible.

Now it appears Congress is getting ready to extend CHIP. The day before yesterday, the Republican Chairmen of CHIP's committees of jurisdiction in both the House and the Senate published a discussion draft of legislation for extending CHIP, and Democrats in the House and Senate have separately introduced legislation.

Commissioners, you have in your materials some information on these. If you want, there is an opportunity now for the Commission to share its views with Congress on some of these specific issues.

So before the process gets too far along, we wanted to remind you of some of the relevant work the Commission has previously discussed in case you want to reemphasize some of those ideas. In addition, you may want to express your support for other changes to offer to Congress while an extension of CHIP is considered.

But first, I will provide you with a brief update of projections of when states will run out of their federal

CHIP funds if Congress does not act, based on the latest available information, and then I will turn it over to Ben who will walk you through issues you may want to raise as part of an extension of CHIP. Then as Diane mentioned, in the next session, we'll take the longer view to address affordability and adequacy of children's coverage.

So to reiterate, under current law, there are no new CHIP allotments after FY 2015. So CHIP funds will run out in FY 2016, which begins October 1st of this year. Remember that existing CHIP allotments are available for two years. So that means once FY 2016 arrives, states will have their unspent FY 2015 allotments that remain.

At the same time, when October 1st rolls around, the CHIP matching rate will increase by 23 percentage points, so that will increase the rate at which states use those remaining allotments. And then there will be some redistribution money that is available and will provide some limited relief.

So this is a chart we have shown before, but this reflects the latest numbers, and I will just start with the middle set there with FY 2015, which is a typical year. The kind of beige column shows the allotment, which was

just announced a couple weeks ago, I believe, and states were notified as to what the allotment amounts were. So they total $11.3 billion, but then states also had unspent balances that they were rolling forward of $5.9 billion, and that's against projected federal CHIP spending of $10.5 billion. So you see there's plenty of money in the system to cover states' expenditures.

As we go to 2016, you will note there is no beige column because there is no 2016 allotment under current law, but states are rolling forward $6.3 billion in unspent money.

At the same time, spending goes up a lot, and that's primarily because of that 23-percentage-point increase, so that's where you see the gap between the funding and the spending.

Which leads to this, that states are going to run out of CHIP funds, and they are going to run out of CHIP funds at various points during the year, depending on how much they project to spend and how much in unspent funds they are rolling into 2016. This is the first time that we have published state-specific numbers of when they will exhaust their funds, and this is based on the latest

information that we have on states' final FY14 spending, the new FY15 allotments, and projections that states provided of their own spending as of November.

They provide those projections quarterly, so they are in the middle of submitting a new set. So these numbers will change, but this gives you the latest that we have right now.

Just to reiterate that the effect of the exhaustion of CHIP funds varies by states' program designs, separate CHIP programs if the money runs out. They can shut down those programs. The maintenance of effort does not require them to continue their separate CHIP programs in the absence of federal money, but the Medicaid expansion CHIP programs, that coverage is really Medicaid coverage funded by CHIP, and so if the CHIP money runs out, states fall back to the Medicaid money, albeit at a lower federal matching rate, but those children's coverage continues.

This slide shows you -- again, this is one we have seen multiple times, but on the right-hand side are the states that have more than 90 percent of their CHIP spending through Medicaid expansions. So, again, those states won't see a large decrease in -- they won't see a

large increase in uninsurance if the CHIP money runs out, but they will have to pay more in terms of federal money to cover those children versus on the left-hand side where you see less Medicaid expansion CHIP coverage in those states and greater reliance on separate CHIP programs.

And so, with that, I'll turn it over to Ben.

CHAIR ROWLAND: Let me have a pause here for a minute. Does anyone have any questions on the material that Chris has just presented?

Patty.

COMMISSIONER GABOW: Could you just -- I think to make sure we all understand this completely, why do states run out at different periods of time, given the way CHIP is, CHIP funding goes to the states based on the program that existed in the previous year? I think just running through that might be useful.

MR. PETERSON: So what your point is, that if CHIP allotments are based on prior year spending, then there should be some kind of uniformity of when states would run out under current law, and that's true the allotments are targeted in that way. But one of the unique features of CHIP is that there is two years of availability

of these funds, and so the balances, essentially, that they are rolling forward from previous years kind of become legacy balances. And so that just affects how they spend the money in the future.

So states are going to begin 2016 with different leftover amounts, which is somewhat -- I want to say "atavistic," but that's not the right word -- but somehow a legacy from prior years.

COMMISSIONER RILEY: I think this is extremely useful information, as “CHIP” always provides.

The other piece of this, though -- the chart doesn't tell the whole story, as Sharon and her colleagues have reported to NASHP in the survey -- the actions that states have to take, to begin to notify people, to begin to change the budgets, states that are on a July 1 budget year, so this is a little bit misleading in terms of how much up-front time states need if this program is going to go away.

CHAIR ROWLAND: So, Sara, did you have a comment?

COMMISSIONER ROSENBAUM: Yes. Just to follow up on Trish's point, that suggests that, for example, if there were rolling short-term patches to the funding, that that

might in the end -- I mean, you can say, "Well, states are going to sort of expire over time, so we only have to fund and make decisions about CHIP a few months at a time." But what you're saying is that states need a very long lead time on the planning part, so you can't view it the way you might view, say, the SGR payment where you can keep it sort of a few months ahead of when it's supposed to fall back.

CHAIR ROWLAND: Sharon.

COMMISSIONER CARTE: I just wanted to reiterate, first of all, thanks, Chris, for going through this material again. I'm sure you could probably do it with your eyes closed now, but it is such a good summary of things that we have previously looked at for short-term points about the extension that I would hope that we could consider a letter to go to the committees.

CHAIR ROWLAND: What I was going to recommend is that this get out as a policy brief as quickly as possible, just so this information is available. I mean, obviously, anyone in the room today who picks up our slides will have the information, but let's put it out with some context. And if we go forward with a letter, this would clearly be then an attachment to the letter and something we consider.

But I am noting Sharon and Chuck both want to get in here.

COMMISSIONER CARTE: The other part of my point is to reiterate or reemphasize what Trish and others were making, that states have very unique conditions.

I believe I have pointed out before, like in my own state, that we have a provision in our state code that authorizes our separate CHIP program, and it does state that if there is an insufficiency of federal funds, the program is terminated. So I feel like, as a director with a board, that I am faced with making a decision very soon, so I hope that we would make a clear statement about the urgency for making a CHIP extension decision in the Congress. It is not like shutting out the lights to close down a program.

CHAIR ROWLAND: Well, I certainly think, given the timing of the congressional consideration, that in addition to the material that would be in our March report that we will clearly want to reiterate to the Congress that what we are discussing here today, rather than wait for the publication of a future report, be included in a letter to Congress, and these are good points to include in that

letter.

Chuck.

COMMISSIONER MILLIGAN: Along those lines -- and, Chris, it's a great presentation -- I think that it's a little overstated, though, for the Medicaid expansion states to say that because of the MOE, there is really no effect on coverage. I think for a state that has a Medicaid expansion version, if CHIP isn't extended, the change in match rates will have budget consequences that could cause the state to change, provide reimbursement rates or other features, or some of the other features of authorization ground rules and utilization management inside of the Medicaid coverage for children that would have effects on coverage.

So I just think we need to be careful in how we nuance the description of the effect on Medicaid expansion states.

CHAIR ROWLAND: Great point. Well taken.

Marsha.

VICE CHAIR GOLD: Yes. Just apropos that point -- and I think this is correct -- I mean, a good example is California that had a separate CHIP program and moved it

over, I think, to become a Medicaid-expansion program, and yet we know they have had all those budget consequences for all those years. And if then the match rate changes, that might be a good example to think about, making some of that real. They were doing that to help integrate coverage for children, I think, so there would be fewer barriers, and so you can create some really counterintuitive things.

CHAIR ROWLAND: Okay. Well, to move on to Ben.

MR. FINDER: Thank you.

As Chris mentioned earlier, the Chairman and Ranking Members of CHIP's committees of jurisdiction in both the House and Senate have publicly called for an extension of CHIP, although the timing remains unclear. As Congress considers an extension, it is possible that changes to the way the program currently operates will also be considered, and today, we have highlighted some issues that the Commission may want to weigh in on during conversations about an extension of CHIP.

The first set of issues that we have highlighted focus on recommendations that the Commission has previously made. The Commission has previously recommended that Congress provide states with a statutory option to

implement 12-month continuous eligibility in separate CHIP. Continuous eligibility is a strategy to address churn and allow states to enroll children for 12 months, regardless of changes in family income or composition that may occur.

CMS permits states to use the strategy under regulatory authority currently, and the Commission recommended creating statutory authority for this policy. The recommendation also emphasized the importance of eligibility determinations and meaningful verification of applicants' self-reported income.

The Commission has also recommended eliminating CHIP waiting periods. Waiting periods are a strategy to prevent crowd-out of employer-sponsored insurance, and 18 states have CHIP waiting periods in 2015.

In its rationale, the Commission noted that it is unclear whether they have been effective at deterring crowd-out and that many of the affected children will churn back and forth between exchange coverage and CHIP or remain uninsured during the waiting period.

The Commission recommended that the Congress provide the children with family incomes below 150 percent of the federal poverty level not be subject to CHIP

premiums. This would align CHIP policies with premium policies in Medicaid, and the Commission noted that eliminating premiums would remove a barrier for families to take up coverage, and that this recommendation would remove states' burdens of collecting and administering relatively small premiums.

The Commission also noted that the combination or stacking of both CHIP and exchange premiums could result in financial hardships for some families.

In a letter to the Secretary and Congress reviewing evaluations and other reports, the Commission supported certain CHIP policies. For example, the Commission supported a permanent extension of the Express Lane Eligibility policy option in a letter to the Secretary on an evaluation of the ELE policy. Express Lane Eligibility allows states to rely on the eligibility information from other public agencies to determine whether a child is eligible for Medicaid or CHIP.

Fourteen states and one territory use Express Lane Eligibility for their Medicaid and CHIP programs, but the provision permitting it will expire on September 30th, 2015.

In November of last year, the Commission reviewed two HHS reports to the Congress on quality. We supported continued funding of state and CMS quality measurement efforts, although we did not specify funding level. These quality measurement efforts were funded in the CHIP Reauthorization Act of 2009 for the Secretary of the U.S. Department of Health and Human Services to identify, publish, and periodically update a core set of child health quality measures for states' voluntary use in Medicaid and CHIP. The funds are also used to encourage states to engage in pediatric quality measurement.

In reviewing the mandated evaluation of CHIP, the Commission expressed its support for improving data collection and monitoring of individuals moving between Medicaid, CHIP, and exchange coverage. These data would allow policymakers and researchers to better understand lapses in coverage and to evaluate those in the coverage gaps.

The Commission has also discussed additional legislative issues for CHIP, and the first is the contingency fund, which was designed to coverage a portion of qualifying states' shortfalls of federal CHIP funds.

One issue is that, as it currently operates, the fund can provide states with more money than the shortfall they face, although this has only happened once. The contingency fund is authorized for the end of FY15, after which no payments can be made, regardless of the fund balance. To address this issue, the CHIP statute could be amended, so that no state receives contingency funds in excess of their shortfall.

The second issue is that the CHIPRA bonus payments or performance incentive payments, which we discussed at a meeting last April, CHIPRA created a way to pay out annual performance bonuses to states that both experienced substantial increases in child Medicaid enrollment and implemented at least five of eight specified outreach and retention efforts in their Medicaid and CHIP programs.

In April, we noted that states are now required to implement four of the eight outreach and retention efforts, and that the authorization for the bonus fund has expired. At that meeting, the Commission noted that it was unclear to what extent the bonus payments were effective at incentivizing states to implement enrollment strategies and

reduce uninsurance among children who were eligible and not enrolled.

The Commission considered some scenarios for the future of these payments but did not draw conclusions about whether the program warranted extension.

Another issue to consider is whether to change the baseline year for measuring enrollment growth in those bonus performance incentive payments.

Finally, there are more substantial changes under discussion as Congress discusses an extension of CHIP. One of these changes would be to eliminate the 23-percentage-point increase in the federal CHIP matching rate. The ACA applied this change to the CHIP matching rate for FY 2016 through FY 2019. This would increase federal CHIP spending, and states will spend their CHIP allotments more quickly.

Competing perspectives on the percentage point increase will emerge. On the one hand, CHIP directors in 18 states indicated that their governor's proposed budget assumes the 23-percentage point bump, and 17 states were unsure. Ten states did dot assume. That's from the NASHP report recently on states' budget efforts or budget

decisions as CHIP goes forward. On the other hand, some believe that the bump is not an effective strategy to cover more children.

Another change would be to lower the CHIP income eligibility cap. States have the flexibility to set their own eligibility levels, and CHIPRA changed the federal matching rate for children with incomes greater than 300 percent of the federal poverty level from the enhanced CHIP matching rate to the regular Medicaid match rate. Since this provision applies to states expanding after the enactment of CHIPRA In 2009, no state has yet been subject to the lower matching rate.

EXECUTIVE DIRECTOR SCHWARTZ: Ben, I just want to point out that it is a percentage point increase in the CHIP matching rate, not a percent increase.

* MR. FINDER: Thank you.

We look forward to hearing your thoughts on these issues, and we are ready for feedback. Thank you.

CHAIR ROWLAND: And I would note that the material that you have predates the discussion draft that was released on the 24th of February by Senator Hatch and Representative Upton, so that there are some other issues

that have been raised in that draft that were not included necessarily in the materials here.

But I'll open the floor for discussion of where we go next.

[Pause.]

CHAIR ROWLAND: Okay. Well, there's a number of provisions here that we have not yet commented on. I think Ben did a nice job of reviewing our recommendations to date, but now it is a time to say if we are supporting, which we are urgently, that the CHIP program be extended, so that children's coverage can be maintained at least during a transition period. What are some of the key provisions that ought to be included in that extension?

Sheldon.

COMMISSIONER RETCHIN: Can I just ask on this, the distribution of the states, that either assumed or have not assumed the 23 percent increase in -- percentage increase?

CHAIR ROWLAND: Point.

COMMISSIONER RETCHIN: Percentage point increase.

Was there any pattern there? Is it just the states' budgets are a different time? Why would 10 states

not assume and then others assume?

MR. FINDER: I'm not sure. In the report, it just lists the numbers of states. It doesn't go into specific detail about which states go which way or the other. I'm not sure how states are thinking about this budget, aside from how the decisions they make.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: Well, I think that we had put a fair amount of thought into the previous recommendations, and I think we should reiterate them in a letter to Congress saying that this is what we think. And I think we should be clear that we thought the extension was necessary to create a more robust and adequate program for children within the other options, not that we were supporting CHIP be extended forever, but rather the other options which now exist have to be not a step back from what we've done to coverage children, and I think reemphasizing that we don't want to step backwards from where we have been, which has been an important change for America's children. And we want to continue that because they're our future.

So I think reiterating our recommendations are

good, and I would go beyond reiterating our recommendations to the things that we supported in letters in addition to what we had as a formal recommendation because it shows our intent.

The one thing that is listed here that we didn't really either say -- I don't think we said in a letter or recommended -- was contingency fund not be -- states not get more than covers their contingency is, it seems to me, like an obvious thing to do. Why would you want to do more than that? So supporting that seems reasonable as well.

CHAIR ROWLAND: We have previously been on record in supporting that in discussion.

Sara.

COMMISSIONER ROSENBAUM: Among the issues that I've certainly focused on myself are the ones that, of course, as we just noted were proposed, but they were proposed after the slides were prepared, so the proposal to lower the upper limit on allowable income levels in CHIP. It seems to me that that proposal actually has an effect that's sort of the opposite of our previous recommendations in that it creates more of a divergence between CHIP and our other principal subsidy system now, and the irony is

that until we address the family glitch problem, which, of course, is a longstanding recommendation, by lowering the cap, you have the potential to push more children into the tax subsidy system where we run into a family glitch.

Now, already, many, many states have income eligibility standards under CHIP that are much lower, significantly lower than the tax subsidy levels, so we have an unknown number of children caught already. If you combine both a narrowed amount of funding going forward with a downward pressure on the upper limit of the eligibility standard, my concern is that states reading the two together may be concerned about length of time, amount of money, whatever further comes down, and then we'll have more children in the family glitch. So that is the area that I think of all the things that Ben has laid out, the one that I am the most focused on.

COMMISSIONER RILEY: It seems to me, to Patty's point, that we ought to reiterate strongly where we've been on this one, that we view this as a transition point, and as such, there is an urgency to do it because the more there's uncertainty, the more confusion for the states and the more likely there will be impact on children and

families. And then make the case for consistency that this is a bridge, this is a transition period to resolve the issues like family glitch. So to change the program now would be to add a layer of complexity that's really confounding and unnecessary and costly.

So what we ought to do is reiterate that this is a glide path to buy time to make the fixes that need to be made, to think about a future in which children are better integrated into existing systems, but again to stress the urgency because the waiting game is just really very troublesome.

And to the point of the 23-percentage-point increase, to me it's fundamentally important to keep that commitment. It's part of the law. States planned on it. It was the deal, and as such, it needs to stay that way, or we, once again, invited the discussion about can you trust the federal government, and there are broader issues of concern to that.

Whether it was a good policy idea or not, it seems to me, go with consistency, make the changes over time.

CHAIR ROWLAND: Chris, it would be helpful, I

think, if you would re-read to us the exact language of our previous recommendation, so that we know what it is we're talking about reinforcing.

MR. PETERSON: My Acrobat had crashed, so give me a few minutes.

VICE CHAIR GOLD Do you want to borrow the piece of paper?

[Laughter.]

EXECUTIVE DIRECTOR SCHWARTZ: It was a chapter from the June report that I think for the purposes of briefing Hill staff last year, we pulled it out and bound it separately, and there were a number of copies left over that I shared with the new Commissioners.

MR. PETERSON: So are you referring to just the general recommendation which says the Congress should extend federal --

CHAIR ROWLAND: The one that you showed Anne earlier.

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

addressed."

And then under the rationale, there was this sentence that's in the June report, "This recommendation assumes no changes in any other aspect of CHIP-funded coverage as it exists under current law, including the 23-percentage-point increase in the CHIP federal matching rates slated for FY 2016 through 2019 which states have built into their budget estimates."

CHAIR ROWLAND: And I would reiterate for the Commission members that we did discuss whether there should be other changes and opted for a simple straight extension as creating less administrative burden. No new regs would have to be written, and the program at the state level could continue without having to figure out how to contemplate other changes. So the straight extension was there to say there's lots of other fixes that we want to see made, but for simplicity purposes and for ease of administration and for continuity of coverage for kids, the best way to go forward may be a straight extension.

All we didn't do was say four years. We said two years instead of four, but we were doing a straight extension, because as you might recall at that time, there

was still some movement in the Congress to try and do a lot of other things to extend and fix CHIP for the short term, and we opted not to go that way.

But I now have -- I did you, Trish, right? So it is Marsha, then Chuck.

VICE CHAIR GOLD: A number of things I was going to say were already said by Trish and Diane. I do think it's important to reinforce the -- you don't want states to be doing a lot of things to deal with change, when what you really want them to do is be focusing on longer term change.

The only thing I would add to that is it seems to me that one thing we've seen, looking at Congress, is that it's hard to predict the specifics in some of the language and how things will come out, and I would think that it is useful to just say continue generally, rather than trying to anticipate which changes people might make and whether we're for or against them, so much as the general principle, and with that also a general sense of where we're going and that it's important.

I also would wonder, particularly -- it seems to me that part of what we're looking for is to reinforce the

point that there needs to be an extension because there are all these awful things that may happen if it doesn't in terms of coverage and things we've heard about, and that it's not -- just rolling it into the ACA now creates some real problems for children, as we've said.

On the other hand, ultimately, there may be reasons, important reasons that you can benefit all coverage for children by doing that. So I'm not sure. I wonder if -- I looked at this as a new Commissioner and said two years. I wonder. Really, the point is that it should be a short-term fix, and I think we certainly heard comments on that from a lot of people, and I wonder whether the point is more that where we're trying to go do, without sort of the specifics, it seems to me -- I'm not sure that this Commission wants to get into a fight with Congress about whether something is two years or four years versus what the extension is and that it be done quickly.

CHAIR ROWLAND: I think our goal ought to be to state that it's urgent that there be an extension, and that that extension be a sufficient time to not cause states to have to constantly reevaluate whether the program is going to be around.

I mean, I think two years or four years, but if it's a six-month extension, I think that is kind of inadequate, and so we need to say for planning purposes, it needs to be of sufficient duration, so that the states can actually continue to implement their programs.

But I also think we ought to be very careful, too, to remember that there are other recommendations that we had previously made that were not related to the pure extension that may also come up in this congressional review, and one of them specifically is that we recommended the elimination of the waiting period because of the new environment in which CHIP exists. And that is something that in the discussion draft put forth by the House and Senate under Hatch and Upton has called for extended waiting periods up to as long as 12 months.

So I think we should also reiterate some of those earlier recommendations that were just key to how the program should work.

I have Chuck. Then I have now Patty and Andy and Donna.

COMMISSIONER MILLIGAN: I think to me, the cleanest way, Diane, is what you said earlier, which is

we're talking about seven months from now, and I think the cleanest thing is to say that CHIP needs to be extended seven months from now and for a sufficient amount of time to work through some of the other programmatic and reform-minded changes that we can discuss -- we had discussed last meeting, and we can discuss further in this meeting.

But I think the short-term issue is that CHIP should be extended in a way that doesn't create budget or administrative uncertainty.

I do think there are some examples, like the contingency fund point that Patty made earlier, where you could say a state shouldn't get more than it needs, without that kind of change requiring a lot of administrative or budget uncertainty. I think, to me, the principle is it needs to be extended. This is an urgent issue, and until such time as the more programmatic reforms are really addressed in a meaningful way, it should be, as the Commission recommended last June, very much in line with the program as it exists now.

CHAIR ROWLAND: And it should be extended, so that the uncertainty for states is also not an uncertainty for families because obviously many of the families depend

on CHIP for their children's coverage right now.

I had Andy, then Donna, and I've got Peter.

COMMISSIONER COHEN: Just taking a little step back and thinking about our role here, I think it is very hard not to get into a discussion of what combination of provisions might delay an extension or what is some progress that we might like consistent with prior recommendations in a given package, but I do think we should take a step back here and say it's not probably really a MACPAC role, or at least this is my perspective, to be putting together packages or tradeoffs in a particular bill. And I would suggest more sort of along the lines of what Chuck said. I think we can both reiterate that we have recommended the elimination of waiting period and other things but not say or imply that we think any particular provision should or shouldn't be in any package, and then to address some issues around this to sort of prioritize what is the sort of biggest concern right now.

So along with Chuck, I would say right now, I would say our highest priority sort of recommendation should be around just making sure that an extension happens

at this point and happens timely, but I don't think we should be in a position of sort of recommending packages that make that more or less likely or that either undercut a recommendation we've made in the past. Unless we change our minds and recommend otherwise, we stand by the recommendations that we've made, but right now, our highest priority is extension, and whether or not that includes those other recommendations, I think we should be agnostic.

CHAIR ROWLAND: Okay. Donna.

COMMISSIONER CHECKETT: Listening to the discussion, of course, I go to what is our authorizing role, and the statutory authority is, as our Chair so often reminds us. So I think in the letter, in addition to the payment, we have to really focus on access, which is the other part of that to which the reason for which we are here.

And I was really struck by the list of states. You can read and read and read, and lots of it is very theoretically, and lots of it is very high policy-minded. When you see the states and you start thinking about the children and the families that are going to be affected by that, which to me is very powerful. So I would urge to the

extent that it is appropriate in our letter that we include that information, because I think that's going to start to people -- I mean, just look. Who didn't look to see where their state was on that? You all look for your state. It becomes very real, and so I just urge us, to the extent it's appropriate, to include that information in any letter. Thank you.

CHAIR ROWLAND: Peter.

COMMISSIONER SZILAGYI: Yes, just a couple of points. To piggyback on what Andy and Donna were saying, as a new Commissioner, I did want to go on record that I totally support what people have been saying around the table about urgently extending CHIP, not creating administrative and fiscal uncertainties at the state level, because children will be harmed. Many children will lose health insurance, and states will be forced to make decisions that they probably don't want to do.

I do think that one of our roles as Commissioners, perhaps it isn't to create an entire package, but I think it is to distill from our point of view, the evidence for what components can create improvements or perhaps harm in access or quality.

As a health services researcher, I have reviewed and participated in the research on waiting periods, and I do want to weigh in on that. Waiting periods cause harm. They don't help. Children lose health insurance, and they lose access and quality of care. So I wasn't here when the recommendations were made before, but I feel that the evidence totally supports that.

And similarly, the 12-month continuous eligibility causes good. It continues access to needed services for a very vulnerable population.

CHAIR ROWLAND: Okay. Patty.

COMMISSIONER GABOW: I just have a question for someone like Donna maybe to answer about just the operational feasibility. If CHIP is not done as a straight extension and a variety of new criteria come into play, from the fact that we've heard in this Commission how administratively strapped states are, what is the timeline for a state to be able, given computer programs, given all of this, to do education appropriately, educate and outreach?

The feasibility of doing major changes at a state level with limited administrative staff and limited

computer flexibility, every time we had to change something in our computer system, I had a migraine.

It is not turning on a dime. It's not a week. It's not a month. From a perspective of what it would take -- because I think that's important.

CHAIR ROWLAND: Well, there is also the issue of notifying beneficiaries --

COMMISSIONER GABOW: Yes.

CHAIR ROWLAND: -- of the fact that they are terminating coverage.

COMMISSIONER GABOW: I think thinking about what that timeline is, not just for budgeting purposes, but a check on administrative purposes, but delineating that maybe in some detail would be useful, I think.

I don't know, Donna.

COMMISSIONER CHECKETT: Well, I'll just comment. I'm sure others could, but I think I agree with you.

The other point, not that I think it has been an issue particularly that Congress has focused on, but the fact is in almost all states, you are going to have to have a statutory change, depending on how much the terms change and how the state statute is written. So you're point is a

good one as well, Patty, that it's not easy for states to jump in and change programs.

CHAIR ROWLAND: Okay. So I think that we agree that we are going to issue a policy brief on the earlier material, adding in some of the context about how difficult it is to do this in a short time period, but we are really going to focus in a letter to Congress, reiterating the importance and the urgency of moving now to provide an extension of the CHIP program. We are reinforcing our recommendation that a straight extension is the preferred way to minimize administrative disruption and hassle and to try to promote better continuity of care, that we're going to really add into that context some of the concern about the fact that Congress likes to do things in three- and six-month chunks, but this is really something where you need advanced planning, where it's a budget issue, it's an administrative issue, it's a family issue for families to know what they're having.

And I would add that as we wait to see what happens in King v. Burwell that we also are in a situation now where the general availability of help through the exchanges, through the marketplaces, may in fact be in

doubt after the Supreme Court ruling, so that it even adds more to let's make sure we don't disrupt the coverage children have now in the period when we're still in flux with some of the other provisions for the ACA.

And I think a strong letter dealing not with all the long-term changes to improve children's health, but the immediacy of the need to maintain children's coverage and the state's ability to provide that coverage.

And we can include a reference back to some of the key other provisions that we talked about, just because as those come up in the debate, we want to at least be on record, as Peter so well noted, that we don't think waiting periods, especially in the context of the new world of health insurance, are a provision that helps get children the coverage they need.

Okay. Well, I think short term, we've managed to get through this session, and now we have to go to long term, and I think Joanne is supposed to join us for long term.

It is always easier to deal in the immediate than in the long range, so let's go to the next level here where we really are going to look at some of the broader and

longer term issues in trying to address how to best provide coverage for our nation's children.

I do think that here, we really want to try and look at a view that is not a view that is kind of CHIP-narrow but that's children-wide, and that looks at for children at different income levels, what kind of services, protections, what kind of financial burdens can those families bear.

One of the things I think we need to really think through is what happens at different income levels and how well do the private plans cover children as well, because I think we want to be sure that we don't forget that there is the Medicaid coverage on one side, there is employer-based coverage on another side, and then there's been this bridge in the middle, which is CHIP, and how do we allocate those responsibilities, so that the bridge is more integrated into the coverage system. But I'll let our great staff kick off our discussion.

Session 2: LONG-TERM POLICY OPTIONS FOR CHILDREN'S COVERAGE

* MR. PETERSON: Thanks, Diane. Hopefully, I'm not going to be too redundant of what you just said, because

that's helpful. We now turn to long term --

CHAIR ROWLAND: Well, that's fine. If you agree with me, I like that.

[Laughter.]

MR. PETERSON: We now turn to possible long-term options to improve children's coverage, aiming to do so in a way consistent with your long-term vision of children's coverage, as articulated in last June's report to Congress.

That vision, which focused on the affordability and adequacy of children's coverage prompted you to call for an extension of CHIP in part to provide enough time to develop sound policy alternatives for children now served by CHIP if they could be integrated into other sources of coverage in the future, but it also raised the notion that this conversation should not just be about CHIP and children currently enrolled in CHIP, but also about coverage for low- and moderate-income children generally.

Based on the discussions that you had, particularly at the last meeting, we are bringing to you options that address some of your specific concerns. These options target exchange coverage. However, there are other coverage options that could also be considered, whether

it's affecting Medicaid or redefined CHIP, wraparound coverage. So while we are presenting some specific options, we don't want to limit your discussion.

We look forward to your feedback on whether the policy options we talk about today regarding exchange coverage adequately addressed the tradeoffs for improving children's coverage, and we would appreciate your thoughts on any other approaches you want to consider.

In last June's report, you noted that if CHIP went away, as under current law, there were going to be problems for children. In the report we're publishing next month, additional evidence has been brought to bear on each of these points. 1.1 million children would become uninsured. Compared to CHIP, premiums are generally higher for employer-sponsored coverage, sometimes for subsidized exchange coverage as well, and of course, that is a big contributor to the increased uninsurance if CHIP went away, those premiums. But even among those who obtain other coverage, what is the right level of premium contribution?

The same is also true of cost sharing. We know that deductibles and copays are higher in exchange coverage and employer-sponsored coverage than in CHIP.

In addition, moving from CHIP to other coverage could result in the loss of critical benefits, like dental coverage, and changes in provider networks could cause disruption, although how networks differ across sources of coverage is less clear.

So which of these are the most important issues to address, and how do you address them? We will talk about some options to address these affecting exchange coverage, and based on your comments, particularly in the last meeting, we are bringing back to you today these five issues you see here that you wanted to explore in greater depth with potential options.

Under each of these issues are specific options we will talk about shortly, and they represent a fairly broad range of options affecting an exchange coverage, generally from most expansive and, thus, potentially most expensive from the federal perspective to less.

Our goal for this session is to get your feedback on these potential options, and based on your feedback, we could then come back to you with more detailed policy memos on the options you want pursued. Those analyses would include initial indications of the effect of each option

and their interactions. Some will be based on modeling by the Urban Institute; however, there is limited capacity in the number of options that can be modeled, so we look forward to your comments on what specific information you would need additionally on these to make decisions on these options.

As you think about whether your preferred options are structured more broadly or narrowly, you might also want to consider what level of income should make one eligible, and we note this Commissioner is on the title slide of your table, which notes that income levels at 400 percent of poverty, which for a family of three is $80,360 in annual income, all the way down to 150 percent of poverty, which is $30,135 in annual income for a family of three.

Before we turn to the specific options and kind of go through them one by one, I want to point out generally the interactive effects of these. As we start from the top, for example, and talking about the family glitch, you, quote/unquote, fix the family glitch; that makes more individuals who are eligible for employer-sponsored coverage therefore eligible for exchange

coverage, but that does not necessarily mean all of them are going to enroll.

You may have to then go to the next step and address premiums, and that may not mean that kids are necessarily going to get the care. These come in stages, and the effects cascade, but then also the cost cascades, so these are some of the considerations that you need to be thinking about as we go through these on the interactive nature.

So, with that, I will turn to issue 1 about the family glitch, and just as a reminder, if employees' contribution towards self-only coverage for the employer-sponsored insurance is considered not affordable based on the definition of the ACA, then they and their family may obtain exchange subsidies. However, the employee's contribution to family coverage is not considered. That's why it's referred to, in shorthand, as the "family glitch."

So if the ACA's definition of affordable, accounted for family coverage, which means more families would be eligible for exchange subsidies.

COMMISSIONER COHEN: Can I interrupt for just one? Can you remind us, Chris, what we know about the

number of people and, by any chance, we know children who are caught in the family glitch?

MR. PETERSON: Remember the slide that we had from our last meeting, which is going to be in our March report? We looked at 3.7 million separate CHIP children in total. Half of those, if CHIP went away, would be eligible for employer-sponsored coverage.

Among those, half would have family coverage that is more than 9.5 percent of family income. In other words, you could say that half of kids eligible for employer-sponsored coverage are affected by the family glitch, if you look at it from this narrow issue of where we have numbers from the Urban Institute.

COMMISSIONER COHEN: Those coming from CHIP, which is about a million.

CHAIR ROWLAND: But those are of children in CHIP as opposed to children and families.

MR. PETERSON: Yes. That's a hard question.

CHAIR ROWLAND: Which is the broader effect.

COMMISSIONER COHEN: So we are talking --

MR. PETERSON: There have been --

COMMISSIONER COHEN: -- about a million.

MR. PETERSON: -- out there, but they vary a lot, and so this is one of the things that in our next meeting, we want to be able to bring to you how many children will be affected. So that, obviously, is critical information. So we can only provide you with the little narrow piece that I have given you at this point.

CHAIR ROWLAND: That is something to remember as we look at these options. We are not here talking about an option that just preserves coverage for children now participating in CHIP. We are talking about issues that affect children who are in family situations but were not taking advantage of the CHIP program.

MR. PETERSON: And in that vein, so these options even go potentially broader, and this is where we want your feedback. If you fix the family glitch and you change the affordability test -- let me say it like that, so it's more precise -- you could actually make the entire family eligible for exchange subsidies, not just the children.

But option 2 there is, well, the focus we've had is on children's coverage, and you could say do you want to narrow it down to just children's coverage or are you thinking more expansively. So that's the difference

between these first two is whether the whole family would be eligible for exchange subsidies or just the children.

COMMISSIONER ROSENBAUM: In other words, that the parent would also move at that point. The parent would forgo self-only coverage and buy the full package from the --

MR. PETERSON: Yes.

COMMISSIONER ROSENBAUM: Okay.

MR. PETERSON: That's right.

CHAIR ROWLAND: Which obviously increases the cost of the --

COMMISSIONER GABOW: Chris, these are all very specific ways of doing things, which expand them broadly. I guess I'm trying to think whether we need to pick one of them or whether we need to support any of them that would work, that can pass the political process or something to fix the family glitch, because it seems that the most important thing is to fix the family glitch. There are different ways to fix it, which have different costs and benefit more or fewer people, and we probably each have our own preferences as to which way it's done, but I guess I'm a little bit wondering how specific we're trying to be with

what we're recommending as the solution as opposed to this is critical, which it sounds like it is.

CHAIR ROWLAND: Well, I think what we're trying to say broadly is that the family glitch is an obstacle to getting affordable coverage for families, including many of their children, some of whom now qualify for CHIP and some of whom don't, but that fixing the family glitch is an important way to improve the affordability and availability of coverage for children and their families.

Sara.

COMMISSIONER ROSENBAUM: I also think that while, obviously, the most important message to convey, which we have done, is that the family glitch has effects both in terms of the relationship of the glitch to CHIP and CHIP's future, but also this broader question of children who should be able to rely on the exchange.

I do think we have to actually grapple with these choices because fixing the family glitch is not just bound up with CHIP. It's bound up with employer-sponsored coverage, and it is a very different thing for us to -- and we could put out two or three options and just simply point out the pros and cons, but I do think we want, if at all

possible, to see what the Urban Institute's estimates would be. We may decide in the end that we don't have a preferred option, that we would just want to show Congress some options, but whatever we have to say about fixing the family glitch, I do think we need to at least show some solid options and what the possible effects of different options are.

MR. PETERSON: In thinking again about the interaction of these effects, I've kind of teed up that we are going to be talking about the effect of the premiums and the cost sharing. The challenge is, like the two options here times multiple options for premium affordability times multiple options for cost sharing and you affect -- you want to vary this by FPL, the challenge is that it will be very complicated for Urban to produce those estimates. It is going to have to be a tradeoff in terms of can you go ahead and say, "Look, right now our focus is on children and the coverage long term for children, so we recognize that number 1 up here is a problem, but we're not focused on that," or are you saying, "No. We want to see all of these options as much as you can"?

COMMISSIONER ROSENBAUM: Well, the other complication, I should just note, is that --I was saying to somebody before, I think to Donna, that I am chair of our benefits committee for the university, and it is not just children and parents. There are 13 permutations on this. For example, there's spouses and children, and of course, in CHIP, we have spouses. We have women who are covered for their pregnancy in some states.

So I think you are absolutely correct that each one here then has a cascade of consequences on our other choices, but this issue is so foundational that, even though it produces a cascading effect, we might, one, ask for estimates on this one, with a clear point that just as -- we want to see as a threshold what the effects are, even though we may on the subsequent modeling choices narrow, begin to narrow down what we ask for, understanding that Urban has limits on what it can do. And we may decide that we really are only going to flesh out number 2 at this point because it bears most immediately, but we do, for example, in number 2 create situations in which potentially spouse and child coverage is not available, and then where does that leave us?

COMMISSIONER COHEN: I agree with the tenor of the conversation so far quite a bit.

I would make a comment about option number 3, though, which I see is quite different and just sort of raise the issues there that employer-sponsored insurance varies tremendously across the country. The ACA standards, like sort of minimum standards, are not very rigorous, in my view, in terms of what employer-sponsored insurance is. So without much further review and thinking about standards and things like that, I would be uncomfortable with pursuing option number 3 as a form of recommendation.

If we wanted to go much deeper and talk about what the limits or standards might be, that might be a different conversation, but I think as a general statement, to say that we want to start applying -- we would recommend applying exchange subsidies to employer-sponsored insurance, I think that is a huge leap kind of beyond where the ACA is and probably not an appropriate one for us to do without a lot of serious work.

COMMISSIONER MILLIGAN: I want to agree with Andy, and the other part about 3 that seems a little like going down the rabbit hole to me is that employer-sponsored

insurance is it is self-subsidized in the Tax Code for employers, so I'm not quite sure what the subsidies on top of the subsidies, how we even get out of that particular rabbit hole. So I would add that comment to Andy's comment.

COMMISSIONER ROSENBAUM: It is the case, though, that Medicaid and CHIP do option 3 today. So the irony is that 3 looks dramatic to us when we are looking at it in a vacuum, and yet we subsidize employer premiums with Medicaid funds and CHIP funds today.

COMMISSIONER COHEN: But although, Sara, in very tightly circumscribed situations, which is different.

COMMISSIONER ROSENBAUM: Absolutely. Absolutely, if it's a cost-effective investment, but it is not unheard of to use one federal subsidization to match another federal subsidization. It may be that we don't want to continue the practice, and so we don't do it. I just would point out that it's not a ground-breaking concept.

COMMISSIONER MILLIGAN: My point, though, may be coming at this conversation from a different direction is we could also just -- if we're going to go down this avenue of touching ESI, condition the employer receipt of tax

credits up on some of the other things instead of the subsidies on the subsidies, and that then is a bottomless pit.

CHAIR ROWLAND: I think we need to both move on, and I think that what we concluded here is that we really do want to look at the family glitch, which is much broader than our mandate, but it does affect how children would get their coverage and then think about whether there are lesser options, but let's at least get the numbers on the family glitch together.

And now we're going to move on to affordability.

Patty.

COMMISSIONER GABOW: I just wanted one clarification on 2. Are we saying that there would be a child-only plan then in the exchange? I mean, that's what we're supporting? Yes. Okay.

COMMISSIONER RILEY: But we are not supporting it. We are examining it, because I don't want us to -- I recognize the cost of number 1, but it strikes me that it's time to begin to talk about children and families. So if a child is healthy and returns to an uninsured, unhealthy family, what have we done to the kid? And it strikes me

that to broaden this conversation -- I know it's costly, and I know it's challenging, but it seems to me that we might want to broaden our conversation. I don't want us to forget one as we think about these options.

COMMISSIONER GABOW: Absolutely.

CHAIR ROWLAND: Excellent. Okay.

Issue 2. Since 1 was so easy, let's go to 2.

* MS. JEE: So we have just talked about who would be eligible for the exchange subsidies; however, we do know that even with those subsidies, exchange premium affordability could still be an issue for some families.

Over the last several months, the Commission has considered the factors causing exchange premiums for children's coverage to be higher for those families. First, if parents are not already enrolled in the exchange plan, the family will not yet have paid its expected premium contribution for their exchange coverage, for exchange coverage. Thus, if the children enroll, the family would have to pay that expected exchange premium contribution.

As we discussed more fully at our last meeting, our analysis gives us a sense of what that means for

families. Take, for example, the family at 160 percent of the federal poverty level, which is just over $38,000 for a family of four, which is what we looked at in our analysis. If the parents are not enrolled in the exchange plan, the family's average additional premium contribution for children's coverage would be 11 times higher than in CHIP.

At 210 percent of the federal poverty level, which is just over $50,000 a year for a family of four, it would be five times higher.

Second, if families also enroll their children in a stand-alone dental plan, they could face additional premium contributions as well. Remember if stand-alone dental plans are offered on the exchange, the exchange health plans are not required to provide dental coverage.

For a family at 160 percent of the federal poverty level, the average additional premium contribution for a stand-alone dental plan is about $242 a year.

CHAIR ROWLAND: But we did also discuss at the last meeting that the premiums under the CHIP program are not actuarially based premiums, and so we really need to make sure we know when we make those comparisons that we are really comparing apples to oranges to some extent.

MS. JEE: That's correct.

Okay. So let's move to some options for addressing exchange plan premium affordability. Remember, Commissioners, that the overarching question for these options, as Chris mentioned, is at what income level should they be applied, and again, I would just refer you back to the income levels that are described in the cover sheet to the table, which is in Tab 3 of your notebooks.

One option is to fully subsidize premiums for children's coverage in exchange plans, regardless of whether the parents are enrolled in the exchange or not.

A second option would be to provide some additional level of premium subsidy, but not a full subsidy, and still require some premium contribution from families.

And the third option would be to take into account the premiums paid for a family member's coverage outside of the exchange when calculating the amount of the premium tax credit. Currently, those premium costs are not included in that calculation.

So moving on to affordability of exchange plan cost sharing, as Chris said, you can address the premium

affordability. It doesn't necessarily address the cost sharing and the point-of-service affordability for families, and when we are talking about point-of-service cost sharing, of course, we are talking about things like copayments and deductibles.

The Commission's analysis, which we discussed in detail at last month's meeting, finds that cost sharing for children's exchange plans will be substantially higher than in CHIP. We estimate that the average annual cost sharing for children's coverage in the exchange will be about 6 times higher than in CHIP for families at 160 percent of the federal poverty level and 13 times higher for families at 210 percent of the federal poverty level.

Of course, actual cost sharing will vary by service use, and certain children, such as those with special health care needs who require more frequent services are likely to have greater than average cost sharing.

So to turn to some options, again, just a reminder that these options could be considered independently or concurrently with the other options addressing the other issues.

The first option would be to provide children with exchange plan coverage with a 100 percent actuarial value. This means that there is no cost sharing for children for covered services, as is currently the case in 12 states with separate CHIP programs. For this option, the Commission may want to consider an income eligibility range or level.

The second option is similar but would provide children's exchange coverage with an actuarial value of 98 percent, which is the average actuarial value in separate CHIP programs now. This means that on average, families would pay for about 2 percent of the cost of covered services for their children, with the plans picking up the rest.

A third option would allow states to apply their current CHIP actuarial values to exchange plans. So the actuarial values and, thus, the cost sharing would vary across the states.

CHAIR ROWLAND: What's the range of state actuarial values?

MS. JEE: The range is 90 to 100 percent.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: I just wondered whether we might, when we come back to this, add a fourth option, which is to use the platinum standard. Since all of this is tied to current CHIP practice, which is in some ways the ideal, but we can't say with certainty the current CHIP practices, current CHIP practice, another way to go would be to take another standard that has gained some acceptance in the context of discussing low income -- lower income families, and that is to think about either the current cost-sharing reduction subsidy model for families under 150 percent or the platinum standard, so that we're sort of dealing with something that has a current -- may be a bit more current.

CHAIR ROWLAND: Yes. I think we are saying that the CHIP standard is not necessarily the gold standard, and really, here it would be both helpful on the premium issues as well as on the cost sharing to review the literature on what is financial burden for families at different income levels and to really begin to put this in a broader context than just we don't want to go backward from where CHIP is.

I have Andy, and then I have Chuck.

COMMISSIONER COHEN: Thank you. Clear

presentation. The issues that these two areas raise are just really huge and broad, and they range from things for which we really can have an evidence base to things that really are very, very much sort of value judgments. That makes it a little bit harder, I think, to talk about, but I wanted to just make a couple of comments and actually ask a question.

Let me start with my question. In thinking about the premium cost sharing, there can be multiple goals when we are talking about the issue of premium affordability. One is to not negatively impact family budgets in a potential change from the CHIP, and that certainly has impacts on children, moving from CHIP to exchange coverage, but the other is to ensure maximum coverage for children. So one is sort of looking at it from the perspective of family budget. One is like what will actually get the kids covered.

I did want to ask just the factual question. Can you just remind us what the underlying issue, what the sort of underlying rules about the mandate are and how they apply to children? Because that is a factor for us to sort of think about in this context unless it doesn't apply to

children. There is a requirement for families to cover their children, which has an impact, presumably -- and it may be a growing one -- on whether families will cover their children even if it is a hit on their budget.

So I think we just need to be clear about the impact of that. Can you just remind us what the sort of rules are and where they're headed?

Sorry. This is another classic multi-part question, but I apologize because this is only part one.

MR. PETERSON: So you are asking about the individual mandate.

COMMISSIONER COHEN: Yes.

MR. PETERSON: For an adult in 2015, it will be $695 per person, and then for every kid, it's half that, so $348.50, somewhere around there, up to some maximum. I think the maximum is up to just over $2,000 a year for the penalty. Then it gets more complicated because there's actually another component that says, "Well, or 2.5 percent of your income if that's higher." That kind of gives you a range.

COMMISSIONER COHEN: In our modeling, in the modeling around -- have we taken that into account?

MR. PETERSON: Yes.

COMMISSIONER COHEN: Okay.

MR. PETERSON: That's actually a huge impact --

COMMISSIONER COHEN: Yes.

MR. PETERSON: -- that that has on families' decisions of whether to take up coverage.

If that individual mandate were not there, we would see a higher number of kids who would be uninsured post-CHIP.

COMMISSIONER COHEN: Okay. All right. Thank you. I did just want to -- so thank you for the answer, but I do think that we still need to sort of think about whether the end goal or the primary goal is around the cost or is around getting the kids covered.

Then I wanted to make a comment, obviously, in a perfect world where there weren't costs and demands. I would certainly prefer that both premiums and cost sharing were really affordable and make a decision to go to receive health care services as the parent believes that they are needed for the kid.

But as between the two, I have to say -- and in part, maybe because of the mandate and the growing sort of

push of the mandate, I am particularly concerned about cost sharing, and that is because -- and I think some review for us, as we go deeper into this in the literature that Peter mentioned last year about sort of the elasticity between sort of decisions to seek care and the cost at the point of service and how that relates to those decisions, I just think it's really critically important.

So I would just say I think there is a difference about sort of a budgeting decision that is made once a year. It's certainly an important one. I really have -- but we have a variety of policies that can help to address that, and I am really concerned about the cost sharing at the point in time when a family has to decide whether to take a kid to a doctor or not. I think that that is an area for a particular concern, and I would say if we had to choose between where to relatively recommend spending more, I might go in that direction.

COMMISSIONER MILLIGAN: So I am going to have to learn to stop following Andy because I always have thoughts after you have thoughts, which is a good thing, but there's two points I want to make here.

The first is that I think this is an area where I

we definitely have to think outside of the CHIP framework, and if we were to pursue this analytic approach and eventually a recommendation, there's a lot of kids in existing qualified health plans who would be affected who are not part of the CHIP world. I am assuming we need to model that, but I just want to be very overt about that because what we're talking about is a longer term, sort of taking it back to the framework. We are talking about under what circumstances would the Commission be comfortable with CHIP not existing, and affordability was one of the pieces. But these principles or this framework that is on this slide would apply to a lot of other families too.

The other point I want to make, following Andy's point, is I agree about the cost sharing, and in particular, because it affects children with chronic illness and families with children with chronic illness disproportionately, which ties into benefits and other things, but I think that the utility of having insurance needs to address the chronic illness access issues that cost sharing in particular raises.

COMMISSIONER SZILAGYI: Yes. Actually, I had

raised my hand before Andy spoke, and I was going to say much the same.

To me, as I struggle with these issues, to me, the premium really affects the millions of families who are going to go into the pool, and so it's really important.

The cost sharing to me -- and I would support what Diane said, that it would be great to have you guys do a really good literature review, not only about cost sharing but how high up the income level does cost sharing change behavior, because the literature that I am familiar with is that children are highly sensitive to cost sharing. Children with special health care needs are a little bit less sensitive, but they need so much more care that it may impact them even more, and that cost sharing, it's also dependent on the type of services. So preventive services are highly dependent on cost sharing.

So if we have a program that has a fair cost sharing requirement, preventive services will go down. I mean, access and receipt of preventive services will go down, whereas --

CHAIR ROWLAND: Unless they're exempted.

COMMISSIONER SZILAGYI: Sure. Unless they're --

right, which gets into maybe the next discussion, whereas acute or emergent services may not change as much.

But some of the other studies that I see, people sometimes cut the income level at 200 percent and federal poverty level, but we have done studies which show that many families have a significant amount of unmet needs, all the way up past 300 percent of the federal poverty level, up to 400 percent of the federal.

So I would suggest looking at these issues all the way up to the federal poverty level and the types of services, because we are an access and I hope equality commission as well.

COMMISSIONER ROSENBAUM: When Jenny Kenney and I wrote an article for Health Affairs that came out last December, there was something that we reflected on, which we both agreed would require somebody asking for a much bigger study before we knew the answer, and this is obviously the possible opening.

One of the things that we pointed out was that in migrating children into the exchanges, of course -- and this has come up before for us -- especially if you, in the end, build a strong enough system to be able to migrate all

children into exchanges, that the effect on the pool might be significant enough in terms of the larger premium question by adding millions of children, that the difficult tradeoffs that we're now thinking about, which are hardly going to go away -- but some of the difficult tradeoffs might lessen a bit if there are salutary effects on the premiums as a whole.

I have to say I find this discussion so complicated because while I have spent almost 40 years now on the issue of cost sharing and children, I think we cannot overstate the seriousness of the premium problem because of not only the fact that families that find the coverage unaffordable end up with none, but because the recoupment is going to come for these families out of their earned income tax credits, by and large. And so the spillover effect is not just that their children are uninsured, but that their children are also losing other vital upstream investments in them that come through the EITC.

So anything and everything we can do to get Congress to see that while there are tradeoffs, when you're talking about tradeoffs in pediatrics, the tradeoffs in

pediatrics are a different kettle of fish from the tradeoffs that one might make for adults, assuming that they're competent to make decisions, bear a level of responsibility in the health care system here, we are talking about a group of people who do not bear legally or even functionally the same kind of decision-making discretion, and that in either way, the tradeoffs are really terrible things.

And that's why I'm also particularly focused on our playing out for Congress and for ourselves understanding what it means to migrate children into a pool. If you migrate children into a pool, what do you gain for populations that are not part of the children being migrated? And is it enough in terms of premium stabilization? Just like the question Arkansas is asking, is it okay to spend a little bit more on Medicaid if what we do is make a viable market for hundreds or thousands of people in the state? Is it a good idea to try and aim for a highly affordable system for families with children because of the salutary spillover effects? You can't do that until you have the system working properly for children, but it's an incentive to make the system work

properly for children.

I would just caution us about rushing too quickly to decide where we're going to trade until we really, really know the effects, the full effects of the migration.

COMMISSIONER GABOW: I think your point is really important, Sara, and I'd echo that, and we had that discussion here about Arkansas that if you increase the pool enough, the insurance rates for everyone go down. We shouldn't lose that in the context.

I wanted to make a point about providers in this for cost sharing. The idea that when you look at what the amount of cost sharing, if you're talking about a dollar or two dollars, from the provider perspective, collecting a dollar or two dollars and putting in place the structure to do that, I mean, the juice is not really worth the squeeze. So that thinking about the provider in this is also important.

The other thing that we saw happen, not infrequently at Denver Health, was when a poor person would come in -- and it was particularly with children, and they didn't have the copay for the medicine -- our providers would pay it for them. So it has this impact on the

delivery arm that shouldn't be forgotten.

There's some level where the amount of copay just doesn't justify the administrative process to collect it and send bills and get -- it's just --

VICE CHAIR GOLD: Yes. This is a really good discussion, and I think all the issues people raised are important ones. I am thinking of the staff and what I would do if I was a staff and had to take all this away. There's a lot of work here, and yet we want to move.

I think part of the challenge, the biggest barrier, which is not one that -- it's one everyone's faced in all these programs is figuring out what -- how to structure a benefit package.

So I am concerned on the lit review. I agree that it really needs to be done, but I also don't want you to have to feel like you have to reinvent the wheel. I know the IOM has looked at things. Peter can probably give you the list of mega reviews that children's literature has done, and some of this has been done. And it would be a real contribution, and I agree with Andy, it's really important to put it in. But I hope we can build on the existing literature, which I think is stronger here than in

many other areas, to sort of summarize it and then be able to spend the energy figuring out what some realistic options might be and why, how they differ from one another and what the rationale is.

CHAIR ROWLAND: Because we want our recommendations when we make them to be based on the available evidence. It doesn't have to be evidence we create. It can be evidence from the literature and from some of the states' experiences.

Okay. So now we'll move on to pediatric dental.

MS. JEE: I've got one more option. I don't know if we should run through it, but it's on the slide. Okay. This is the last one.

So this last option takes the same actuarial values that are used currently and providing the cost-sharing reductions for exchange plans, but just applies then at a different income level, so it basically just shifts them up on income.

Again, the table on page 4 in your meeting packet provides sort of which actuarial values would apply to which income level, so that's the last option here, and we can turn it over to Ben.

CHAIR ROWLAND: But I think what we're telling you is that we're not ready to look at these specific options. We want a broader framework, levels of cost sharing, financial burden, and the impact on access.

Ben.

* MR. FINDER: So I'll try to wrap this up a little bit more quickly.

For this issue, Joanne alluded to it earlier, pediatric dental benefits. In your consideration of affordability and benefits, it's become clear that some children in exchange plans may lack coverage for pediatric dental services.

In CHIP, pediatric dental services are covered. In exchange plans, pediatric dental services are one of the 10 required essential health benefits. You'll recall that when pediatric benefits are not always embedded in exchange plans when stand-alone dental plans are available. Exchange premium subsidies do not reflect the additional cost of stand-alone dental plans.

So let's look at three options that could be considered independently or concurrently with other options. The first option is to require all exchange plans

to embed pediatric dental services. A few states have already moved to do this on their own. Secondly, premium subsidies could be augmented to include the cost of stand-alone dental plans, and thirdly, you could consider providing children with wrap-around pediatric dental coverage.

I should mention that for at least the last two options, you could also consider scaling these options in some way based on family income.

The story on other benefits is less clear. As a brief summary of our conversation on benefits, you will recall that most major medical benefits are covered in both CHIP and exchange plans, but our research has identified some areas in which benefits vary between programs and plans. For example, the March report found that audiology exams were covered by a separate CHIP in each state, but only by 37 percent of exchange plan benchmarks.

Covered services can vary within each source of coverage. For example, separate CHIP covered, supplied behavioral analysis therapy in some states but not others.

From those conversations on benefits, a couple of options have emerged that might address some of the

variation in covered benefits between programs. The first three options that I'll present revolve around how coverage is defined in exchange plans. All exchange plan benefits are based on the same essential health benefit benchmark established by the state. So policymakers could consider providing states the option of establishing a separate pediatric-specific benchmark.

The first option would allow states to establish a separate pediatric benchmark tied to Medicaid's EPSDT definition.

The second option would allow states to establish a separate pediatric benchmark tied to benefits generally available in each state's separate CHIP.

The third option is less prescriptive. We would just allow states the option of establishing a separate pediatric benchmark. Alternatively, you could consider changing how pediatric services are defined in the essential health benefits to include certain benefit categories; for example, audiology services.

The final option is to provide wrap-around benefit coverage for children through Medicaid.

So we presented a lot of options for your

consideration, options that generally reflect an exchange-targeted approach to addressing some of the concerns about affordability and adequacy that have surfaced in conversations about your long-term vision for children's coverage, but this list is by no means exhaustive.

Like Chris said, we look forward to your feedback, so that we can bring more detailed analyses for you to consider at a future meeting. We look forward to your feedback on these options and your feedback on the bigger policy decisions or choices. For example, what role should Medicaid play in your long-term vision for children's coverage, and what role can CHIP play or a Medicaid wrap-around or other more targeted approach?

And with that, I'll close.

CHAIR ROWLAND: Thank you.

Gustavo.

COMMISSIONER CRUZ: Thank you.

I want to comment on some of the options for the pediatric dental benefits. One of them is the option 3. I am going to start from the worst to the best. Sorry. I mean, the option 3 of the wrap-around Medicaid, it would create such administrative problems. We have some, which

I'm sure has been discussed here many times, sort of legendary issues in terms of access to care to children under the Medicaid program. Those issues of access are eased out under the CHIP program, so it would be sort of roll back to Medicaid. The only sort of positive aspect of that would be if these children would be covered under EPSDT, but they are not. So that would create added bureaucracy.

The second option in terms of the augment existing subsidies, that, in my view, will only work if you require to buy a stand-alone dental plan if it's not embedded within the plan, and there are four states that are already doing that. So if you go into the exchange and you choose a medical plan and you have children, you cannot get out of the exchange unless you buy the dental coverage.

The option number 1, which for me would be sort of the best, instead of providing comprehensive dental care. The only issue that we're finding is that in some of the states that offered embedded dental coverage within the medical plan, some -- not all, but some of the plans actually apply the full medical deductible to both children and dental. So if you have a deductible of $3,000, let's

say, which is the average, you can be rest assured that the preventive services for those children are not going to be provided when parents have to sort of add and subtract their budgets. So that is a caveat that could be solved if you sort of exempt the deductible for pediatric dentists or create a separate deductible that many other plans have done.

Thank you.

COMMISSIONER RILEY: I just had a question on the benefits issue in item 4, expand the definition to include certain benefits, because I was stuck recently that mandates in insurance have been enacted in states for a very long time, and yet there's been a real rise of mandated benefits for kids. Thirty-seven states mandate services for Asperger's. Twenty-five, I think, are doing audiology. It would be interesting, a data point, to know how many dates for children services currently exist, so that we can think more about option 4.

COMMISSIONER GABOW: I wanted someone to clarify for me, and then I'll have a question.

My understanding is that the stand-alone CHIP plans did not have EPSDT as a mandate, and since there are

many stand-alone CHIP plans, do we understand what the impact of not having EPSDT included in stand-alone CHIP plans have been to access quality of care for children?

I mean, that's a pretty robust sample that is different.

COMMISSIONER ROSENBAUM: I was going to say that there are a couple of different studies. There's one, actually, that's in the materials that you are about to publish, I know from academic pediatrics, that suggest that special needs children -- it's sort of interesting -- do better than uninsured children, but it was not clear that there weren't specific services where they would do -- these were in CHIP plans.

In a study that we did at GW about 12 years ago now, 12, 13 years ago, after the '97 CHIP enactment, we interviewed plan administrators in both Medicaid managed care plans that had to do the full complement as well as stand-alone CHIP plans. What we found was that the problems tend to cluster in certain very specific kinds of cases. It's children with very long-term, very severe physical and mental health conditions who need a very high frequency of care where, of course, the EPSDT benefit

mandate is important not so much for the covered class of benefits, although that is certainly a value, but it is the restriction on the use of amount, duration, and scope limits not related to medical necessity.

So even a good CHIP plan if it is separate -- at least this is what we found years ago, and it may be different today. A good CHIP plan would have some durational limits in it, 30 visits for X or X number of days of Y. Whereas, under the Medicaid program, in theory, there would not be a fixed day or durational limit, and so it's a very tiny, but very expensive, very costly sliver of children who are affected by this -- and in fact, in a lot of states under Medicaid managed care today, and that's why the discussion of wrap-around, I always find a little hazy, because there are states that have their managed care organizations handle the EPSDT benefit up to a certain level, and then they may do -- as an administering entity, they may handle all of the claims on a non-risk basis, but with the state kicking in beyond a certain level. So, in other words, there could be the equivalent of a wrap that goes on inside EPSDT today, which further complicates things.

COMMISSIONER GABOW: If there is a small sliver of children where this -- not having the EPSDT coverage in the separate CHIP program, then it does have implications for our saying that EPSDT should be part of every benefit package, rather than focusing on the narrow group.

CHAIR ROWLAND: Peter.

COMMISSIONER SZILAGYI: Yes. Just to embellish, I don't think anybody has or can do exactly that study that you were asking about, Patty, because enough of the separate CHIP plans have a lot of the essential benefits. There's a variability in those states, and there are other confounds or other things that affect those states. So it's not completely, I think, answerable, although it's a really great question.

Regarding dental, do people realize that the most common chronic disease in childhood is dental caries? It is actually more than -- some of the other things. And secondly, do people realize that dental caries is almost completely a disease of the poor?

So if we can solve this issue in terms of adequate coverage and services for dental care for poor children, we will be able to potentially eradicate a major

chronic disease in this country.

CHAIR ROWLAND: But we need to look at that not just in the context of CHIP, but especially in the context of Medicaid.

COMMISSIONER SZILAGYI: Oh, absolutely. And by poor children, I don't mean that it stops at 100 percent of the poverty level because there's an awful lot of dental caries among children between 200 and 400 percent of the poverty level, but you just don't see it in high-income populations.

CHAIR ROWLAND: Chuck.

COMMISSIONER MILLIGAN: Yes. I guess I just want to raise a point. As I'm listening, I'm not getting a good sense of the sort of consensus of the Commission about whether what we're trying to solve for here is what do kids need as a national standard versus what should be done in terms of a potential bridge out of CHIP, where there is state variability.

There is state variability in EHB. There's state variability in the existing CHIP programs that would need to bridge to whatever the future might be. So I can't figure out listening to ourselves here whether we're trying

to solve for a national standard or whether we're trying to solve for a bridge where there would be probably variability in states.

CHAIR ROWLAND: I think one of the things we are looking at is what would a national standard be and then how do we measure up to it as we look at the bridge issue, because I think we've been struggling with -- is the national standard, CHIP, which has all of its variations, or is there a different level that we would say this is the minimum level of protection that children in America should have, and then how do we use the CHIP program as a bridge to try to get there.

COMMISSIONER MILLIGAN: I think even that statement would be helpful to confirm and then where is that foundation.

CHAIR ROWLAND: Marsha.

VICE CHAIR GOLD: I think that last discussion is a really important one. I am concerned that we are realistic in looking at these things because one can recommend everything, but it doesn't -- it may not come to pass.

The thing I wanted to suggest we also put on the

table is sort of access to providers and health plans and administrative simplicity. Some of these options are more consistent with the way health plans in the exchange work and the way providers work than others. In particular, some of the EPSDT things, if you're thinking about relating kids' coverage to Medicaid, it makes sense, but to provide plans and private providers, they are not used to dealing with them, and I think they probably don't like them too much because of the paperwork requirements.

So recalling, I would guess that one of our principles would be we want to give people access to the plans in the exchanges in a way that allows those plans in the exchanges and the providers they contract with to be interested in serving children, and so I think the kind of solutions we come up with may want to sort of reflect what the common practices are there.

COMMISSIONER COHEN: Great points and questions, and I just figured I would take my personal crack at sort of answering them.

I think that what we are looking at is something that we could have looked at in the absence of a cliff on CHIP. This is the question of whether coverage for low-

income children and potentially low- and middle-income children across the country, whether it should be reexamined in some way or another, the financing, the benefits, or otherwise. As it so happens, this question is forced by the potential cliff in CHIP, but I do think that our frame should be looking at coverage for low- and potentially low- and moderate-income children across the board and not just those who might be in CHIP at a point in time when it expires because there's lots of moving in and out.

I would also say that while we don't need to be terribly -- it's one thing for us to say what we think is an important goal and we don't have to be terribly specific in all cases about what we recommend, I am really not excited about wrap-around options in this context.

I think one of the principles that we mentioned in saying that for all the good that CHIP has done, that it's the long-term future we think is in a different program that has better sort of -- a better continuum of financial support for health coverages was because of simplicity and then the costs, not just financial, but all sorts of costs of having multiple programs interesting with

each other, and I think that the wrap-around, I personally would be inclined to take it off the table and personally would support a look at a separate children's EHB benchmark.

Again, I always come back to this. I would love to get a little bit more clinically oriented sort of research summaries around the extent to which that is necessary and in what areas, but that is my orientation at this point.

COMMISSIONER MILLIGAN: Yes. Just a really quick point. I do think contextually, if and when this gets written into a chapter down the road, we need to keep in mind that in this time frame, we're talking about the Section 1332 waivers under the ACA would be available, which could alter EHB, alter subsidy levels, alter cost sharing, and so I think we will need to contextualize this in the time frame in which that waiver would be available, since we're getting into QHP land.

COMMISSIONER ROSENBAUM: I realize I've raised this earlier, and I certainly appreciate the complexities of some of these options, but again, I think it's important to note that we use something called "wrap-around." I've

never understood exactly what wrap-around is. What I understand is that you might be eligible for some supplementary coverage, and I think we underestimate the degree to which actually today we have a fairly sizeable number of children with dual enrollment.

And I'm not sure that it's so much --

COMMISSIONER GABOW: But, Sara, is it good? Does it work well for them?

COMMISSIONER ROSENBAUM: Oh. If you ask a parent of a child with cystic fibrosis if the extra Medicaid coverage is working for the child, they would trade their lives before they would give up the extra coverage. Their employee benefits do not cover the drugs they need, the therapies they need.

I'll never forget one hearing we had a few years ago, actually, on the Hill that was held to do a briefing around children's coverage, and we had three families with cystic fibrosis come and testify, all of whom had workplace coverage. And this was before. Actually, it was in relation not to CHIPRA per se. It was in relation to Medicaid.

And so I couldn't agree more, Andy, that there

are issues in making supplemental coverage work, but I think before we tackle this issue in theory, we need -- and I've actually asked MACPAC staff this question once before and got a totally startling answer. I mean, the number was high -- asked how many children showed up in Medicaid who also had private insurance coverage because, of course, Medicaid does not have a crowd-out provision, and the number is significant.

So I find --

CHAIR ROWLAND: We are sure that MACPAC staff will produce that number.

COMMISSIONER ROSENBAUM: Right. And I find it particularly compelling, going back to the priori exchange, when in fact we can identify with some certainty which of the benefits it is. It's drugs. It's extra mental therapy. It's extra speech and occupational therapy. It's not sort of just this crazed agglomeration of services. There are distinct places where commercial benefits fall short, and that is because of the norms underlying commercial benefits.

So I just want to be sure that we're having this discussion with the benefits of a lot of information on

dual enrollment today, among children especially.

CHAIR ROWLAND: Well, and there is another big wraparound in the Medicaid program, which is the dual-eligible Medicare and Medicaid population. That works fairly well.

COMMISSIONER COHEN: May I just -- so, Sara, point extremely well taken, and perhaps taking the option off the table is a little strong at this point.

I would say we are in the maybe privileged position of not thinking about what might -- I mean, the question of whether additional benefits might be necessary is -- on top of commercial coverage, I think we understand that there are times when commercial coverage does not provide what some children need. I think the question is: In a design phase of a new opportunity, would you design it as the wraparound, is a solution to do that. And if you're thinking about, say, dental coverage, you are talking not just for kids with illness, but every child needs that benefit in particular.

So the idea that you want to design the program with a Medicaid wraparound for virtually every child, for, you know, tens of millions of children, I just think as a -

- it would not be a preferred design.

CHAIR ROWLAND: It depends on what the wraparound is.

COMMISSIONER ROSENBAUM: And we could give everybody EPSDT benefits, but I think that actual is more jarring than thinking about a situation where a child is -- there is a tiny number, and Peter's really one of the great experts on this, a very small number of children for whom normative coverage standards are not going to be sufficient, and --

CHAIR ROWLAND: Okay. I think we're getting --

COMMISSIONER ROSENBAUM: -- we need to think about them --

CHAIR ROWLAND: -- too stuck on wraparound benefits here and sort of getting into the weeds before we get to the top of the mountain to be able to look down.

Is it about wraparound benefits, Donna?

COMMISSIONER CHECKETT: Let me assure you I wouldn't dream of raising that issue after those strong words of caution from our Chair.

[Laughter.]

COMMISSIONER CHECKETT: I actually am going to

really take this discussion in another direction, which is to say I don't feel that -- I think as we're moving into the exchange population, that I would like to have more facts about what the real needs are instead of kind of a gut reaction that it's not enough. And so I know that we've done some analysis in that regard, but I am stating the need for more data and facts around that. And I don't want us to just assume that it's not good enough. That would be my concern.

CHAIR ROWLAND: Great contribution.

Patty, did you have another comments or was it about wraparound benefits?

COMMISSIONER GABOW: It was about wraparound, and I'm willing to defy the Chair.

[Laughter.]

COMMISSIONER GABOW: I think that as we look at long term -- as you all know, I'm in favor of simplicity and administrative ease. But I think as we think about the long term of the country, it's not -- and the future of Medicaid in general, it is not unrealistic, I don't think, to think about saying that we're going to have coverage that is, you know, in an exchange, whether it's commercial

or subsidized coverage, and we're going to have Medicare, and in both those instances Medicaid will wrap around what no basic insurance plan would ever offer. And if you make every insurance plan offer everything that anyone could possibly need, it rapidly becomes unaffordable.

So I think as we think about long term and the future of Medicaid, it is not unrealistic to think, Is Medicaid's long-term future a wraparound for extraordinary services that the average person would not need?

CHAIR ROWLAND: I think it's important to recognize, as Sara pointed out earlier -- so I'll talk about wraparound --

[Laughter.]

CHAIR ROWLAND: -- that Medicaid has in its history been designed as a wraparound program. There was no crowd-out provision. It was intended to either fill the void for those who had no other source of Congress or to provide wraparound services, whether that would be for long-term-care services, whether that would be for additional coverage for people who had skimpy private insurance plans. So that we really need to think about the Medicaid context, but I also think as we go forward in

looking at these options, we have to remember what the coverage is for those under 138 percent of poverty who are on the Medicaid program, what their cost sharing is, what their benefits are, and then try and figure out how to not create a notch as you go forward with kids at slightly higher and higher income levels. And for that I think it would be very helpful if for our next discussion the staff brought in a table that really shows us what the Medicaid eligibility levels are by state so that we know how many states actually cover kids on Medicaid above 138 percent of poverty and how many kids are affected at what income levels in what states so that we have some sense of how many kids are falling under CHIP and Medicaid and to which income groups.

And then I think we really need to think through, starting back at the family glitch, I mean, so what's the family glitch and how many are affected there, but how are we really structuring premiums and cost sharing up the entire income scale and not just starting at 138, and then looking at kind of the choices, as you've laid out, between the coverage in the exchange that provides some special cost-sharing help to families at lower-income levels, well,

maybe that needs to be changed. But I think there's a range of options there that we ought to look at, but we need to wed it in keeping the Medicaid end of it part of our discussion.

COMMISSIONER CARTE: Having administered a separate CHIP program, I would just say that the separate CHIP benchmark I think has been highly satisfactory for states. I know in my state and in looking at surveys that NASHP has done, I don't think you see lots of demand for wraparound. I think it really is a great standard that has satisfied the needs of most families, and you don't see a big cliff. Of course, there have been exceptions, like for special populations like children with autism, but also that has been changing rapidly as those mandates have come into the commercial market.

CHAIR ROWLAND: One of the options we might want to consider is to look at having a provision for children with special needs who -- it's not every child would have access to wraparound Medicaid benefits, but if there's a child with special needs and those services are best served within the Medicaid program, to have them have that as an option, and I think that's one thing we might look at and

put on the table.

MR. PETERSON: To follow up on the factoid that was mentioned, 3 percent of children in Medicaid/CHIP also have private coverage -- 3.3. Percent. That's based on the National Health Interview Survey.

CHAIR ROWLAND: Okay.

COMMISSIONER ROSENBAUM: [off microphone] -- generally, you wouldn't go looking -- you might -- there might be children who start as public and end up picking up employer coverage. But my guess would be -- and maybe we can find out more -- that the opposite is true, that these are -- whatever group this is, somewhere between a million and 2 million children, whatever the number is --

COMMISSIONER SZILAGYI: About a million.

COMMISSIONER ROSENBAUM: Yeah, are -- start off with employer coverage exhausted. They're essentially Grassley children, and people, you know, don't remember the Grassley children who Senator Grassley created in 2006 who were designed to deal with this problem of parents exhausting their employer benefits.

MR. PETERSON: So to that point, if you look at just children with SSI or who do not have SSI but are

qualified as children with special health care needs, 6 percent have private coverage versus 3 percent if they are neither SSI nor children with special health care needs.

VICE CHAIR GOLD: And I would suggest, Chris that maybe you could talk with -- I don't know if it's the people at AHRQ or people at NCHS. Some of that has to be reporting error, because people -- these come from self-reports of whether people have coverage. And when you're talking such a low percent, it does not take that much reporting error, I would think, to have one of the 3 percent be people who have something odd or something they think they had or maybe they had it last month but they don't have it now.

So I'm not sure I would agree they're all people who were double, and I think those groups may be able to provide you some -- the issue is how accurate is the reporting of private insurance data or Medicaid coverage and could that explain some of it, and then how much is left for what Sara's saying.

CHAIR ROWLAND: Okay.

COMMISSIONER ROSENBAUM: One last point. Just one last point, which is an important analogy in all of

this, is the medically frail exception to the benchmark plan. And so one of the things -- I mean, there, going back to Diane's point, it's just a decision at the threshold that certain people don't go into a benchmark, i.e., don't go into a plan modeled on an employee benefit plan at all. And so one variation, going to Andy's point of administrative problems or Patty's point, is to think about sort of this variability, right? You can do it as a supplemental insurance plan. You can do it as a voluntary choice for families or even a screening tool to make Medicaid the primary insurer for certain services with financial adjustments to go along with that. But, I mean, you know, it's sort of two ways to get at the problem.

CHAIR ROWLAND: So what we're asking the staff to do is to continue to look at the family glitch and the implications of it more broadly and then potentially just looking at it on a children basis. We're asking you to really comb the literature for what we know about financial burden for premium and cost sharing and especially its impact on access. And we're looking at then trying to figure out what levels of skin in the game are going to be problematic for families and how that would change as one

goes up the income scale. So obviously what is a burden for someone at 150 percent of poverty isn't at 300. Finding out where we are today with regard to levels of coverage for children and their income eligibility.

On the benefit side, I think we've also identified in much of our work that there's a very slim set of benefits -- not slim, but a very limited set of benefits that are outside of what the normal scope is. So let's think about special needs children and what benefits they need, and then let's have a special focus on availability of dental care. And I'd like that to be looking at kind of how we merge Medicaid problems with problems outside of the Medicaid program.

And, finally, I think we ought to really be sensitive to the fact that what kids get if they qualify for Medicaid and they are under 138 percent of poverty or another state is at a higher level, and what kids get if they are outside of the Medicaid program, so that we don't create a big notch where $1 of income that puts you out of Medicaid throws your kids into a totally different situation. And I think all of that is perfectly doable by our next meeting.

[Laughter.]

CHAIR ROWLAND: So I want to thank our team, and obviously the Commission has been well engaged in this discussion, and I know we will continue to be. And I'm going to take the Chair's prerogative of moving our next discussion on an update of Medicaid expansions to post-lunch. But I'm going to ask if there are public comments on the morning session before we adjourn for lunch.

PUBLIC COMMENT

* [No response.]

CHAIR ROWLAND: Seeing and hearing none, we will stand adjourned, and we will reconvene at 1:00 instead of 1:15.

[Whereupon, at 12:15 p.m., the Commission recessed, to reconvene at 1:00 p.m., this same day.]

AFTERNOON SESSION

[1:03 p.m.]

CHAIR ROWLAND: Okay. If we can please reconvene, we will finish up our morning business before we get to our afternoon session, and we are asking Martha and Sarah to give us an update on the Medicaid expansion which it's at Tab 4 in your briefing books.

Session 3: Update on Medicaid Expansions

* MS. MELECKI: Good afternoon.

With most state legislatures currently in session, there's been a lot of recent activity and news coverage surrounding Medicaid expansion discussions, and so we felt that this would be a good time to update you on the state of Medicaid expansion decisions in the states.

So I'll begin today by providing a brief update on state expansion decisions. Martha will then provide more information on expansions by waiver and traditional expansions, followed by the most recent Medicaid enrollment data available. We will conclude with an overview of future MACPAC work in this area.

As of today, 28 states and the District of Columbia have chosen to expand Medicaid, and this includes

states who have chosen to expand traditionally and those who have used Section 1115 demonstration waiver authority. Currently, 22 states have not expanded Medicaid.

The map in this slide shows expansion decisions. Dark green states are those that have expanded traditionally. The light green states have expanded by waiver authority, and red states have not expanded.

Given that most legislatures are currently in session, we're monitoring movement closely. Examples of states we're monitoring include Idaho where the Governor is interested in expansion and has convened a work group to study a possible expansion. The work group has released a plan which they've presented to a House committee.

In Utah, the legislature is currently debating three different proposals for a waiver application, including one from the Governor. Just yesterday, one of those proposals passed the Senate, and it's unclear if it will be considered in the House.

In Alaska, the newly inaugurated Governor favors expansion and released an expansion proposal in early February.

Turning to Florida, the state currently has a

low-income pool, or LIP, funding waiver, which provides federal money to help hospitals treat low-income and uninsured patients. CMS officials have said that they will not approve a continuation of the waiver, and so some in the state are proposing Medicaid expansion as an alternative to help balance the state's budget in lieu of the LIP waiver.

Finally, looking at Ohio, the state expanded Medicaid through the legislature's seven-member controlling board in October of 2013. The Governor wants to continue the expansion, but it's unclear what steps would need to be taken in order to do so.

There's also been recent activity in several states. In Pennsylvania, the newly inaugurated Governor is in favor of a traditional expansion and has begun work to move the state from the 1115 waiver that was approved by CMS last year to a traditional expansion. The waiver program has been implemented, and so the move to traditional expansion will have a transition period.

In Indiana, CMS approved the state's 1115 waiver on January 27th, and eligible persons began to be enrolled on February 1st.

In Arkansas, the waiver stipulates that the legislature must vote to extend funding each year, and the current legislature has voted to extend funding through 2016. They also voted to create a work group to look at options for years beyond 2016.

In Tennessee, the Governor released a plan last year to expand by waiver authority. The legislature did not pass such an expansion during a special session that was called specifically to address expansion, and the legislature is currently in regular session.

In Virginia and Wyoming, proposals were brought before both legislatures, and both legislatures failed to pass expansion legislation, which effectively ended expansion efforts in the current legislative session. Both Governors favor expansion.

MS. HEBERLEIN: So moving on to the traditional versus Section 1115 waiver expansion.

As Sarah mentioned, 5 of the 29 states that have expanded have chosen to do so through Section 1115 waivers, which give them the option to try out different approaches to benefit and cost-sharing design than would be available to them under their traditional Medicaid expansion.

So I'm going to give you some highlights of these waivers as I go through them.

Arkansas, which is also known as the "private option," and you've heard a lot about it, is using a premium assistance approach to purchase qualified health plans on the exchange for enrollees. A recent amendment to this establishes health savings accounts that require monthly contributions for enrollees beginning at 50 percent of the FPL.

Iowa is actually two waivers. One, which is very similar to the Arkansas model, is using premium assistance for enrollees, but it's just for those who have income between 100 and 138 percent of the FPL. There are those who are under 100 percent, are covered through managed care, and that's a separate waiver.

Premiums are charged for those starting at 50 percent of poverty, but they are waived in the first year of enrollment and in subsequent years if you complete certain healthy behaviors.

Just as a reminder for returning Commissioners, you may recall that I presented a chapter at the December meeting that will appear in March that talks more about the

Arkansas and Iowa premium assistance approaches.

So, as Sarah said, Indiana was just recently approved and is probably the most complex. I won't go into all the details, as we are still trying to sort all of it out, and this is a continuation of an existing program that they already have that relies on health savings accounts as well.

Those with income at or below 100 percent who don't make monthly contributions to these health savings accounts actually get a lower benefit package that doesn't include dental or vision while those above 100 percent who don't make contributions are locked out of coverage for six months.

Michigan is using managed care plans to expand Medicaid. They also are using sort of a health savings account approach where all enrollees will make contributions based on the prior six months of utilization, and again, contributions are reduced through healthy behaviors. Enrollees above 100 percent also pay premiums.

Pennsylvania is also covering their expansion population through managed care. They charge monthly premiums of about 2 percent of income for enrollees above

100 percent, and there, again, are incentives for healthy behaviors. As Sarah mentioned, the Governor is in favor of more traditional expansion, and so they're transitioning from their waiver coverage to a traditional expansion.

Finally, in New Hampshire they have a pending waiver that looks very much like Arkansas as well where they are going to use premium assistance in the exchange beginning in January 2016. Their waiver has been in since the end of November, so we expect something shortly on that. Currently, they are covering the expansion population in a bridge program and as well as through premium assistance with employer-based coverage.

CHAIR ROWLAND: Martha, when we look at the waivers and the waiver experience, I am going to channel Patty for a minute, and I think one of the things that we haven't always looked at is we've described the features of the waivers, but we haven't thought through kind of the administrative complexity of much of what is in the waivers, and I think that's a criteria we should also look at because just having reviewed some of the terms of the Indiana waiver, I think it adds more complexity to the program than one really anticipates it would.

MS. HEBERLEIN: And I will give more on our work on waivers in a minute.

We also wanted to give you the latest update on the enrollment figures. These are hot off the presses. These came out on Monday. They show that as of December 2014, nearly 69.7 million people were enrolled in full-benefit Medicaid in CHIP. This is an increase of 18.6 percent or about 10.75 million enrollees from the July-through-September-2013 baseline.

As you would expect, expansion states reported increases much higher than those states that have chosen not to expand Medicaid. Expansion states saw increases of over 27 percent compared to over 7 percent in non-expansion states.

Fifteen of the 26 reporting expansion states saw an increase of enrollment of 30 percent or more. This includes Arkansas, California, Colorado, Kentucky, Maryland, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, Washington, and West Virginia.

Also, at the end of January, CMS released data that looks at the Medicaid enrollment in the new adult

group for the first time. These data are a bit older, so we have data as of March 2014, but it shows us that 4.8 million expansion adults were enrolled in the program. And it's important to note that this excludes California, D.C., and North Dakota, and because California is such a big state, it's probably significantly larger than that.

It's also important to note that since March, that quarter, four additional states have expanded, including Indiana, Michigan, New Hampshire, and Pennsylvania. So as data come out more, that number is expected to increase.

Two-thirds or so of the new group qualify for the 100 percent matching rate, while the other third do not. As a reminder, the 100 percent match is available only for non-elderly, non-disabled adults, with income up to 138 percent of the FPL who would not have been eligible as of December 1st of 2009. So the vast majority of those 1.5 million of new adults that are ineligible for the 100 percent match are in states that expanded coverage prior to the ACA, and so if they are adults without dependent children, they would be eligible for a transitional match rate that is higher than the state's traditional FMAP.

Enrollment in the new group represents about 9 percent of all Medicaid enrollees in the 48 states reporting data and about 18 percent of enrollees in 22 expansion states.

COMMISSIONER ROSENBAUM: Can I just ask one question about the data? Do we know, of the expansion adults, what proportion are, as you know, adults who are neither caretakers nor people with disabilities nor Medicare beneficiaries, and how many are parents who got picked up because of the exceedingly low eligibility standard for parents? Because I think people talk about them as childless adults.

MS. HEBERLEIN: Yes.

COMMISSIONER ROSENBAUM: In fact, this expansion has helped a huge number of parents of children.

MS. HEBERLEIN: And I know we looked a little bit at the data when they were more preliminary. They're not in the report that CMS released at the end of January. It doesn't break down where -- it breaks down whether you're newly eligible for the 100 percent match or not, but it doesn't break down what category you might be in.

I know that we looked at those data when they

came out, but they were still sort of preliminary. But that's something we can certainly look at more.

CHAIR ROWLAND: Sara, among the potentially eligible, it was about two-thirds childless adults and one-third parents, but that was in all the states. And so the southern states, which are not expanding, you would have a much higher proportion there of parents in the mix. So I think there's been a -- the parents are more affected by the non-expansion states than by the expansion states.

* MS. HEBERLEIN: So just to give you a little preview of what we are working on, are continuing to work on, Sarah and I -- Sarah Melecki -- will continue to track the Medicaid expansion decisions in the states on a daily basis, and we'll be sure to look at states that are going the traditional route versus the waiver route and track what CMS is -- what they are actually asking for and what CMS is approving in those waivers.

Sarah and I are also working on a brief that summarizes the features of the existing expansion waivers in more detail as well as looks at trends across states, and we will certainly add in administrative complexity to that list.

We also will continue to provide updates through MACStats and other means on the enrollment data as they are released.

And finally, we talked a little bit about this at the last meeting, but under contract with the Urban Institute, we are using data from the Health Reform Monitoring Survey to get characteristics of the new adult group, and so some of those data that Sara was just asking about, we'll get a little bit more from the HRMS.

Just to remind you, it is a quarterly Internet-based survey that was designed to track implementation of the ACA and the impact on coverage, and so we are working with Urban now actually to pull the data on the new adult group to get their demographic and socioeconomic characteristics as well as their access utilization to the services and hope to present those at an upcoming meeting.

COMMISSIONER MILLIGAN: If you are open to another, maybe, ongoing activity, it might be worth capturing how different states do the administrative side of the medically frail adult piece of this and identification, transition, and so on to really back to the morning conversation, but to see from a process point of

view, how different states manage that activity.

COMMISSIONER RETCHIN: Going back to the group of adults that were part of the expansion but were not newly eligible, was that the woodwork phenomenon or not? Because you said that it was different than the organic FMAP but not as much as the expansion. I didn't really follow that.

MS. HEBERLEIN: So a number of states had expanded Medicaid eligibility prior to the ACA, and so in order to sort of equalize, because they wouldn't be eligible for the 100 percent match rate, there is a provision in there that says they get this transition match rate, and so over the years, as the 100 percent FMAP goes down for the new group, their FMAP goes up, and they become sort of equal. So it's to try to compensate the states that were early expansion.

CHAIR ROWLAND: Yes. It was basically a provision that said you shouldn't be disadvantaged because you already expanded coverage to these groups, and yet they didn't give them the full 100 percent, but then they phased together at the 90.

Chuck.

COMMISSIONER MILLIGAN: I think I might want to

just build on the point you made a minute ago about parents and the non-expansion states. Correct me if I'm wrong, anybody.

But I think part of what we're talking about here is when welfare reform happened and states were required to sort of stick with old AFDC kinds of standards and states could then have some income disregard in other rules to deal with how to cover parents, a lot of the really lower parent thresholds as a percent of poverty tended to be states that aligned with the states that chose not to expand Medicaid. So you might see a state covering parents up to 20 or 25 percent of FPL pre ACA more aligned with states that chose not to expand, and states that chose to expand the parent coverage pre ACA might have been 45 or 50 or 70 percent of poverty.

So I just wanted to elaborate a little bit on the point that you had made, Diane.

VICE CHAIR GOLD: Yes. I can't recall what subgroups the Urban study lets you do, whether it has state estimates or types of characteristics of states, but as you get the information on the characteristics of the new adult group, whatever you can do to sort of put people in buckets

by the type of state programs they're in, it may help you make sense of some of that stuff people were talking about because depending upon what their underlying existing program was, that may affect the characteristics of the new eligibles. And to the extent you can talk about that, it may help talk about, a little bit, the effect of the states that are not in and what they might look like or something like that to try and help make sense of the data, because I have a feeling, the total aggregate may not be as interpretable as if you can get some of those buckets.

CHAIR ROWLAND: I think the real difficulty on the parent side here is the variability in where states were covering parents to begin with, and the expansion states, as Chuck noted, often were covering parents at higher, sometimes even at the poverty level than the non-expansion states. So that the benefit to parents is going to be greater if the non-expansion states expand than it was to the expansion states, but we'll track it all and have numbers.

I think it's also important that there's two ways here that enrollment is being counted. The first one was really looking at the number of people enrolled in

Medicaid, without necessarily teasing out how many of them were just the normal turnover, to add people onto Medicaid versus the people who were newly entitled to Medicaid coverage.

The second one does reflect newly entitled because it's where the states are claiming the 100 percent match, but that one is one in which I'm sure a lot of states haven't even turned in some of their match, since this is part of what's going on, the administrative material, and so, certainly, we should not go out and say that only 4.8 million people benefited from the expansion. And when California comes in, that will be even higher, but it's just a caution that this is a very incomplete number, although it will ultimately be the number that reflects how many people were covered under the 100 percent match.

Chuck.

COMMISSIONER MILLIGAN: I'm sorry. Just one other point. I think having lived through a lot of this in the Maryland side, I think a population we shouldn't lose sight of is former foster care kids up to age 26, because that -- to create equity with kids covered through their parents under employers. It may not be a big number, but

it's an important part of the expansion.

CHAIR ROWLAND: And we'll see in some later data that it could also be a costly part of the expansion.

Thank you.

And, reflecting the other part of our name besides "payment" is "access," and, obviously, we have tried to look at gaps in access, at where Medicaid beneficiaries and others get their access to care, and so Anna is going to present to us with some of the analysis that she has been conducting on site of care. Thank you, Anna.

Session 4: SITES OF CARE SERVING MEDICAID ENROLLEES

* MS. SOMMERS: In the context of many different discussions you have had, you have raised the question, where do Medicaid enrollees receive care? Is it the most cost efficient place? Is it the most appropriate place of care? So, this presentation is intended to set the stage for future dialogue about access and payment policies related to sites of care.

First, I'll briefly place this topic in policy context, and then I'll present some preliminary data identifying the sites where major populations of enrollees

receive care. And, then I'll wrap up with some of the potential areas for future work.

Medicaid services are provided in over 30 distinct sites of care reflecting a wide spectrum in service capacity, facility types, and payment incentives. Encouraging broad access to lower cost sites can help to meet program objectives related to cost efficiency and economy of care. However, higher cost providers are needed to provide more intensive and specialized services, when appropriate.

So, looking at where enrollees get their care is an important first step in a discussion of whether enrollees are getting care in the most cost efficient places and in the settings most appropriate for their needs.

To set the stage, we conducted a preliminary analysis using the 2011 Medicaid Statistical Information System, or MSIS, data. We estimated the percentage of enrollees having contact with each site of care identifiable in the MSIS at any point in 2011 for major eligibility categories and age groups. Contact with a site is defined as having any service at that site. That

includes non-practitioner services, case management, imaging, and lab tests. We used both fee-for-service claims and managed care encounter data to derive these estimates.

So, of course, we had to exclude some populations known to have incomplete data on utilization in the MSIS, individuals dually eligible for Medicare and Medicaid, and also those eligible for limited benefits.

In addition, individuals enrolled in comprehensive managed care plans in 11 states were excluded due to known problems with completeness and quality of their encounter data.

So, the analysis population reflected in your tables is non-dual, full benefit enrollees.

CHAIR ROWLAND: But, it does include people with disabilities.

MS. SOMMERS: Yes. So, your handout includes four tables showing these estimates in detail, and I'll just give you the highlights here.

Overall, 83 percent of enrollees had contact with at least one site of care in 2011. That includes ambulatory care sites, inpatient hospital, psychiatric

facilities, substance abuse treatment centers, residential and long-term care facilities, and the patient's home.

Individuals enrolled for just part of the year are included in these estimates and they have much lower contact rates than full-year enrollees. So, this is one reason the overall percentage of contact is only 83 percent. For most full-year enrolled groups, the percentage with any contact is between 92 and 95 percent, whereas part-year enrolled groups have contact that is 20 percentage points lower.

Non-disabled adults are an exception to this pattern. Even for the full-year enrolled, only 86 percent had contact with any site. And, among part-year non-disabled adults, this rate was only 66 percent, lower than all the other part-year groups. On the other hand, disabled children had the highest overall contact rates.

So, let's look briefly at institutional and home-based settings. The percentage of enrollees accessing inpatient acute care hospital services ranged from one percent to 29 percent. Part-year non-disabled adults had the lowest rate, at one percent, and part-year disabled adults had the highest rate, at 29 percent.

Very few non-dual full-benefit enrollees accessed any non-psychiatric residential or long-term care facility, less than one percent overall. Among groups with higher than average rates -- that means disabled groups and the elderly -- the percentage receiving care in their home was much higher than the percentage receiving facility-based long-term care. For example, among disabled children, one percent received care in a residential or long-term care facility, whereas 27 percent received services in their home.

Now, we'll look at ambulatory care. Overall, 82 percent of enrollees accessed at least one ambulatory care site. This is broadly defined. It includes contact with community health centers, school-based clinics, state and local public health clinics, ambulatory surgery centers, independent laboratories, and other sites. Of these, more enrollees accessed office-based settings than any other site. The lowest contact with offices occurred among part-year enrolled adults, about 49 percent, and the highest contact with offices occurred among full-year enrolled children, at 84 percent.

The percentage of enrollees accessing emergency

departments on an outpatient basis varied widely based on eligibility category and age, but there were three patterns consistent for all groups. First, a lower percentage of enrollees accessed EDs than hospital outpatient clinics in every eligibility group. Two, a higher percentage of people in disabled eligibility groups than in non-disabled groups accessed EDs. And, three, a higher percentage of full-year enrolled individuals than part-year enrolled accessed EDs.

Health centers -- health centers served 16 percent of enrollees. These include federally qualified health centers as well as the services provided by FQHCs in other places off-site that qualified for the enhanced payment as an FQHC service, rural health clinics, and community mental health centers. FQHCs amount for most of this contact. Eleven percent of enrollees accessed FQHCs. A higher percentage of disabled adults, 25 percent, compared to other enrollee groups received care at health centers.

So, those were the data highlights and there are just a few things to keep in mind when considering these results. Where we could compare our estimates to those

from other data sources, we did, and for the most part, the MSIS is consistent with these data sources. National household surveys also found, as we did, a small percentage of individuals reporting no ambulatory care at all, and they show this -- the surveys show this in all insurance categories and socio-economic groups.

The MSIS does not capture services provided to Medicaid patients and billed to another payer or provided free of charge to Medicaid patients.

And, services through limited benefit plans, meaning plans providing only mental health, dental, or transportation services, are known to under-report encounter data.

So, just a few ideas of future work that could be undertaken with these data or with other data. The analysis could, of course -- the data set could be used to explore in greater depth selected groups of interest and their service patterns between sites. And, some other questions that could be explored are what explains low ambulatory contact by some groups? Would a different mix in sites yield cost savings? Which trends are important to track? Do certain payment policies explain certain

patterns of service use? And, how does the availability of sites vary geographically, and what are the implications for state planning?

So, we look forward to hearing your ideas about future work that we could conduct around sites of care to assist you in developing recommendations related to access or payment.

COMMISSIONER GABOW: Thank you. I have four questions, and it's not even Passover.

[Laughter.]

COMMISSIONER ROSENBAUM: We are getting close.

COMMISSIONER GABOW: I know. So, my first question is, what group are pregnant women included in when you break down these groups, because I suspect if you looked at pregnant women as a discrete group, you might find some different data. That's the first question.

The second is, when you take out managed care, are there providers that would be differentially impacted? For example, are you likely to have more health centers who are in an HMO, Medicaid HMO, than office-based practice, and, therefore, if you exclude the large volume of managed care data, this could significantly skew the outcome.

The third issue is there are some providers that do not take Medicaid, so that also would skew results. For example, I don't know, but my -- I thought I had some data that some urgent care centers, the for-profit urgent care, won't take Medicaid payment. It's cash on the barrelhead. And, we certainly have had experience in Colorado with non-public psychiatric and substance abuse providers not taking Medicaid. So, if you already have a barrier, this will affect the data.

And, as you look at -- the last comment is, one of your questions was about cost efficiency. It would be useful, if you could ever get the data, when you compare an office visit to an FQ visit, since FQs are cost-based, is there a difference? So, that turns out to be significant in payment. Those are my questions and/or comments.

COMMISSIONER ROSENBAUM: So, my question actually is on the residential finding, and I just wonder, out of curiosity, whether you can go back in time to look at the distribution, because I think it would be incredibly educational for Congress and the administration to see how far we've come in where we are delivering services to people with extreme disabilities that previously might have

landed them in an institution. I mean, I assume that the drop since the mid-1990s has been quite notable. So, I think that what Congress has done over the past, now, 15 years or so to make it easier for states to design community-based programs and then couple that with whatever recommendations we might have on building on past reforms.

But, you know, basically, residential care has disappeared from the Medicaid program. I mean, it's phenomenally, at least to a lay eye like mine, I would say there's a very, very modest level of residential care for a program that had nursing home care as one of its mandatory services 50 years ago -- and still does, but the numbers, I'm sure, are dramatically different. So, I think that would be incredibly useful to do.

And, I also wonder, going back to the point that Patty was raising as sort of having the same issue -- same thought -- whether we can do some apples-to-apples comparisons. So, if it is, in fact, the case that people with disabilities are more likely to end up visiting health centers, if we can try and start to figure out the extent to which that might bear into their -- on their high unit cost as well as the mix of services, you know, are there

underlying cost drivers because health centers are, in fact, absorbing more people with disabilities in their care systems. I have long suspected it, but, I mean, this jumped out at me as interesting.

COMMISSIONER COHEN: Thanks, Anna. That's so interesting. I think this presentation is like a Rorschach's test because you can see so many things in it depending on what you are focused on when you first hear about it. But, I thought it was really interesting.

So, my angle on this is I am really interested in seeing if we can tell or learn how this sort of site of care analysis would line up with different populations, like a Medicare population, commercially insured, and actually -- this might be hard to do -- dual-eligible, because I have always wondered, does the dual-eligible population in general use a Medicaid sort of set of providers or a more mainstream Medicare set of providers. So, I am really interested in it from the comparative perspective, in part to just sort of understand, and I understand there is not one answer to this nationwide, but to what extent are Medicaid beneficiaries, are they using a different set of safety net providers than other insured

populations, and to what extent is it really integrated and in what context.

And, I think that matters both from the perspective of thinking about Medicaid's role in the larger health care system. It matters in terms of thinking about sort of segregation of Medicaid beneficiaries and where that might be particularly problematic. But, I was also thinking that while the rest of the health care system, I think, is very focused on some issues around, say, transforming primary care and moving to more patient-centered medical homes and other sorts of things, it is important to understand that if the Medicaid sort of primary care provider base looks different than, say, mainstream commercial insurance or Medicare provider base.

So, are people, you know, the extent to which they are mostly being seen in clinics and large sort of OPDs, and people -- I think that has been a perception. Certainly, in New York, it is commonly assumed that that's mostly where Medicaid beneficiaries are seen. But, I actually think the data suggest that there's lots that are actually going to small practices. And, what are the implications for that in thinking about transformation

towards better primary care and other things like that.

So, anyway, I think it's a great analysis. I'm very interested in how it really relates on sort of some of these comparative issues.

CHAIR ROWLAND: Andy, I'd just point out that this analysis is only based on Medicaid --

COMMISSIONER COHEN: Oh, no. I mean, I understand --

CHAIR ROWLAND: -- you're asking for a totally broader study.

COMMISSIONER COHEN: Well, I'm saying it is to me particularly interesting as sort of a baseline from which maybe comparative work could be done if perhaps -- perhaps there are analyses, similar ones in other -- for other --

CHAIR ROWLAND: -- using MSIS --

COMMISSIONER COHEN: Right. No, but I do understand that this is not that.

COMMISSIONER RETCHIN: Building on the Medicaid provider population that Andy just referenced, I've been concerned for some time that there is an out-migration of physicians from the inner city for a variety of reasons that don't need to be expanded on here, but it would be

interesting -- I don't know how you would find that, maybe through ARF or something, but to look and see -- because you have two things working against you there. One is the falling, rapidly falling interest in primary care from graduates of medical schools, now down to, I think, in terms of their interest, about 22 percent of medical students. And, then, those who go into primary care are actually locating their practices increasingly in the suburbs, even those who 20 years ago would have located in underserved areas.

So, I think, most definitely, these are different providers who take Medicaid. I'm astonished when I meet with -- or I've met with community providers who -- they don't take Medicaid at all, and I've wondered in terms of the expansion how they've been able to accommodate that in a network for adults, particularly in states that really had no coverage before.

COMMISSIONER MILLIGAN: I wanted to mention a couple things, I think. One is we did a study in Maryland about site of care and we looked at CPT Code 99-213 and 99-214, the two most frequently coded things, and we looked over time for Medicaid, and it was done at the Hilltop

Institute, where Anna and I first met. What we saw is a couple of important trends -- in one state, but a couple of important trends.

The first is that the physician office site of care was about -- we paid about $48, as I recall. The weighted average for FQHCs, because each of them has a separate rate, was about $150. And, then, the weighted average for a hospital OPD, if you include the facility fee piece -- and, again, Maryland is unique because of the all-payer hospital rate setting system -- but, on a weighted average basis, one 99-213, established patient, routine visit, was almost $400. So -- and, we saw that the trend was moving toward hospital OPDs because hospitals were increasingly employing physicians, and I want to stay on that point for a second and then come back.

There has been a huge trend toward employment of physicians for reasons that are very understandable for new physicians about schedule predictability and coverage, but also for covering, really, the costs of practice, like EMRs and other things that are very hard to sustain in a small office. So, there's a lot of reasons that things are moving toward hospital OPDs, but we saw the percentage

shifting very dramatically and almost all of the new visits going to the most expensive site.

We then had conversations with other payers in the state about whether they were seeing the same thing and they were typically not seeing that trend because they were using co-payment, a co-payment on the facility and no the professional fee, and raising the co-payments to try to influence decision making about site of care, which was a tool we didn't have in Medicaid.

So I just want to kind of raise some of those broader themes about employment, the cost to practice, facility fee and professional fee co-payment issues, and the very significant difference in cost that Medicaid was paying a lot.

But I guess the other point I want to make about this is it's going to be very hard to look at site of care because it's changing so fast, and I will tell you from what I'm observing in my current work, the demand for convenience care models, the Minute Clinics and the pharmacy-based clinics, the demand for telehealth models, the demand for workplace-based clinics is disaggregating sites of care in many, many ways, and co-payments again on

the commercial side are influencing those decisions. We just launch January 1st where I work now that there's no co-pay for a telehealth visit to try to keep some of the volume out of physician office urgent care or urgent care settings.

So I think this is really important work, and I guess I'll conclude with this point. I think we have to be careful that we not emphasize efficiency so much that we indirectly encourage the kind of Medicaid mills that are anathema to where we want Medicaid folks to be able to receive care.

So those are my comments.

VICE CHAIR GOLD: Hi, Anna. I want to sort of bring the conversation up a level and down a level at the same time and sort of suggest sort of what's new here and maybe what some of the constraints are, because I think one of the key questions is: What's most important looking forward? That's what you asked us.

I think -- this is claims data. It's probably one of the -- I haven't seen a lot of analyses like this that look within service, within claims, so it's new that way. It's different than the survey data. The survey data

have information that's a whole-person focus. Their advantage is they have things that you don't have on claims to adjust, like health status, age, things like that. So you have this and you don't have that, and so two things from a technical perspective, and then I'll talk more broadly.

When you look at some of the disabled or other people, people who use more care have a greater likelihood of using more settings of care just because they use more. So you haven't looked at the denominator of the total care used by the person, so I'd be cautious in drawing conclusions about the disabled using this more than the other. I mean, yes, they use everything more, maybe, or something like that.

The second is when you're comparing it to the survey data on the share that use a visit, you might want to pay attention to what the denominator is of the population, because I don't know on yours whether it's month of eligibility, people who are eligible months, the survey data is people reporting for a year. It may be that they're reporting different things and the numerator and denominator aren't the same, because I think it would be

important, because people focus on it a lot, to sort of see what's similar and different about the share that make a visit in a year.

My other set of questions, you know, it's sort of funny to see this. This goes back to my earliest research, I mean my master's thesis in 1971 -- I shouldn't say that, it ages me -- was on use of the emergency rooms. And in the 1970s -- '80s, I guess, I look at substitution of inpatient and outpatient care. You've got a lot of stuff going on here, and it seems to me what's really most critical looking forward, some of these things are substitutes, some of these things are complements. What's the question?

I mean, I guess the question is: You want to sort of figure out what's important to look at and what you can look at with these data, or you can't and what data to use. And I'm not sure what it is. I don't know that even if you answered any of the questions you had here you'd take it anywhere further to understanding from a policy sense what some of the issues might be. Ultimately I think what you want to do is look at patterns versus need.

Now, you have a hard time with that because you

don't have data on the demographics and other things. Maybe you can look at some by states or state characteristics or there's some controls you have. But I think bringing it back -- and some of the questions people have had here have sort of brought up problems that people know exist. Some of them can be looked at with these data, some can't, and maybe thinking a little more about the why and what the question is that this is answering might be helpful as you sort that out.

COMMISSIONER RILEY: Well, I would just echo Chuck's points, most of which I won't repeat, I was going to make. I think they're really important ones. It seems to me that one of the issues is also the issue that you raised about geography. Supply drives demand, so do we really know anything about population behavior, or is it more that there happens to be these services in this service mix in this community.

The others are on payment reform, to Chuck's point about all the variation and change in delivery systems and payment. It would be sort of intriguing to me to think about the medical home movement within Medicaid, and we certainly have seen the data that it appears not be

saving money, but has it driven people to different sites of practice into more primary care sites? And could we cut the data that way to take a hard look at whether these payment reform models are really driving changes in patient behavior?

COMMISSIONER SZILAGYI: Just a couple -- I actually had a question, and then a couple points piggybacking onto what Chuck and Marsha said.

My question has to do with the population that was not covered for the full 12 months. Did you analyze the data for the full -- of visits for the full 12 months even though they weren't covered for the full 12 months? Or did you control for the number of months that they were covered?

DR. SOMMERS: No, we didn't control for --

COMMISSIONER SZILAGYI: Because if it was the former, then I don't think that data is really valid, because if somebody was covered for six months out of the 12 but you looked at visits for the whole year, you know, you can -- there's ways to adjust for that. So I guess my general theme is to be careful about over interpreting data on utilization and certainly the partial months. So I

would kind of go back and rethink that.

The point that Chuck was making I think was really important, and I want to do kind of a counterpoint, that I would be really careful in overinterpreting data simply based on costs or visits, and the reason is that the population that visits community health centers or outpatient clinics, even though they're both on Medicaid, is different from the Medicaid population that visits private offices. So the Medicaid population -- what you haven't done, because it's partially impossible to do it, although you can get there if you start looking for ICD9 codes, is you haven't done risk adjustment or looked at the risk of the population attending outpatient departments.

For example, just as a very concrete example, many, probably most outpatient clinics have social workers. Virtually zero primary care practices out in the community have social workers. So the population that visits those two places is different. The needs are different. And just looking at costs to the system isn't the entire answer, because there's different populations and different levels of services that are delivered. And I'm not against trying to save costs, but we shouldn't over interpret

trying to drive this population out of outpatient departments or community health centers because they appear to be more costly.

COMMISSIONER MILLIGAN: Peter, I just -- first of all, I want to say I agree with -- that the cost in some of the cost data I presented isn't meant to say that those are all identical services, because I do think there's definitely more supportive services in an FQHC than in other settings, so I wasn't trying to make an apples-to-apples comparison. But I want to maybe -- a friendly amendment to what you just said. The population that seeks services in a hospital OPD may be different, not certainly is different, because one of the things that we observed in Maryland was hospitals hired groups that previously were independent and brought them inside their clinics, and so the patients followed their physicians into a facility-based model. But I don't -- and a lot of what I was observing wasn't an academic medical center delivered OPD. It was community hospital OPD. So I just think it may be different, it may not be different.

VICE CHAIR GOLD: It varies by state.

CHAIR ROWLAND: Anna, you noted that you excluded

individuals in managed care in 11 states. What do you think that -- that really does change, I think, potentially some of the conclusions one can draw from this, because if those 11 states are really big states with high penetration of managed care, you're mainly picking up people who may be more in the disability population than in the children and families population.

DR. SOMMERS: Just quickly, the percentage of enrollees that the remaining states represents is still pretty high, I think 88 percent of all enrollees. I can tell you the states that were excluded.

CHAIR ROWLAND: Did you include California?

DR. SOMMERS: California was not excluded. D.C., Illinois, Maryland, Massachusetts, Mississippi, Nevada, Pennsylvania, Ohio, South Carolina, Utah, and West Virginia.

CHAIR ROWLAND: Well, I think one of the interesting things in this analysis is really the differences in the array of sites of care by the different eligibility groups. I totally agree with Peter's comment that you really need to look at the full-benefit, full-year people because the partials, it's too hard to tell what

they had before, what they had later, or how long they were on.

But I was thinking that there's a theme here that we might want to also pick up about foster care, because we pick up foster care here. In the work Amy is going to present, we're going to pick up foster care again. In the psychotropic drugs, we're going to pick up foster care again. And I think some of what we can learn from this kind of data and from the next sets of reports is how within Medicaid there are some special needs populations and what happens to them, because I think the thing that jumps out is just the real difference often with the foster care and the disabled children versus the non-disabled.

So I think really looking at this by population is one of the ways that we can get some insight.

COMMISSIONER SZILAGYI: Actually, I forgot to make another point, and it's related to what we just said. We might consider an entire chapter on foster care since it's, you know, not just focusing on their mental health but on -- because they are all on Medicaid. There's some interesting changes now with the post-foster care period. There's legislation right now being considered by Congress

about making some other changes with the foster care population. So it's one of the populations that may be worth a separate chapter.

VICE CHAIR GOLD: Diane, has the Commission -- when it did their broad overview of Medicaid, did the Commission's report ever summarize the issues with foster care? Because I know I've been in health care for ages, and this is not a population I know well. And I'm wondering, if it hasn't been done, whether that would be a contribution as to what we're learning about where this population fits within the Medicaid --

COMMISSIONER ROSENBAUM: I would just add to that special needs adoptions, which are a distinct Medicaid eligibility category, and it's one of the places where -- you know, we were talking before about the 1 percent cases. I mean, Medicaid has probably done more to promote special needs adoption than almost any other policy you can think of, and very little is known about it. So I would raise the same thing.

CHAIR ROWLAND: We obviously discussed it since one of our previous Commission members was a foster care parent -- Robin -- but we really have never dealt in any

depth with it in terms of a chapter. It's occasionally woven in, and I think that's an excellent suggestion because I do think as you read the next three sets, you begin to say foster care has a particular difference here or really why shouldn't we examine it.

Okay. Thank you, Anna.

[Pause.]

CHAIR ROWLAND: And now just because we've been talking about eligibility and enrollment issues, and we always love data, we're going to ask April to join us and to talk a little bit about reviewing Medicaid eligibility and enrollment issues.

Session 5: REVIEW OF MEDICAID ELIGIBILITY AND ENROLLMENT ISSUES

* MS. GRADY: Thank you, Diane. I seem to have a technical glitch. Well, I'll just go ahead and start while we're waiting for the slides to come up.

You've been hearing a lot obviously about eligibility and enrollment issues in many of our presentations. For example, we've clearly devoted a lot of time to the current status and future of CHIP. You also heard an update this morning on the adult group expansions.

And you're going to hear more about the Medicare savings programs in the session directly following this one.

But based on those examples I just gave, you can see that our discussions tend to be about very specific populations, and the current session is intended to bring us back to the big picture of Medicaid eligibility and enrollment. And we have a few purposes here in taking a step back. One is to review the basic eligibility pathways, not because you're not already familiar with them -- clearly you know them very well -- but to emphasize the fact that Medicaid currently has a very bifurcated system of eligibility methods and rules, one that applies to non-disabled children and adults and one that applies to seniors and people with disabilities. So we really want to highlight that in this presentation.

Another purpose is to highlight the issue of full-benefit eligibility versus Medicare savings program eligibility within the population of seniors and people with disabilities. And this is a key distinction, and it's an important one for the presentation you're going to have from Katie Weider right after me, so please be sure to grill me here if there's any questions that you have about

the Medicare savings program pathways and how those interact with full-benefit Medicaid eligibility pathways.

And the final purpose is to give a preview of some of the eligibility and enrollment work we're planning or have in progress that you haven't necessarily heard about already.

I keep doing that, pushing the wrong button. Here we go.

Historically, coverage of Medicaid was tied to receipt of cash welfare for families with children, people with disabilities, and those age 65 and older. And when the Medicaid program was enacted, there were grant programs to states, and Medicaid was directly tied to your receipt of assistance under one of those programs.

Of course, there were many expansions and changes over the years, and Medicaid has really evolved to cover specified low-income groups for the most part without regard to welfare receipt. So your eligibility is based on your income level, not because you participate in another program.

That being said, there are two important exceptions there, and one is the Supplemental Security

Income program for low-income seniors and people with disabilities. In most states, if you receive SSI benefits, you are automatically eligible for Medicaid. And foster care and adoption assistance is another category of programs where, if you receive those benefits, generally you are automatically eligible for Medicaid.

And, of course, the most recent expansion, income-based expansion, was to adults without dependent children.

General requirements for Medicaid eligibility, I'll just go through these very quickly. Only citizens and qualified aliens can receive full Medicaid benefits, and "qualified alien" is a very technical term that was defined in the Welfare Reform Act of 1996. And generally speaking, most legal permanent residents, people who are qualified aliens, have a five-year bar on their Medicaid eligibility, and during that time they can only receive emergency benefits that I'll cover in just a minute.

Some groups only receive limited benefits. Again, you're very familiar with the Medicare savings programs that provide assistance with Medicare costs.

There are some people who only receive family planning and related services. In some states that's actually a very large number of enrollees. California, for example, I believe has about 2 million people who only receive family planning assistance under Medicaid. And there is also a population of non-qualified aliens who only receive emergency services. And the largest group of these folks are unauthorized people, folks who are illegally present, but it also includes students and other legal non-immigrants who have been admitted for a temporary purpose.

They can only receive emergency benefits. They have to meet all of the other financial and eligibility criteria for the program.

In addition, for people who are seeking long-term services and supports under Medicaid, a functional assessment may be required that demonstrates your need for assistance. Usually, these functional assessments look at your ability to do activities of daily living, things like bathing, dressing, feeding yourself, but there's a range of things that states look at, and we have a project on that, that I'll talk a little bit about later on.

Here, I just want to point out the major

eligibility groups for nondisabled adults and children. Of course, we have parents, pregnant women, and the new adult group. And for children under age 19, what I want to point out, of course, is the maintenance of effort that you're familiar with through fiscal year 2019, and the fact that some Medicaid coverage is financed with CHIP funds. So they are Medicaid-eligible children who happen to be financed with CHIP dollars.

In terms of enrollment, nondisabled adults are about 30 percent -- or were about 30 percent of Medicaid enrollment in fiscal year 2011. Of course, as Martha just presented on, there's increased enrollment in 2014 as a result of the new adult group in expansion states, so that share of the Medicaid population may increase somewhat.

With regard to nondisabled children under age 19, that's nearly half of all Medicaid enrollees, and in 2014, we might also expect to see a little bit of an increase in that enrollment because of an increase in CHIP-financed Medicaid that I'll touch on in the next slide.

Some of the relevant changes to nondisabled adults and children, eligibility for those groups, include the Modified Adjusted Gross Income standards and methods

and the fact that the asset test has been removed for most of these eligibility groups.

The thing I want to emphasize here is that prior to the move to modified Adjusted Gross Income, or MAGI, states had a lot of flexibility in the way that they counted income and assets for nondisabled adults and children. So even if two states appeared to have the same income eligibility level, say 100 percent of poverty, one of them might use income disregards that effectively reduce the amount of income that's counted in an eligibility determination, so people above 100 percent of poverty could actually end up being covered.

In contrast, a state that had no income disregards would be only covering people up to 100 percent of poverty, and the reason I'm telling you this is that situation still exists for the seniors and people with disability populations, and that's an important thing to understand for our discussion of the MSP pathways, but again, I'll cover that when we get there.

We've covered a lot of these. I'll just focus on the former foster care children until age 26 because that's something that came up in your previous discussion. As I

mentioned, there are child welfare programs, including foster care and adoption assistance, where Medicaid eligibility is automatic, but generally, children are only eligible for that assistance until age 18. Some states actually cover them at older ages, but they do eventually age out of the child welfare system. And this is a new pathway that will allow coverage for those children up to age 26 if they were in foster care when they aged out of the program.

In terms of our work here that you may not have heard about, you will recall that last September, we gave you an update on eligibility and enrollment in the new adult group and noted that application backlogs were still a problem in some states. It seems that since that presentation, things have been pretty quiet on that front, and for the most part, it seems that states have been able to work out a lot of the problems and the issues that were leading to their application backlogs. There still are some issues, but now what we're tracking is renewals rather than those initial applications.

As you will recall from the previous meeting, our focus groups with newly enrolled adults revealed that many

of them were unaware of the need to renew their coverage and were concerned about the possibility of losing that coverage. So it's something that we want to pay attention to.

Other than tracking news from the states on this front, one of the things we're going to see if we can learn anything from is the enrollment data. Only a handful of states have opted to extend their renewals for nondisabled children and adults into 2015. Many of them should have wrapped up that process by now.

Martha presented data from, I believe, November of last year, so we haven't seen any big decreases in enrollment that could indicate a potential problem with renewals, but we'll keep an eye on the December and the January data to see what might be happening on that front.

As I noted earlier, previous income counting rules could lead a state with an income level of 100 percent of poverty to actually be covering people at effectively a higher level. So when there was a conversion to the MAGI rules that no longer allowed income disregards and state flexibility, states were required to convert their income eligibility levels to reflect the disregards

that they had previously been using. So if you were at 100 but you had disregards that really brought you up to 110 or 120, that is your new MAGI-converted eligibility level. And the effect of that conversion has been to increase the stated Medicaid eligibility levels in some cases, and if you increase the Medicaid eligibility level, that creeps up into separate CHIP territory in some states.

So what you have is a little bit of a shift from separate CHIP eligibility to Medicaid eligibility, and what we're seeing from some preliminary data is that there has been a reduction in separate CHIP eligibility in some states, and a portion of that reduction may be owing to the MAGI-converted levels, so that's something we're going to be analyzing a little bit more closely and reporting back to you on.

This last point here about transitions between Medicaid, CHIP, and exchanges, I won't go on about that. You've heard many presentations about the work we're doing with the Urban Institute to model what could happen with CHIP in the future and the interactions between those programs with regard to eligibility and enrollment.

Okay. Now I will move on to major eligibility

groups for seniors and people with disabilities. Here, I am going to break this up into two slides. This slide here is talking about full-benefit Medicaid eligibility pathways. Most people age 65 and older or those who are eligibility on the basis of disability are coming in because they are receiving Supplemental Security Income benefits, and most of these people are at or below about 75 percent of the federal poverty level. As I mentioned, in most states, this is a mandatory eligibility group. You are automatically eligible for Medicaid by way of receiving SSI benefits.

Additional options for states include the poverty level pathway where they can cover folks up to 100 percent of poverty, medically needy pathways where your income may exceed the regular levels for Medicaid eligibility in your state, but you have high health care spending that is deducted from your countable income to bring you down to a lower income level that's counted for Medicaid eligibility.

And then the other major pathway is the special income level and the related home and community-based waiver pathways for people who need an institutional level of care, and there's some overlap between this special

income level and the medically needy concept, but these are also higher income people who spend a large proportion of their income on medical expenses, either in a nursing home or in the community if they are receiving home and community-based waiver services.

I'll also point out here that there's a disability determination that applies to people under age 65, and those are based on federal rules that are used for the SSI and the supplemental -- I'm going to get this one wrong -- Social Security Disability Insurance, SSDI rules, so those are uniform rules that generally apply in the same way across states. Again, there's always an exception with Medicaid, but generally speaking, the disability determinations use the SSI and the SSDI rules.

Once you turn 65, your income is really the determining factor. There is no longer a disability determination being done. That being said, as I mentioned earlier, if you do need and are seeking coverage for long-term services and supports, you may have a functional eligibility assessment that looks at the need for services, but that doesn't affect your eligibility for Medicaid per se. It's once you get onto Medicaid, we give this

assessment of your need for long-term services and supports within Medicaid.

So now I want to talk about the Medicare savings programs because separate from your determination of eligibility for full-benefit Medicaid, we have the Medicare savings programs, and we've got the acronyms up here. But the point is that these are separate from full-benefit Medicaid, and if you are a dually eligible beneficiary, you can qualify under the MSP-only pathways, and those are the people we generally refer to as partial duals.

You can qualify for an MSP and for full-benefit Medicaid -- and there are several million people who do -- or you can qualify for full-benefit Medicaid only. And most of the full-benefit dually eligible beneficiaries are the higher income, medically needy folks, special income-level folks who are living in nursing homes or otherwise receiving long-term care in the community, who may have higher incomes but again are spending most of that income on their health care. So I say they're higher income, but effectively, their net income is still low because of their health care expenses.

The other thing I want to point out here is that

the income and asset counting rules for the MSPs are generally similar to what's done for full-benefit Medicaid pathways within a state, and those rules build off of the rules for the Supplemental Security Income Program because of the historical link to SSI eligibility for these populations. Those are pretty complex. There's all kinds of disregards and other special provisions, but within a state, you generally have consistency in the way income is counted for MSP and full-benefit Medicaid.

The issue here that Katie will talk to you more about is that the rules for MSP eligibility determinations within a state, which again are linked to those SSI rules that I talked about, those may differ from the way that Medicare Part D counts income for the low-income subsidy. So when it comes time to talk about aligning the rules for the Part D low-income subsidy with the MSPs, you have to remember that there's an interactive effect here because the MSPs are doing what full-benefit Medicaid does. If you then make the MSPs do something different and you're aligning it with LIS, you are misaligning it with full-benefit Medicaid. So simplification and alignment sounds great until reality hits. We'll talk more about that in

the next session, but if you do have any questions, let me know.

In terms of enrollment, people age 65 and older, people with disabilities are about a quarter of total Medicaid enrollment, and many of these people are dually eligible for Medicaid and Medicare, and the dually eligible beneficiaries account for about 15 percent of total Medicaid enrollment.

Getting back to the full-benefit versus MSP only, about a quarter of the dually eligible beneficiaries are MSP only. So for those folks, you don't need to sort of worry too much about how their income is counted. If we changed that, there's no effect on full-benefit Medicaid eligibility. They're only getting MSP benefits, but the remaining three-quarters of duals do receive full Medicaid benefits, so a change in the way that the MSPs count income would have an effect on those folks.

Just briefly covering some work that we have going on this front, in last year's June report, we had a chapter on long-term services and supports that provided some information on financial eligibility for people who require long-term services and supports, and we're

currently updating and expanding that information.

As you might remember, the income and asset counting rules, the requirements for documentation are quite complex, and it's actually a big undertaking to go and try and gather that information from the states. But I think we're close to bringing that to you in a future Commission meeting.

We also have a contractor who is researching and reporting on the LTSS assessment tools that determine functional eligibility status and the level of services that you might receive in Medicaid, and of course, as part of that, but it's not listed on the slide -- but staff are also researching some states that are using presumptive eligibility for LTSS. Before the formal assessment is completed, you might receive services in the interim based on a presumptive eligibility determination.

And then finally, of course, we are presenting some policy options and discussion around MSP eligibility and enrollment.

One last thing I want to mention is some data analysis that is still in the planning stages, so we'd like your feedback on the particular issues of interest that you

all might have here.

The first issue is about how people become dually eligible beneficiaries. In the joint data book that we published with MedPAC back in January, there's some information there showing that close to 40 percent of people who have become dually eligible in a given year, so we looked back two years, they were new to dual eligible status.

About 40 percent of those people were Medicaid beneficiaries who gained Medicare coverage, so those are people who had either aged onto the Medicare program. They were Medicaid enrollees, low-income people who then turned 65 and gained Medicare coverage. There could also be some people in there who were receiving Social Security Disability Insurance and were in their two-year waiting period for Medicare coverage, who had Medicaid in the interim. So we could look a little bit more closely at those people.

I think one of the issues is, with this population, some of them are very long-term Medicaid enrollees, and what we found in the analysis with MedPAC is that many of them, their receipt of Medicare benefits is

actually based on them being the dependent of someone who receives Medicare benefits. So many of them have been disabled since childhood or they're spouses who became disabled at some point, so there's sort of a long-term need for care in this population.

The other portion of folks are those who were Medicare beneficiaries who gained Medicaid eligibility, and this is where we think of the people who are spending down, people who require nursing home or extensive home and community-based services. So those are two very different groups of people that you might want to consider differently, and that's why we're going to look a little bit more closely at their characteristics.

I will mention that Hilltop at the University of Maryland does a lot of work for Maryland Medicaid, has published a lot on this, and we've looked at that work to sort of see where we might go with ours.

We're also -- for the overall Medicaid population and for subgroups, so this is moving on from the dually eligible work -- going to be looking at fee-for-service and managed care spells to inform our encounter data work. The issue here is that for people in managed care, even where

we have good encounter data, it may not reflect the entirety of their service use for a couple of reasons.

One is that if you need long-term services and supports, for example, you may be getting your acute care through managed care, but fee-for-service is handling the additional long-term care benefits you receive.

The other issue is that there may be people who enroll in Medicaid because they went to a hospital, so they have a very intense period of fee-for-service use before they get into a managed care program, and then maybe there's almost nothing happening in managed care, so that's something we want to be aware of when we're trying to characterize the managed care encounter data.

And then the opposite can be true. You could have someone who enrolls in Medicaid and sits in fee-for-service for a few months until they get enrolled in a managed care plan, so they don't have any fee-for-service use, but then once they get into their managed care plan, they have this intense period. So there's sort of countervailing things here that we want to be aware of when we're doing our encounter data analyses.

Then finally, here the idea is to look at the

person-level Medicaid Statistical Information System data where we can to look at transitions between Medicaid programs and separate CHIP. Separate CHIP data has been optionally reported by states in MSIS for many years. More of them are now reporting it -- and so we want to sort of assess where they're at on that front -- and also see where Mathematica and other people have done some work here to look at gaps in coverage when children transition between Medicaid and separate CHIP programs within the same state. And knowing that, one of the things we'd like to look at is the service use that was happening under Medicaid and what happens when they eventually end up in the separate CHIP programs.

The good thing is we do have longitudinal data here, so we can look across a period of months or years to get an idea of what's happening.

So I will end there and take any questions you might have.

CHAIR ROWLAND: You have the first comment.

EXECUTIVE DIRECTOR SCHWARTZ: Yes, which is I want to let Commissioners know that there will be a test on this material.

[Laughter.]

EXECUTIVE DIRECTOR SCHWARTZ: It will be either multiple choice or fill in the blank. And for those of you who are visual learners, we will accept a diagram of these pathways.

COMMISSIONER CRUZ: I was wondering if any of this data -- and I was thinking that on the previous presentation -- can be broken down by race and ethnicity. We have these tremendous disparities and inequities in health, and we know a lot about the epidemiology of it, but not really sort of the health services research aspect of it. I mean, who's eligible? Who enrolls? Who utilizes the care? What sites of care do they utilize? And eventually what are the outcomes? I think that would be really very interesting and will fill a gap in research.

MS. GRADY: That's a very timely question because we are going to be coming to you in the near future on that issue. But in the data we have in particular, we are able to identify race and ethnicity to the extent that states report it. So we do have a lot of missing information in their eligibility records.

The other thing is it's not always clear how that

information is getting from the beneficiary to the record, whether it's self-reporting or whether a caseworker is filling something in. But the ACA did have a number of provisions that were intended to standardize the collection of race and ethnicity data in Medicaid, CHIP, and other programs, and I believe they just issued a report on those provisions that we're going to be coming back to you on to talk about.

So the answer is yes, but I think we sort of view the data with a cautious eye at this point in time.

COMMISSIONER CRUZ: I do remember the ACA did, you know, try to standardize all of the data collection, but I haven't seen anything since then.

VICE CHAIR GOLD: I assume you know the people who have used that data with CAHPS, like Alan up at Harvard. And I would check with them on any tricks they've developed to deal with that messiness, because they've been dealing with it for a while, and I know there's some surname stuff -- well, I guess you can't use that, but there's zip code stuff. There may be some other things that they've developed that can help you apply this the right way, because I think the data are getting better.

COMMISSIONER ROSENBAUM: So I always explain to people that I went prematurely gray because 40 years ago this year, basically, I went through my first training as a legal services lawyer, and the first thing we went through was Medicaid eligibility at Vermont Legal Aid, and it was, like, "Oh, my God, I quit." And it was so much easier then. It's really horrendous now. But everything here is for a reason, and that is -- you know, you have to remember that.

A couple of issues, one minor -- not minor, one sort of micro and one is more macro.

So there's an issue buried in people with disabilities policy that we've not really ever looked at, but given our name and given our mandate for children, I think we might want to, and that is -- and it's also an issue for adults, and that is the large number of states -- I think it's still about 15 -- that are classified as 209(b) states, and those states can depart from the definition of disability as it was adopted in 1972. And some of those states actually today I believe still do not recognize children as a group of people with disabilities. And for adults, some of those states may use a disability

test that is even more restrictive than the Social Security Act disability test.

Now, for children, the poverty level expansion mitigated some of the damage, but not completely, because, of course, there are children with disabilities who have incomes well above the 138 percent of poverty test, and if they can't be considered disabled, then they have no attachment potentially to Medicaid.

Those states may have either altered their definition or they may have through home and community-based waiver programs at this point essentially negated the effect of the definition. But it may still be an issue for children and adults on Medicaid, and I think, you know, a really important question for us is how much is poverty a proxy and how much do you really still need a disability definition? Who gets left out when you either have none or have a restrictive -- an even more restrictive test?

Which brings me to the other point that's more macro, and it's an issue that I've raised before at MACPAC. You cut the information in lots of ways that are really important, but I think given what has happened since 2010, we have to do a very clear job explaining to Congress and

other policymakers who the greater than 138 percent of poverty group is, because beginning January 2014, of course, the maintenance of effort provision in Medicaid for adults is presumably gone, although there was never a big flag waving around it. The Justice Department has noted in all of its King briefs that the MOE period is over.

For children, we are closing in on it, and I have been concerned for a long time that we will start to see erosion in this population, and it has, you know, of course, a lot of eligibility implications for the population, but also it has risk implications for the exchanges in states. And it's everybody from women with breast and cervical cancer to people with disabilities and alternative arrangements. I mean, it's everybody in the world who has a special need, as you pointed out. But I think that giving policymakers a clearer picture of who are we talking about here, and that, of course, feeds over to this question we've circled back to any number of times, which is should there be -- I don't want to go down this road again, but I'll flag it. Should there be a formal mechanism that would enable a state to do some supplementation of commercial coverage, or do we really

want to treat these folks as medically frail under a much bigger umbrella and keep them separate? What are some of the options? As opposed to just letting them slowly get sort of thrown off the program because the MOE period is over, and we don't even really know whom we've missed.

People have alluded now a few times to the fact that states have begun to start coming back on their adult coverage, and, you know, it could be that it's just the demo stage, they were covering some people who were low-income adults now eligible for subsidies. But I think we need to watch this carefully.

CHAIR ROWLAND: You know, April, when we next return to look really in-depth at the disability population, the working disabled, who, of course, would fit perfectly into Sara's analysis of who's above 138, and the whole role of the substantial gainful activity test, since most people think the disability test is based on your disability, but it's also based on your inability to earn substantial gainful activity, which we touched on only minorly in the past in our work on disability, but I think it's an increasingly important thing to look at given that everyone assumes that Medicaid is now just going to cover

everyone under 138 percent of poverty.

COMMISSIONER RILEY: I've been thinking in the discussion of CHIP about children with developmental disabilities, and now I think more about it when I look at the long-term care assessment tools. It seems to me that's a population we need to spend more attention on anyway, but it strikes me that -- and it's not an area I know a lot about, but there's a new SIS assessment tool to look at DD eligibility and what kind of services they get, and I wonder if we could add that into our work.

VICE CHAIR GOLD: April, I have two suggestions on the work you have on slide 13 on longitudinal data. One is that it gets -- you know, when you start talking about the duals, they're so complicated and you start talking about this -- and I was intrigued by this, you know, stock and flow, where they come from, what they stay, and it seems to me you might think as you do this about how to visually lay some of these out over time, over like a life cycle of, you know, the ages of people or whatever, so we understand a little bit how people are coming in, and maybe differences across subgroups and similarities in their age or their needs or their service patterns, to help us sort

out who this dual-eligible population is and sort of how they relate to the Medicare and Medicaid programs.

CHAIR ROWLAND: I have a little comment to add to that. We always talk about how Medicaid is taking care of Medicare's population. But there's a little twist in this in that Medicare is now taking care of some of Medicaid's population. And I think that's a very important story.

VICE CHAIR GOLD: And the other question I had, I just wondered how you were dealing with defining managed care in your analysis. Are you looking at just comprehensive managed care? Are you distinguishing the types of managed care? Because, as you know, that gets really messy in understanding who these people are and what the situation is with using fee-for-service and managed care.

MS. GRADY: So the answer is yes, we are looking at the different types of managed care. With regard to the encounter data analysis we've done thus far, it has just been focused on comprehensive managed care.

VICE CHAIR GOLD: Then at least you know what you're talking about there. Sort of.

MS. GRADY: Right. It seems that from work your

former colleagues have done, the other limited-benefit plans, for example, behavioral health plans, don't have a lot of information that's being submitted right now. We have anecdotal reason to believe that the stand-alone dental plans also probably are not providing good information or we're not getting good information on those.

The other major type of limited-benefit plan is transportation, and that's one where it's highly variable in terms of the contracting arrangements that states are using and what we would even expect to see if we had data. But we do have a contract that I didn't mention on that right now, on non-emergency medical transportation, so hopefully we can get at some of those issues and understand what we can know from the data. But to date, the analysis has focused mostly on comprehensive managed care.

VICE CHAIR GOLD: That's fine. You have to focus somewhere --

CHAIR ROWLAND: Non-emergency transportation is very important because that's one of the main things they're trying to waive in most of the waivers, so that would be useful to have.

VICE CHAIR GOLD: But one other comment. When

you're doing this, it's not just this presentation and others. It seems that the staff are learning stuff about the completeness of the encounter data, which states are more complete, which programs are more complete. It would be nice to track that across your different results and actually, you know, produce a brief or something on it, because everyone is very interested.

For example, those states you left out, it wasn't clear which ones or what you knew, and I know that gets a little sensitive, probably, because no state wants to be viewed as having provided poor data. But as users of data, it's really good to know.

And the only other -- Alan Zaslavsky is who I meant from Harvard. He's a guru on this stuff.

CHAIR ROWLAND: Well, on the data, one of our charges from the statute is to report on what data we need and what data others need to actually manage and evaluate the program, so that's a good point.

COMMISSIONER SZILAGYI: Just a simple point. By the way, I will flunk your test, Anne.

[Laughter.]

EXECUTIVE DIRECTOR SCHWARTZ: I don't think I

would get a passing grade either.

COMMISSIONER SZILAGYI: So as I -- I'm learning about all these adult populations, and as I try to understand the forest, one of the things that would be helpful, at least for me, with all of these different populations, is if kind of consistently we could talk -- you know, if you could present information about how many people are in this group and what is the total cost and what percentage of all Medicaid does this cover. Because where the access and cost -- you know, we're trying to figure out how best to optimize access and reduce costs, if possible. So, you know, it would help me in terms of where to prioritize and what to focus on. You know, if something is a relatively small population but an enormous part of the cost, that would be certainly worth focusing on.

CHAIR ROWLAND: One of the things you'll find out is that that also varies tremendously by state.

COMMISSIONER SZILAGYI: I meant more at the national level.

CHAIR ROWLAND: What else is new about our Medicaid work?

COMMISSIONER MILLIGAN: I'm sort of late to the

party. So I need to ramble for a second. Working in Maryland through a lot of the ACA launch and a lot of ELE, express lane eligibility, and some of the CHIPRA bonus and all of those pieces, there was a lot of discussion about other programs, TANF and SNAP, and how to align the eligibility pathways and what it meant for systems, what it means for caseworkers, what it meant for data transfer, because Medicaid at a state administrative level isn't -- the eligibility pathway isn't isolated from those other means-tested programs.

And so just in the context of how we think about this in terms of simplification, in terms of retaining people from churn, I think we also have to be mindful of the context in which -- a couple things. One is express lane eligibility doesn't work in both directions. Somebody still has to come back in if they want their TANF cash assistance; they have to come back in if they want their SNAP food assistance. And some of the asset and income tests vary a little between programs. And so I think that we're going to need to contextualize some of this work around -- from a family's perspective dealing with food security, dealing with cash, is part of what they might be

pursuing.

And so I just want to make sure that we don't lose sight of the entry points and what drives entry in those other senses as well.

MS. GRADY: One thing I would point out on that issue is that one of the things that was in the President's budget was an indication that the 90 percent match for eligibility systems is going to be extended, and in particular, integrated eligibility systems where Medicaid, TANF, SNAP, other programs are being determined at the same time. There's been a waiver in place actually that's allowing the 90 percent match to be used for those integrated eligibility systems. Whereas the other programs would normally have to pay, they don't currently, so there is funding available -- if not to align the actual eligibility standards and processes, to at least have a system that works well with Medicaid.

COMMISSIONER MILLIGAN: Waiver of OMB Circular A-87. Sorry.

But one of the points I would want to make about that is if you look at SNAP, which I think it's 135 percent of poverty, it aligns pretty closely, like within margin of

error, of 138 percent MAGI. But food nutrition services at USDA, you know -- so the ELE pieces don't work both directions.

CHAIR ROWLAND: Okay. Well, I think that we've managed to all flunk Anne's quiz, but not because April didn't do a great job of walking us through a program that has been built one layer on another layer on another layer over the last 50 years that ends up to be as complex as it is today. And we will work as a Commission toward how we can try over time to simplify and to integrate the coverage in a better manner.

But April has given us a good start, and now we're going to turn to Katie to give us a little bit of an update on the Medicare savings programs that April has just alluded to. And what we want to do here is to understand a little more about how they work, about some of the gaps in them, and about kind of the broader world in which we may be seeing and hopefully implementing at some point in the future reforms that help to smooth out the way in which these programs work with Medicare and Medicaid.

Session 6: IMPROVING ELIGIBILITY AND ENROLLMENT FOR THE MEDICARE SAVINGS PROGRAMS

* MS. WEIDER: Okay, great. Thank you. So, the purpose of my presentation today is to revisit the Medicare Savings Program (MSP) eligibility and enrollment issues.

At our October and December meeting, we discussed barriers to MSP enrollment and opportunities to improve the MSPs. However, during these previous conversations, the real focus was on Medicaid payment of Medicare cost sharing. And, as a result, we didn't include MSP enrollment issues in our March report. However, now that we've addressed cost sharing, we can turn our full attention to MSP eligibility and enrollment.

Today, I'll briefly highlight barriers surrounding MSP enrollment. And you'll notice in the background paper provided, in Tab 7, we provide examples to improve the MSPs. But, in today's presentation, I'll discuss their benefits and challenges at a higher level. Today, we're seeking your feedback on the presentation and identifying if you need additional evidence to move forward.

So, now to focus on the issue. Enrollment in the MSPs has been historically low. In 2004, the Congressional Budget Office estimated that only 33 percent of individuals

who were eligible to enroll in the Qualified Medicare Beneficiary program, that is the QMB Program, were actually enrolled in the program. As a reminder, the QMB program covers Medicare Part B premiums and cost sharing to individuals with incomes between -- or, excuse me, up to 100 percent of the federal poverty line. And, in 2004, CBO also estimated that only 13 percent of eligible beneficiaries were enrolled in the SLMB program. And, as a reminder, the SLMB program covers Medicare Part B premiums for individuals with incomes between 101 and 120 percent of the federal poverty line.

Now, there are a number of reasons why people don't enroll into the MSPs, and here, we highlight four major barriers, and the first is lack of program awareness. Research suggests that people don't know about the program and, as a result, don't apply or enroll into the program.

Second, there's also a complicated application process which can be too long, too difficult to understand, or require extensive documentation. Additionally, some states do not make MSP applications readily available to applicants. For example, some states do not allow applicants to submit an application electronically, while

other states require authorized representatives to be physically present with the applicant in order to submit an application.

And, third, we have financial eligibility. Not only do states have varying income and asset standards for the MSPs, they also have varying methods in how they count assets. Additionally, there is also a misalignment between the MSPs and the Part D Low-Income Subsidy Program. These factors create confusion regarding the programs and differences in eligibility levels.

And, finally, we have the expiration of the Qualifying Individual program, the QI program. The QI program is currently only funded through short-term Congressional authorizations and periodic reauthorizations. It is set to expire on March 31, 2015, and I'll discuss this issue in greater detail in an upcoming slide.

So, what's the rationale for fixing these barriers? Here, we have three major reasons. One, the MSPs can improve access to care. Two, MSPs can reduce out-of-pocket costs for low-income beneficiaries. And, three, simplifying the MSP application could reduce administrative burden to states and also beneficiaries.

So, with that being said, there have been methods to improve MSPs for potential enrollees. Some of these methods have been used in past efforts to increase MSP enrollment.

One such effort is support of MSP education and outreach. As previously noted, one of the major reasons people don't enroll in the program is due to a lack of knowledge regarding the program. So, in 2006, the State Health Assurance Assistance Programs received about $30 million from CMS to support MSP and Part D LIS education and outreach. And, in 2008, MIPPA provided approximately $18 million to the SHIPs, Area Agencies on Aging, and Aging and Disability Resource Centers towards MSP education and outreach. Since 2009, SHIPs and these other agencies submitted nearly 900,000 applications to the Part D LIS program and the MSP programs, which equaled approximately $2.3 billion in benefits.

There have been recommendations and efforts to continue the support. In 2008, MedPAC recommended increasing funding to the CHIP -- to the SHIPs, excuse me -- to support outreach to low-income Medicare beneficiaries for MSP and Part D LIS enrollment. And, recently, the

Protecting Access to Medicare Act of 2014 provided additional funding to support the SHIPs and these other agencies on MSP education and outreach for fiscal year 2014 and 2015. For 2015 -- for FY 2015, excuse me -- this funding totaled approximately $13 million, but at this time, there is no other appropriations to continue this funding.

Another effort to improve MSP enrollment is examining the QI program funding. The QI program provides Medicaid coverage of Medicare Part B premiums to Medicare beneficiaries with incomes between 121 and 135 percent of the federal poverty line. Unlike the other three MSPs, the QI program is entirely federally funded. However, this program is only funded through short-term Congressional appropriations and periodic reauthorizations.

Most recently, the Protecting Access to Medicare Act of 2014 extended the program to March 31, 2015. If the program is not continued, almost 600,000 QI beneficiaries could lose coverage of their Part B premiums. The FY 2016 President's budget proposes to extend the expiration date of the QI program to December 31, 2016. And OMB estimates that this extension would cost the federal government

approximately $975 million.

Additionally, states have made individual efforts to improve the MSP application availability. However, not all of these efforts have trickled down to all the states. As I previously noted, not all states allow applicants to submit an application electronically and there are also barriers for some authorized representatives to submit applications on behalf of potential MSP enrollees.

Now, attention has been paid toward aligning the MSP eligibility with Medicare policy, specifically, the Part D LIS program. Aligning these programs could potentially: one, increase enrollment to the MSPs and the Part D LIS program; two, simplify the application process for MSP-only beneficiaries; and three, could shift responsibilities for MSP administration from the states to the federal government.

Now, I'm raising this issue because the Commission has been continually interested in simplifying the Medicaid program, but I want to highlight that MIPPA did make efforts to align these programs in the past, but it did not completely align the programs as income and asset counting methodologies are different between the

programs. And, some of the reasons why MIPPA didn't completely align these programs is because they have ripple effects outside of the MSPs that can harm beneficiaries and also increase costs to the states and federal government.

And, April alluded to some of these, so I'll go through them right now, and the first one is the loss of medically needy Medicaid eligibility. As a result of gaining MSP eligibility, beneficiaries will have their Medicare Part B premiums paid for. And because their Part B premiums are now covered through an MSP, they may no longer have enough medical expenses to qualify for Medicaid under the medically needed Medicaid eligibility pathway.

Two, the program does not -- aligning the programs do not change full benefit Medicaid eligibility determination processes or its eligibility standards. For individuals who want to qualify for full-benefit Medicaid, aligning the MSPs with the Part D LIS program would also require these applicants to submit two separate applications, one for the MSPs and another for Medicaid. This could also result in states conducting two methods of counting income and asset testing, which could increase their administrative burden.

And, three, some states have expanded their MSP income and asset levels beyond the Part D LIS thresholds. And if states adopted the Part D LIS income and asset levels and they were not able to keep the expanded thresholds beyond the Part D LIS program, then aligning the MSPs and the Part D LIS Program could actually decrease MSP eligibility for individuals in those states.

And, finally, aligning the programs would increase the number of people enrolled in both the MSPs and the Part D LIS program, which would lead to increased costs to the states and federal government.

So, now, we're seeking your feedback on this information, and we can provide additional evidence, as needed, in the upcoming meeting. And, at this point, I can answer any questions.

CHAIR ROWLAND: Thank you. Patty, and then Chuck.

COMMISSIONER GABOW: If this doesn't convince us that we need to simplify the whole program, then there is absolutely nothing in the world that will convince us that we need to simplify it.

CHAIR ROWLAND: Chuck.

COMMISSIONER MILLIGAN: Patty, what are you trying to say?

[Laughter.]

COMMISSIONER MILLIGAN: So, I want to go up to the, like, a problem statement level, and I think a problem statement is there is an affordability issue regarding Part B premiums and that sort of thing. From that problem statement to the remedy, there's a couple of options that I want to just ask maybe a question or two.

For a lot of the individuals who we're talking about, they increasingly have access to and are taking up Medicare Advantage, where there might be a zero premium and there might be very low copayments for physician visits and pharmacy and so on. Do we have any data on take-up of SNPs or just traditional Medicare Advantage plans for the cohort of individuals who would be eligible for MSP to find out if, in some way -- or the markets nationally who are served by zero premium Medicare Advantage plans, because I'm trying to figure out if, in some ways, the problem is getting solved because people are choosing to join MA plans where there is a zero premium and relatively low copayments for physician visits and so on, separate from a kind of a

Medicare fee-for-service model that MSP is really built around.

MS. WEIDER: Dual enrollment in a Medicare Advantage plan is about 20 percent. The specific breakdowns on the no premiums, I can -- we can look into that. I don't have that off the top of my head.

COMMISSIONER GOLD: But, even a no premium plan -- few of them subsidize part of the Part B premium. So, even if someone is in an MA, the regular Medicare Part B premium still applies, so that issue would still remain regardless of that. And, I'm not sure how they counted. The data in this area is pretty crummy. But, if they are partial duals and not full duals, then they don't get the extra benefit -- they only get what the Medicare Advantage plan pays. They don't get Medicaid benefits. So, it's a little bit complicated.

CHAIR ROWLAND: Obviously, it's a complicated population as well as a complicated issue, and it could get more complicated as some of the discussions that are now underway about restructuring the Medicare coverage and looking at alternative ways of combining Parts A and B and introducing new low-income subsidies. So, I think what,

really, we need to tease out of this is what are the lessons for who this population is? What are the differences between those who are getting full benefits and those who are just getting the premiums and the cost sharing, which is where Patty started it, saying why are they in Medicaid in the first place. But, I think it's important to recognize that some of the full benefit beneficiaries also get the premiums and the cost sharing and you wouldn't want to have them lose that if you sent the partials back to Medicare.

But, I think, really understanding more about who the population is, how much they are using -- and, I'm struck by the fact that we really don't know -- 2004 was a long time ago. It was before the implementation of the Medicare drug benefit. So, do we have any sense of how many people are actually benefitting from these programs now, what the real counts are? And, I would think that CMS ought to know that, because aren't they collecting those premiums? So, at least they should know how many people from each state have states paying premiums for them.

MS. WEIDER: Yeah. I haven't seen too much data out there regarding this. Most recently, GAO did a report

on examining what MIPPA did to increase MSP enrollment and they saw that the overall program expanded about five percent in the first three years of MIPPA, but, also, those first three years were also during the recession, so that's also something to keep in mind, just what was going on in the economy. But, overall, I haven't seen any new data on potential enrollees who aren't enrolled, or what that number looks like.

CHAIR ROWLAND: Well, I would suggest that the Commission ask the Department to provide us with some of that information, that we do have the right to request information to inform our deliberations, and certainly putting together a data request to HHS, especially since they're engaged, as well, in the dual demonstrations and there is an Office of Duals, perhaps that office could respond, because I do think that we need more information about how many people are benefitting, about what some of the lessons are, are there states where this is more of a problem and states where there is less of a problem, and how to proceed.

Sara.

COMMISSIONER ROSENBAUM: I'm curious. I mean,

usually, things don't happen for completely irrational reasons. So, why -- why is the application process burdensome in a number of states? What's the logic behind not -- no, I mean, I'm asking the question. I'm trying to ask the question, you know, in a serious way. I mean, I realize it's a cost. That, I realize. There are a lot of things in Medicaid that are a cost. So, is it a more -- is there something about this part of the program that is more cumbersome? This is not having to supplement on all the benefit front. This is just the premium and the cost sharing. And, I --

CHAIR ROWLAND: Don't you have to apply for the whole elderly and disability eligibility under the state? There's no federal streamlined form for just the MSP, is there?

COMMISSIONER ROSENBAUM: Well, I'm sort of trying to get to the bottom of why hasn't the process of entering gotten further along. The way we've thought about all these issues in the case of families with children, no wrong door and this and that, and yet we sort of -- we seem to be in the stone age when it comes to the group, and I'm wondering if you could talk a little bit about what we

know.

MS. WEIDER: Yeah. So, I don't know exactly why states have more burdensome process than others, but I know of at least one state that does not have the MSP application on their website. You have to call or go to a local Medicaid office to get the actual application.

Other issues about electronically submitting the form. What I mean by that is an applicant cannot fax in a form or e-mail a form in. And, what I think there is -- it's two separate reasons why they don't allow that. One, it's just technology. They don't have the technology. And two is on the physical signature, so -- I just did my taxes, so when I did my taxes on TurboTax, I typed in my name and that was my signature, whereas they need the actual physical signature. I don't know why.

And, on the authorized representatives, I do not know why that some of that --

COMMISSIONER ROSENBAUM: And, does CMS not -- I mean, CMS has done so much work around simplifying enrollment, and I realize the ACA pushes in that direction from a broad policy point of view, but does CMS have sort of a counterpart thinking machine that has sort of tried to

come up with best practices and models and working groups and everybody around simplification? I know about the SHIPs, of course, but other than sort of -- we have one at the law school, and other than empowering lawyers and law students to sort of try and overcome all this for people, it doesn't sound like there's a lot of enrollment streamlining going on.

CHAIR ROWLAND: Well, part of that, I think, is that this is the same form being used if you need home and community-based services and if you need long-term care, and it also retains an asset test which is not there in the children and families. And, so, the asset test requires yet another level of documentation. Even the Medicare Low-Income Subsidy program still retains an asset test, which, you know, we've eliminated for families in most states.

Okay. Well, thank you, Katie.

Now, we'll take a ten-minute break and then return, since I think after going through Medicaid eligibility, everyone needs a break.

[Laughter.]

[Recess.]

CHAIR ROWLAND: If we could please reconvene. We

are going to reconvene to take back up our discussion of Medicaid behavioral health services, and Amy is going to report to us on some of the analysis we requested that she has now completed, and I think this is really going to speak to the many issues that we raised and wanted to know more about in terms of the Medicaid eligibility system.

So, Amy, kick it off.

Session 7: USE OF BEHAVIORAL HEALTH SERVICES BY MEDICAID BENEFICIARIES

* MS. BERNSTEIN: Thank you very much. Good afternoon. Welcome back.

So at our last meeting, as Diane said, you requested more analysis of utilization expenditures, diagnoses, and issues by population group, including age group and basis of eligibility, so we have very busily tried to do that for you in the interim.

What I'm going to present to you today is a very high-level overview to inform your discussion of where we might go in this area, and I will give you some overall information on use expenditures, diagnoses, and sort of issues or targeted concerns for different age and basis of eligibility groups.

We used 2011 Medical Statistical Information System expenditure and claims data and encounter data. We looked at all services, including behavioral health and medical and long-term care services. So when you see estimates of expenditures, they are total expenditures. They are not expenditures for behavioral health conditions, which is a more complex analysis, but we could do that in the future if you're interested.

Again, we used both encounter and fee-for-service data, and just a few caveats, we did include all states, even the ones that had issues with their encounter data, because the purpose of this was to give you sort of a broad-level overview. So the numbers, we're not making them public yet, and they may underestimate or even in some cases overestimate the true number of enrollees with service use for a couple reasons. One is, again, some of the encounter data are questionable. Two, again, we don't have utilization for services that were not provided by the Medicaid system, and three, Medicaid or any sort of behavioral health diagnoses may be subject to underreporting due to stigma and other underreporting issues. So there are some services for which a diagnosis

that was considered a behavioral health diagnosis was not reported, or there were many diagnoses, and there was not sufficient space to record that diagnosis.

The way we defined a person with treatment for a behavioral health condition was we looked at all of their service use, using claims and encounter data, except for behavioral health drug data. We did not include the drug data, and I'll talk about that in a minute, and Chris Park will talk about that in his presentation on behavioral health drug estimates.

We looked at all of the diagnoses that were associated with that claim, and if any of the diagnoses were considered to be behavioral health diagnoses based on the chronic illness and disability payment system classification, then we considered that a person with a behavioral health diagnosis. So if that is not clear, I can try to clarify that further at some point.

The tables are at Tab 8 in your binder. There is no paper associated with it, just the tables.

The first table gives you sort of a broad overview of who these different classes of enrollees are. Looking at all of the Medicaid enrollees that we could

identify that had a behavioral health diagnosis based on what I just described, there were about 13 million enrollees, which is about 18 percent of all Medicaid enrollees had some behavioral health diagnosis. That constituted about $170 billion, and again, this is total expenditures, not just expenditures on behavioral health conditions or behavioral health treatment. This accounted for almost half of total Medicaid expenditures, so people with one of these diagnoses accounted for almost half of total Medicaid expenditures, and total spending for enrollees with a behavioral health diagnosis was about four times as high as for those with people without behavioral health diagnosis.

Again, you asked for everything to be broken down by age group and basis of eligibility, so I am just going to go through each of them sort of one slide for each and give a high-level summary.

Starting with children, we divided children into foster children, children who qualified on the basis of a disability, and children who did not qualify either on the basis of being a foster child or having a disability, so three different groups.

The first group that I will talk about is the nondisabled non-foster children. This is most of the children with a behavioral health diagnosis, which is 3.9 out of a total of 5.2 million children. There are a total of 5.2 million children we identified as having a behavioral health diagnosis. Three quarters of them did not qualify on the basis of being a foster child or on the basis of a disability.

The most common behavioral health diagnoses were hyperkinetic syndrome of childhood, which includes the ADD, attention deficit disorder and attention deficit hyperactivity disorder, and learning disorders, but it's important to note that although this was not a large percentage of children who had a behavioral health diagnosis, there were an additional 500,000 nondisabled children who had episodic mood disorders, which includes bipolar disorder, and another 500,000 with anxiety dissociative or somatoform disorders, which is basically anxiety disorder. This is the largest group of children with a behavioral health diagnosis.

Concerns that have been raised for this group related to behavioral health treatment includes appropriate

prescribing of psychotropic drugs, particularly ADHD and antipsychotic drugs or atypical antipsychotic drugs, and also appropriate and timely screening for behavioral health problems under EPSDT and in general and providing appropriate referrals and treatment, which is sort of related to the whole issue of integrating behavioral health into primary care. You want to try to catch conditions early through screening, so those are again very, very summary level.

So children eligible on the basis of a disability, we identified about 900,000 of these children who had a behavioral health diagnosis, which is almost half of children who qualified on the basis of a disability. They had the highest total Medicaid expenditures of all of the child eligibility groups, and the most common diagnoses were, again, the hyperkinetic syndrome of children, but also specific developmental delays and pervasive developmental disorders, including autism spectrum disorders. So these are very functionally or otherwise limited children, which is why they qualified on the basis of a disability. I should also note that about 5 percent of them, although many of them had autism spectrum

disorders and other developmental -- also had or had instead of episodic mood disorders, including bipolar disorder or anxiety and other dissociative disorders.

I should also note -- and I forgot to say this -- that disorders are not mutually exclusive, so you could have more than one. Many of these children had more than one disorder.

As far as behavioral health-targeting programs for these children, many of them are under waiver specifically for their behavioral health disability. There are many states that have waivers for children with autism spectrum disorder to serious emotional distress, and many of these waivers and other special programs concentrate on integrating medical and behavioral health in order to provide services more effectively and to have better outcomes for this sort of functionally and high-cost, high-need population.

Foster children is the smallest group of children that we identified with behavioral health disorders. It's about 42 percent of them have a behavioral health disorder out of all foster children, which is about 400,000 children, and the children with behavioral health disorders

account for about three-quarters of total spending for foster children.

They have, as you discussed at the last meeting, a high percentage of traumatic and emotional disorders, and the most common diagnoses were again the ADHD syndromes and adjustment reactions, but many of them also had conduct disorders, episodic mood disorders, and other behavioral health diagnoses.

You spoke a lot this morning about various issues related to foster children, and behavioral health drug prescribing has been raised, and Chris Park, again, is going to be talking more about that in the next session.

So moving on to adults, non-elderly adults -- and let me just highlight this is the group to which the Institutions for Mental Disease Exclusion does apply. Just keep that in the back of your mind, but I will not mention it again. About two-fifths of this group had a behavioral health diagnosis, which is about 3.5 million people, and that accounted for about 58 percent, more than half of total expenditures for this group.

This is a large portion of the SSI population. I believe about, according to my notes because I haven't kept

up with myself, about one-third of SSI recipients qualify on the basis of a mental health condition, which includes depressive disorders, but also adults with autism spectrum disorder and intellectual and developmental disabilities. This is where a lot of the SSI population is. The most common diagnoses were depression, anxiety, and again, episodic mood disorders.

This group has the highest prevalence of diagnosis of psychotic and personality disorders. It is only about 8 percent of the group, but it's higher than in other groups because, in general, those conditions are relatively rare but also very expensive.

Concerns have been raised here, and you raised them at the last meeting as well, about the lack of coordination between behavioral health and medical care resulting in possible inefficient use and suboptimal treatment and outcomes.

You look like you want to say something.

Again, this is very high level, so there are many other activities targeted to all of these groups, but just to sort of show the difference.

Nondisabled adults age 21 to 64 are a

heterogeneous group. There are about 2.9 million of them that we identified as having a behavioral health disorder, which is about 16 percent of them, but this includes pregnant women, parents with very low income, and people who are basically eligible on the basis of something that is not a disability-related pathway.

The most common diagnoses were anxiety, dissociative and somatoform disorders, and depressive disorders, which are very common in the population at large, and also nondependent abusive drugs.

One other thing that I again probably should mention is this doesn't get at the severity of any of these conditions. So this is anyone with a behavioral health diagnosis, regardless of sort of how severe it is.

Here again, the concerns have been raised about inadequate screening and referrals for primary health conditions and as diagnosed through primary care providers, and other initiatives have been to identify and treat behavioral health conditions in pregnant women in particular to help improve perinatal outcomes. Many of the pregnancy special programs have been targeted to women with behavioral health, both substance use disorder and

behavioral health and mental health conditions.

COMMISSIONER MILLIGAN: Amy, I'm sorry. Can I just stop you there for a second? This is 2011 data?

MS. BERNSTEIN: 2011, yes.

COMMISSIONER MILLIGAN: So I think with the expansion population, this information would change quite a bit.

MS. BERNSTEIN: Yes. And I should mention that this is the group, as with the new expansion, you will have more adults who have interactions with the criminal justice system, for example, that we talked about last time as well, and possibly adults or homeless adults that hadn't been in before, and yes, substance abusers who are not otherwise qualified but who can come in through the expansions, so yes. Thank you. I had it written down.

CHAIR ROWLAND: It's good to not say everything, so we have something to say.

[Laughter.]

MS. BERNSTEIN: Adults aged 65 and older, it was harder to get information on use for them because, again, a lot of their care is Medicare care. Since we identified them based on their use and the conditions that were

associated with their use, I actually took these numbers from the dually eligible Medicare and Medicaid data book. Based on that, if you look just at the dual eligibles, 20 percent of dually eligible Medicare and Medicaid enrollees 65 and over -- and they used 2010 data -- had a diagnosis of depression. Eleven percent had an anxiety disorder, so there is a high prevalence of behavioral health conditions in this population as well.

Several of the financial alignment demonstrations have attempted to integrate behavioral health care with medical care, and concerns have also been raised in this group in particular, and there have been national CMS and SAMHSA and other initiatives to try to address issues of inappropriate psychotropic drug use with elderly people with dementia in particular where these drugs have been shown to be harmful, and also with the need to screen older people for depression and other behavioral health conditions in primary care settings to improve overall health care outcomes.

So, in summary, the groups are different. All age and eligibility groups include a substantial number and/or percentage of enrollees with behavioral health

diagnoses, and for every age and eligibility group, which the audience doesn't have, but which you have in your tables, enrollees with a behavioral health diagnosis have higher total expenditures per person than those with no behavioral health diagnosis. In some groups, that is four times or five times as many, and in some, it's about half as much, again.

These differ in terms of their diagnoses of the services provided, of expenditures, treatment concerns, and programs targeted to each group, and as we begin our investigations into behavioral health, we would welcome your direction as to which of these groups, which of these interventions, what you are most interested in pursuing, as you discussed at the last meeting.

So I welcome your discussion.

CHAIR ROWLAND: Okay. Thank you.

Marsha.

VICE CHAIR GOLD: I wasn't here at the last meeting, although I read your paper, and I enjoyed it.

I really liked the tables you had, especially the first two tables. I think the way you have laid this out here really helps to sort of bring to life some of the

behavioral health issues and who these people are, and I think that's important in its own right because unless something is described, it's invisible, and so I think that's great.

I had two areas where I think I might suggest you go a little further. One is that your tables look at means, and it would be very useful to understand the shape of the distribution of people and expenditures, so that the big issue is there a chronically ill population among these cohorts or these subgroups that is different from a sort of not-that-sick population, because they get cared for in different systems. So I don't want to complicate your charts, but I think to the extent you can look at some medians and look at some quartiles and things and just come to a conclusion as to whether maybe some of the diagnoses you have in the subgroups are associated with the big fat part of the distributions, and others are the tail that counts for a lot of expenses -- or anything you could do to just see if there's a chronically ill and others within these subgroups would be useful.

The other is more a caveat. I was surprised when I looked at the dually eligible that they had almost as

much spending as the non-dually eligible. I think that's probably for the under-65, and I was surprised because, obviously, Medicare spending isn't in your numbers.

I think your numbers are probably right. I mean, you know how to do numbers, but I think there's probably a case mix issue, and maybe you have even said that somewhere that there's different people who are dually eligible for non-dually eligible adults. And you just may want to look at it, so you can flag it, because it was only about $1,000 less, I think, that they used.

The other thing, I was sort of thinking about where you go with this. To my mind -- and I don't know what's feasible and what makes sense with what the work flow of the Commission staff is, but I think that the first part, especially the first two tables and the description of the population with a little bit of work could be ready to get out, either in the June report or as a stand-alone brief.

But I think I am not sure that from the policy perspective -- and I think that's important in itself. From the policy perspective, I am still not quite sure that one understands enough about where the Commission's

interests are best applied, so that I don't know -- and I would think it's where are the federal issues here because that's what we focus on and where are the people issues or something like that, but that can be done later. It seems to take a little more work, because I'm not sure we've gotten in the sort of how does care work for each of these subgroups, now that you've defined them, and what are the major barriers or facilitators at the federal level that we need to be aware of and where might we productively focus, but others may have some other comments on that.

CHAIR ROWLAND: Donna.

COMMISSIONER CHECKETT: Amy, thanks. I really enjoyed the analysis, and your pithy synopsis was just helpful. So I step back -- this is an area of great interest I think to all of us who are in a role of providing and managing care for highly complex beneficiaries. So I asked myself looking at this, because I think you said, well, where would you like to take this?

So I think one of the big issues for states and for people running these programs is for people who have serious mental illness and in designing programs that are going to help manage costs and get these people as healthy

as they can be, understanding that may be very different than what we might hope it to be.

I hear quoted a lot people who have dual diagnoses are going to live 25 years -- they have 25 years less in their life span than, quote, the rest of us. And you hear things tossed around that they're 50 percent more expensive. And I know we've looked at those numbers or variations of that in the past.

But what would really be helpful for me, to get to my point, I guess, is if we're going to pick a population or sort one out, that would be the one I would really like to go to, because, in fact, they are very, very expensive, they are very, very ill, and I think states have a lot of questions about do we do carve out, do we do special -- like Arizona just did a special integrated program just for SMIs. But what is really the best way to manage these folks? Should they never be in managed care because they're so sick that you could never possibly get managed care to take care of them well?

These are the policy questions that I see states struggling with, and I think to really understand, you know -- so if the behavioral health diagnosis is the driving

diagnosis, what are the physical health care costs that need to be addressed and how can we best address those?

I guess I'm at this point rambling, but picking out all these areas, I just think that's the one that probably is the greatest need.

My thoughts. Thank you.

COMMISSIONER RILEY: I would wholeheartedly endorse Donna's sense here, and the bigger question is: Access to what? You know, as much as we struggle with what are the quality metrics and what are the metrics of performance and outcome on the pure health side, it's a much more complicated arena with less data. So what kind of services? Where are we seeing successful interventions? What works, what doesn't with these populations? And it seems to me we have a natural sort of data set here that's going to be quite useful. I would love to be able to track the expansion group. There's so much discussion in the states, particularly those states that haven't expanded, and the discussion we had about what is the future of Medicaid.

You know, the discussion is these adults are able-bodied and ought to be in an employer system and ought

not to be on Medicaid. I would love to be able to look and drill down on the expansion group in the new coverage populations and see their behavioral health diagnoses, their service use, and get a better handle on who they are and how they compare to a traditional Medicaid population. And I think it could inform a bigger access decision.

DR. BERNSTEIN: Can I just clarify? So not necessarily for the SMI population, just for the new expansion group population.

COMMISSIONER RILEY: The expansion group and how many of them are behavioral --

DR. BERNSTEIN: Okay. But separate from SMI, okay.

COMMISSIONER MILLIGAN: Amy, thanks. I think this is really helpful information. When I think about areas of focus, I do want to reiterate, I think, that the foster care side is really important, and I think one of the complexities in the foster care world is how frequently judges get involved because of the state custody issues, and a lot of times the social supports and housing supports get kind of interwoven with behavioral health supports when it comes to meeting a foster child's needs. So I think

that's an important group.

But I want to focus on the other end of the age spectrum, actually. The life expectancy of people with behavioral health needs is increasing. There are more people with behavioral health needs aging into Medicare, and there's a lot of complexity in terms of the Medicare piece and the Medicaid piece. You know, with the physician side and some of the pharmacy side in Medicare, a lot of the actual specialty behavioral health service is not in Medicare but in Medicaid. A lot of age bias because people perceive that depression is a part of getting older and it's treatable. And so I do think that there's a dual-eligible piece here that is often overlooked in discussions about duals.

COMMISSIONER GABOW: I think that as we look at this and think about the policy issues, understanding the physical health needs that are so tied with behavioral health needs, and it goes both ways. People with serious medical illness have much more behavioral health issues, and people with serious behavioral health issues have more medical needs, and that data is well available.

So the policy issue that has bothered me for a

long time is Medicaid is in general separating the delivery model from the behavioral health and the physical health, which takes -- particularly when you're talking about the seriously mentally ill, asking people who are the most vulnerable to navigate two complex systems that don't talk to each other because of the often HIPAA rules about communicating behavioral health diagnosis.

And so I think thinking about how we can increase the coordination of this group that's expensive, complex, and has big needs in both, so to the extent that we can demonstrate their medical cost as well as their behavioral health cost and make an argument for integrating these delivery models, I think that's a key policy question.

The other comment I would just --

CHAIR ROWLAND: Maybe just looking also at what the co-morbidities are so that you have a better sense of, you know, is it diabetes and mental health, or is it other things.

COMMISSIONER GABOW: Well, in our study, even the simplest thing, which I would say is not a disease, pregnancy, when you have a behavioral health diagnosis and you're pregnant, the cost and the complications go up

amazingly. So as you get more complex chronic disease, you can imagine how it's exaggerated.

I was surprised by the overall number of 18 percent because in our experience, when we looked at our Medicaid managed care population, the percentage of people with behavioral diagnosis was significantly higher than that. So I was wondering how that 18 percent compares overall with the number that you see in the literature, because it seems low to me. And the substance abuse numbers seemed very low to me given -- maybe in Denver everybody is high. I don't know.

[Laughter.]

DR. BERNSTEIN: Again, this doesn't include all care, and this is definitely an underestimate because it doesn't include care that wasn't paid by Medicaid. So you're going to miss a lot, and it's only based on -- and it also doesn't include behavioral health drugs. And the reason that we didn't include behavioral health drugs in the denominator for this particular analysis was that Chris will show that there's actually a fair number of people who are taking behavioral -- what are defined as psychotropic drugs that don't actually have behavioral health diagnoses.

So it gets complicated.

So this is an underestimate. There is no question about that. It is consistent with other studies that have been done. The last one that I'm aware of is the Center for Health Care Strategies, which was, I believe, 2008 data, and they did include drugs, and they were at I think 18 percent or 20 percent instead of 15 percent. So it's in this same ballpark.

COMMISSIONER ROSENBAUM: Just to go back to the earlier discussion, if there's any way to include the population of special needs adoption children, I would, because there's so much interest in special needs adoption children on the Hill, and because I think it would be interesting to contrast that group with children in foster care because they're obviously closely related.

COMMISSIONER SZILAGYI: Yeah, I had a -- this is really well presented and very -- I think a big step forward, so thank you very much.

I did have one question -- a couple points. One was about the co-morbidity, particularly for the adult population, because it's well known that for -- and exactly what you mentioned, Diane, you know, adults with diabetes,

if they have a co-morbidity of depression, have far worse diabetes outcomes, and so that's not just diabetes. That was just the example that I brought up. But that would be maybe worth teasing out.

And that gets to one of my questions. How did you -- this is the MSIS data? This is an analysis of the fee-for-service -- okay.

[Comment off microphone.]

COMMISSIONER SZILAGYI: Okay. How did you -- can you clarify again for me how you counted -- or how you selected for disability? So these were disabilities other than mental health diagnosis?

DR. BERNSTEIN: No, the disability is just whether they qualified on the basis of having a disability so it's--

COMMISSIONER SZILAGYI: Got it. If they qualified based on --

DR. BERNSTEIN: Yeah, it's the eligibility category. It's not --

COMMISSIONER SZILAGYI: Okay. So it's just looking at disability in a different way then.

DR. BERNSTEIN: Yeah, it's totally how they

qualified on the basis of eligibility.

COMMISSIONER SZILAGYI: Got it. But I think just even sometimes some very high level data, like this highlights the importance. I mean, if you look at the percentage of this population that has a mental health, a behavioral health diagnosis, it's enormous for every one of these, you know, 38 percent of dually eligible, 14 percent of children. I mean, it's much higher than the general population, and, you know, it doesn't necessarily point toward a particular policy lever for us, but it really highlights the importance of focusing on behavioral health for this population. You could see the next wave of high-cost, high-disability population as these children grow up.

COMMISSIONER COHEN: Also thank you. I thought this was so interesting, like I've been reading about this now for a little while. I'm not an expert by any stretch, but I've never actually seen sort of percentages of different particular diagnoses in the population, and I thought that was really helpful.

In many ways one might say this is almost a different topic, but I just did want to flag it as an important part of behavioral health in Medicaid. There are

those obviously who are diagnosed that we can ascertain on the basis of a claim -- not a drug but a claim -- and they're sort of a constellation of both diagnoses and other things. But I think there is literature to suggest that there are an awful lot of people who are undiagnosed but, you know, suffering with real burdens of depression and anxiety. And I think -- and probably I shouldn't say this because what do I know, but, you know, one could imagine that, you know, with the stresses of low income, you know, being low-income people, which is almost, you know, definitional, if you don't have a disability and you are on Medicaid, that the sort of rate of that as compared to the regular population might even be higher, and it's very high in the mainstream population, in the general population. So I think we should at least sort of have a flag or place keeper for the issue of whether or not in regular primary care in Medicaid people are being sort of screened and their behavioral health needs are being attended to and sort of flag that as another area for concern, because it does -- there are studies that suggest that it impacts cost for sure, but mostly it's just -- it's morbidity and suffering, and, you know, being depressed may not

completely incapacitate you but may keep you from being able to sort of fully participate in life. And it's a very serious issue and a very, I think, extensive issue in the population in certainly Medicaid. So I think we should park that.

COMMISSIONER MARTINEZ ROGERS: Thank you. It was a great report, Amy.

I just want to add to what Andy was saying, and that is that -- and it's well documented that amongst the Latino population, adolescent girls have a high rate of depression and suicide tendencies. Also with the African American population being diagnosed with major psychotic diagnoses more than any other population in the United States. I don't know if there's anything that we can actually put in this about it, but it has a lot to do with income, and the lower income, and who is -- you know, it's usually around the minority population. So somehow or another, some -- I don't know if we can just write a statement, a paragraph, or something that we notice that, we take that into consideration. I don't think that I would expect for you to change anything other than just making it noticeable the way Andy was talking about. I

would really appreciate it.

Thank you.

CHAIR ROWLAND: Well, I think that also, because this is the Medicaid population, we need to note that this is the low-income population, because to qualify you have to be low income.

Did you have a small point, Trish?

COMMISSIONER RILEY: I just want to be Pollyanna instead of Debbie Downer, but, you know, all our conversation this morning was, Oh, my God, how complex this program is. And I think that -- and it is. And that thinking leads us to tomorrow's discussion about should we just change Medicaid, should we, you know, throw it out and start again. And I think we need to remind ourselves and always frame these discussions around it's complicated because these populations are complicated. They have extraordinary needs that cut across services in unimaginable ways, in ways that we haven't yet even figured out, and in many respects, to use a phrase we've used at the Kaiser Commission before, the Medicaid program makes Medicare and private insurance work. It effectively serves as a high-risk pool, and we can't forget that.

So as we struggle and pull our hair out over the complexity of what we've created here, I think we can't forget that its fundamental role of serving people with profoundly challenging needs is in part what makes the complexity.

CHAIR ROWLAND: Well, and it's also far more than a health insurance program. It is really a health services program across the spectrum.

Amy, I think what you have done is terrific, and I think we really ought to think about obviously there's -- we want more. We always do. And you're going to provide us with more, we know, because you always do. But I think that the pieces that are here, we should really think about pulling together as just a spotlight to put at least some of this initial data out as part of our June report.

[Laughter.]

EXECUTIVE DIRECTOR SCHWARTZ: She didn't see that one coming.

CHAIR ROWLAND: Thank you, Amy.

It's hard to stun Amy, but we seem to have done it. We liked it, Amy, a lot.

And now, Chris, we like yours, too, so that's a

good set-up because you're going to take us to the next level of looking at psychotropic drugs and medication.

Session 8: USE OF PSYCHOTROPIC MEDICATIONS BY MEDICAID BENEFICIARIES: PATTERNS AND POLICY

* MR. PARK: Right. Thank you, Diane.

Amy has kind of laid out the big picture of behavioral health use and services in Medicaid, so this is going to take a small slice of that and look at the use of psychotropic medications by the Medicaid beneficiaries.

During last session, last month's session on behavioral health, many Commissioners expressed an interest in learning more about the use of psychotropic medications by the Medicaid population, particularly vulnerable populations, such as foster children. So, this session presents our initial analysis of the use and spending of psychotropic medications in Medicaid.

First, I'll walk through the analysis methodology and then present some of the key findings on spending and utilization. Then, I'll highlight some of the risks of psychotropic medications and federal and state activities that have been designed to improve psychotropic use and try to ensure that these medications are being used

appropriately. And, finally, I'll present a few policy questions for your consideration as we kind of decide on what future work we may want to consider.

So, our analysis used 2011 Medicaid Statistical Information System eligibility and outpatient pharmacy data and we identified enrollees with at least one psychotropic drug prescription. The list of drugs and drug classes that we included in analysis can be found in Appendix A of the paper that's included in Tab 9.

For counts of psychotropic prescriptions, we used both fee-for-service and managed care claims. For spending numbers, we only used fee-for-service claims because the payment amounts are typically not included on the managed care encounter data reported at MSIS. Also, I'd like to point out that the drug spending is before any Medicaid rebates are applied.

We also excluded several populations due to limited pharmacy data. Individuals dually eligible for Medicare and Medicaid receive most of their medications through Medicare Part D, so they were excluded. We also excluded the all-year institutional population, such as individuals residing in a nursing home, as drugs are often

bundled as part of the total facility payment, such as a per diem. We excluded limited benefit enrollees as they may have limited or no pharmacy coverage. And, we also excluded five states with what appeared to be limited managed care pharmacy data.

As Amy pointed out, this analysis is an analysis of users of psychotropic medications and it doesn't necessarily equate to people with behavioral health conditions, and for a couple of reasons. One, people with behavioral health conditions may not use a psychotropic drug. And, two, psychotropic drugs may be used for conditions not considered to reflect behavioral health or mental health. For example, anticonvulsants are typically used to treat seizures, but they can also be used for bipolar, and so we haven't necessarily controlled for uses outside of behavioral health conditions.

Overall spending on psychotropic drugs in Medicaid is substantial. Medicaid spent $8 billion in fee-for-service on psychotropic drugs, which was about 30 percent of the total drug spending, and it only represented 18 percent of all of the prescriptions.

Enrollees who qualify for Medicaid on the basis of a disability accounted for over half of the psychotropic prescriptions and 60 percent of fee-for-service spending. And, again, this may be partially explained by many of these individuals becoming eligible on the disability pathway due to a mental illness.

The spending varied greatly by different eligibility groups. On a per user basis, spending for foster children and beneficiaries with disabilities was about $2,000 per user, which was about two to four times that of other groups.

Looking at spending and use by therapeutic class, antidepressants were the most commonly used. About one-third of prescriptions were for antidepressants. For spending, antipsychotics were the most costly. They were over half of the fee-for-service spending. In fact, the top three drugs in spending in Medicaid fee-for-service were antipsychotics, and they were over ten percent of spending.

Use also varied a little bit by the eligibility groups. For non-disabled children, they used ADHD drugs the most, which corresponds to some of the analysis that

Amy did, which presented that non-disabled children frequently had ADHD. For the other eligibility groups, antidepressants were used the most.

This table presents the psychotropic use by eligibility group. Overall, about 14 percent of the Medicaid population used a psychotropic drug, and this varied greatly between the different eligibility pathways. For example, foster kids, about 24 percent of them had at least one psychotropic prescription during the year, compared to five percent of the non-disabled non-foster care children. And, between these two groups, we see foster care children had about 16 prescriptions during the year, versus eight prescriptions for the non-foster care children. So, they used about twice the number of psychotropic prescription drugs.

For the disabled population, about half of them used psychotropic drugs, and similar to the foster children population, they used 17 scripts per user. So, this averages out to be more than one psychotropic prescription per month.

This table looks at children under 21 by the basis of eligibility group, and so we see non-foster

children who are not disabled, foster children, and disabled children. Overall, across all of the different age bands we looked at, the disabled children had the highest use of psychotropic drugs. About one-third of the disabled children used a psychotropic drug, compared to about 24 percent of foster children and five percent of non-disabled non-foster children.

The foster children overall were more similar to the disabled population in terms of their psychotropic use, especially for the older age bands of, like, the 7- to 14-year-olds, 15- to 18-year-olds. And, again, we see that in terms of the number of prescriptions per user, there were about twice as many as the non-foster children.

This table looks at the disabled eligibility group by age, and in general, the use of psychotropic drugs increases with age. About one-third of disabled children use a psychotropic drug compared to over half of the adults using at least one psychotropic drug during the year. And, again, they used about twice the number of prescriptions compared to the non-disabled populations.

I just want to quickly mention the use for adults over 65. We found 19 percent used psychotropic

medications, but this is an underestimate of use due to some of the exclusions mentioned earlier of the dually-eligible population and nursing home population, and it leaves, like, a really small sample size, so this might not be representative of the actual use in that elderly group.

The high usage rate of psychotropic drugs in the Medicaid population has created concern among stakeholders and policy makers regarding the use of these drugs due to some of the risk associated with psychotropic medications. For example, these drugs can increase the risk of suicidal thinking and behavior in children and adolescents. Atypical antipsychotics can increase the risk of weight gain and metabolic disorders, which can increase the risk of heart disease, obesity, diabetes, and other health conditions. In fact, the FDA has not approved atypical antipsychotics for use in children under five years old. Antipsychotics also pose an increased risk of illness and death in older adults with dementia, which has led the FDA to require a black box warning regarding this increased risk of illness and death for elderly population.

Due to these risks, and particularly for the elderly population with dementia and foster children,

federal agencies and states have undergone several activities to improve the use of psychotropic medications and try to ensure that they are used appropriately. CMS and the Agency for Health Care Research and Quality are developing performance measures regarding the use of psychotropic medications in children. For foster children, this often involves the coordination of several agencies -- welfare agencies, Medicaid department, and also the mental health agency within both the federal -- at the federal level and state level. The Child and Family Services Improvement and Innovation Act requires that the state welfare agency report annually on what they're doing to monitor the use of psychotropic medications in foster children.

CMS, the Administration for Children and Families, and the Substance Abuse and Mental Health Services Administration have recently started coordinating initiatives among agencies and have recently issued several informational bulletins highlighting different programs that states have undertaken to address this issue. Also, CMS, in regards to use of psychotropics in the elderly population, has created a National Partnership to Improve

Dementia Care, and one of their goals is to reduce the use of psychotropic medication in the long-term nursing home population.

At the state level, we see similar efforts regarding the use of -- improved use of psychotropic medications. Some examples include obtaining informed consent from the parent, legal guardian, or child welfare agency before these drugs are prescribed; providing peer review, consultation, or prior authorization for certain drugs, ages, or doses, for example, if you submit a prescription for a child under five for a psychotropic drug, there might be a prior auth triggered at the point of service. They also provide education to providers to inform them of the risks associated with these drugs, and the appropriate prescribing guidelines recommended by different agencies. And, also, states provide utilization and performance reports regarding the use of psychotropic drugs for certain populations, for example, providing these reports to nursing homes.

So, here, we have a few policy questions for you to consider as we develop our future work on this topic. What have we learned about the effectiveness of state

psychotropic improvement initiatives? Are targeted initiatives needed for populations beyond foster children and nursing home residents? Do Medicaid programs have appropriate protocols in place to monitor for the risks associated with these drugs? And, what is CMS's role in promoting appropriate psychotropic prescribing patterns?

So, with that, I'll conclude my presentation and we would appreciate any feedback you have in terms of the data presented in this presentation and what next steps you might want us to consider.

CHAIR ROWLAND: Thank you, Chris.

Andy.

COMMISSIONER COHEN: Great job, and sobering. I guess I would just respond to your last question by saying I am very interested in the question number four, which is one that we've sort of only lightly touched on before, but what is CMS's role in sort of actually overseeing the appropriate use of services and drugs, and this is a very concrete example, and there's obviously lots of other players in the mix, but what is CMS's role if Medicaid is the payer? In many other contexts, payers are responsible for thinking about these things and I think it's an

appropriate line of inquiry for us.

I guess the one other thing I just wanted to mention is, I mean, there's the question of whether the drugs are being prescribed appropriately. I think another huge question, and it's a hard one and I don't know what Medicaid's role can be, but what is going on with our children that is sort of making people think that prescribing psychotropic drugs is necessary, whether or not they're doing it with the sort of finesse that they should, and are there prevention or other activities that Medicaid can be promoting that could get to that sort of root cause issue.

CHAIR ROWLAND: Marsha.

COMMISSIONER GOLD: Yeah. A couple of different comments. One, in the paper, you talk about the difference in managed care. I think you need to go back to who's enrolled in managed care. A lot of the SSI population isn't in that, so it may be a function of case mix and I think you may just want to mention that.

Second, I'm not sure you really want to bring in the 65 and older population because you have so few of them, because you don't have the Part D data, and the

analysis is quite strong without them. They could be mentioned, but with the reason for not being there.

Third, and this will sound funny, but I think, if we think about it, given that this is on adverse effects of drugs or whatever, it probably is important -- I think it's important -- to put a statement in here that drugs can be really useful. Rightly used, drugs have an important role to play. The concern is the other side of it, and I just think that might balance what you have to say.

And, then, finally, and this is one I would hope Sheldon talks about -- I am going to put you on the spot -- because there are clinical issues. I, actually, also am interested in the oversight issues. But, I think, as we talk about them, sort of philosophically, we should talk about, and these are things that happen between patients and their clinicians. There are roles of professional societies in educating clinicians as to what is appropriate use. There are certainly appropriate oversight provisions and incentives that both health plans and Medicaid has to build in to oversee and sort of from their perspective do things right. But, as we're sort of talking about those, I think putting it in context with the broader health care

system and who's responsible for what might be important.

CHAIR ROWLAND: Patty, Norma, Yvette, and then Chuck.

COMMISSIONER GABOW: I have my usual four comments. Well, the first is just to clarify, when we look at the percent of people with a prescription for a psychiatric drug, if they have one prescription in a year, does that put them in the "yes" column, and if so, it may be more interesting to try to figure out if -- and I don't know if the data permits it -- the people who are on a psychotropic for a longer period of time, not a single prescription, but multiple prescriptions for the same drug.

The second point I would make is while we all love drugs, especially in Colorado --

[Laughter.]

COMMISSIONER GABOW: -- that this is an area where there's tremendous misuse and overuse, where off-label use as sleeping aids, et cetera, are being used. And, so, being able to figure out how we can attack the misuse, overuse of psychotropic drugs and the overuse of high-cost non-generic new drugs as opposed to the drugs that there is, as you pointed out, a lot of the cost is in

the newer drugs.

The third issue that would be interesting if the data -- I suspect it doesn't allow it -- but, I know that in our system, there was a substantial amount of prescribing that were done by the PCPs not in the mental health arena and it was out of necessity. The patients couldn't get into the mental health system, so they were coming to their PCP with a variety of issues. And, so, thinking about how it could support primary care physicians more effectively in utilization of these drugs and prescribing would be important.

And, the last point I would make is with the expansion into adults, the criminal justice system -- people coming out of the criminal justice system onto Medicaid are going to have a huge impact on this. I always said in Colorado, the biggest mental health institution in the state was the city-county jail, and we ran the medical part of that, and our biggest expense after personnel was psychotropic drugs. So, as these individuals become eligible for Medicaid, the implication of how this is going to be dealt with is non-trivial.

CHAIR ROWLAND: Norma.

COMMISSIONER MARTINEZ ROGERS: I just want to mention that I think that sometimes what happens is that instead of dealing with the symptoms -- of what is causing the behavior problem, we sometimes just give the medication and not include the behavioral therapies that may help this individual change eventually, because you just -- you go to a psychiatrist. Most psychiatrists, even children's psychiatrists, which you have very few of them, prescribe. That is one of their major roles. Unless you are referred to have behavioral therapies, it is not going to happen.

My research is with federal female offenders who are under community supervision. Every single one of those female offenders that come out of prison receive their children on the day that they come out of prison, even if they had been in foster care or wherever they were. The day they come out of prison, those children are handed over. When we started working with them, the Feds wanted us to do a 16-week program. It ended coming out to be a year program. But, in that year program, we had to have family therapy included in there, because every single one of those kids had anger management problems, had problems with substance abuse, or high at risk for substance abuse.

So, of course, they put them on psychotropic drugs because that's the way a lot of people deal with anger management problems.

You know, this is an area -- and, I truly believe what Andy says. What is Medicaid paying for other than just a drug, because in the state of Texas -- great state of Texas, which, you know, whatever --

[Laughter.]

COMMISSIONER MARTINEZ ROGERS: -- they have cut the amount of money being spent on behavioral therapies. That is the number one complaint we get from caseworkers and social workers, is that we're not getting reimbursed for this. So, I guess we really do need to look at that. Thank you.

CHAIR ROWLAND: Yvette.

COMMISSIONER LONG: As I look at this, it just upsets me to see that a lot of children here are on these type of drugs. And, I go back to think when my son was 12 years old, I took him to the primary care doctor and the doctor was observing him and said to me, "Is he like this all the time," because he kept moving around and, you know, doing things there, but he wasn't getting into any trouble.

And I said, yeah. And he said, "Well, I'm watching him. I think that he needs to go on some type of Ritalin" or something that they were talking about at that particular time. And I said to the doctor, I don't think that he need any of that. I said, if he can sit eight hours in school and do his work, okay, and then when he come home, if he want to get into whatever he want to get into, as long as he ain't bothering anybody, it's fine. So, I didn't understand that.

But, I think that just looking at this here, and I do agree with what Patty said -- Patricia said -- I gave you a new name, Patty -- I agree what she said. I think that there is a lot of prescribing that is unnecessary here, and I think that I'm just not understanding the part about how is it a child from zero to two years old -- and, I'm not a doctor, I don't understand it, you know, and I'm just trying to figure it out -- to be prescribed these type of drugs or what not.

So, I think we need to really take a real look at this here and begin to hold states accountable, especially for the managed care program. And, the reason that I say for the Medicaid program is this here, is that in

Pennsylvania, we have a DUR Board, which is a Drug Utilization Board, and I sits on that and I hear a lot of psychiatrists and doctors and all stating that children are being given these drugs that should not be given these drugs, and they have a good monitoring system in place. And, I'm hoping that other states have something like that, too. So, I want to keep number three on the issue as to making sure that states are monitoring these type of programs or what not. Thank you.

COMMISSIONER RETCHIN: Well, I just wanted to echo what Marsha had said. I mean, as I look at these data, we know there is some inappropriate prescribing going on, but that the drugs are also very applicable to this particular population, as well.

So, one question I had was in terms of site of prescription. In Virginia, we found a lot of the abusers -- so, now go onto the inappropriate side -- would come to the emergency rooms to get refills, especially for sedatives and antianxiety drugs. And, so, they put in -- and I saw that another state did it, as well -- a system where you could click on it and see where they were prescribed in real time. So, that worked.

COMMISSIONER SZILAGYI: Yeah, just quick. I don't want to repeat what other people said. I do agree that CMS does have a role in overseeing psychotropic prescribing patterns. The word "appropriate" is a really difficult game to get into, but at least overseeing it. And, one area that data could be useful is signals, is comparing across states, or where there are outliers, or where there's huge variability in psychotropic prescribing. If there's an -- I mean, that's a general rule in medicine. If there's an enormous amount of variability for a certain population or for a certain disease, it's probably not all great, even though everybody may think they're doing great. So, that might be one area, of identifying signals.

I do see things both ways, so if -- psychotropics includes here Ritalin, so I know there's sort of a common sense that people have that 90 percent of kids on foster care are taking antipsychotics, and your data clearly show that's not the case. Ninety percent of kids in foster care are not taking antipsychotics, are not on antipsychotics. The most common psychotropic is Ritalin, by far, and the second most common is antidepressants. So, I think there is a problem with overuse and there's huge variability in

overuse, but it's very helpful to look at the data and to notice that there's -- not all children in foster care are drugged up, and so what we need to do is kind of hone in and get under the hood a little bit better, I think, in trying to identify what is the best therapy and where are there outliers and try to reduce those outliers.

And, Norma, I totally agree with what you said, and I mentioned this last time, too. One of the newer areas in foster care is that almost every child in foster care has been traumatized, and so they need this newer level of mental health care called trauma-focused care, and that's not easily obtainable in the data, because there are often not ICD-9 codes for this, if this is sort of a newer level of care. But, if CMS is going to go into the business of sort of overseeing this type of care, that is the evidence-based newer level of care. And, if these kids received trauma-focused care, a lot fewer of them would be on psychotropics.

COMMISSIONER CHECKETT: You know, just a, like, a comment, I guess, for the Commissioners and perhaps helpful to Chris, but, you know, what I am hearing is people are saying, it's an interesting issue. We agree it's something

to be concerned about, but not necessarily clear what our role is or what Medicaid's role is. And, I would point out that in -- that a number of states who are moving their more medically complex populations into managed care, in fact, are requiring extensive PIPs, as we call them, Performance Improvement Programs, where they will say, you know, we're concerned about this. You managed care plans, we want you to put a program together that tells us how you're going to identify these kids or these adults, what are you going to do. And, so, I guess I throw that out, because initially, I was thinking, I don't know what our role is here, but, I think, actually, there are a lot of things that we could guide, whether it's CMS or Congress or whomever to say, it is an issue and here are ways to think about making it meaningful to Medicaid, so --

CHAIR ROWLAND: You know, I think that some of the state activities that were identified here, we really do want to know more about do they work, what's their experience. I think that being able to report on best practices is something that we really can do.

I think this is really important to shine a spotlight on the fact that this is a serious area that we

need to do more work in and to look at more extensively. I would be a little interested in knowing how these utilization statistics compare to those in the general population. I mean, are children on Medicaid more likely to be getting psychotropic drugs, or is this more of a societal problem that Medicaid is just picking up the theme there?

And, I think that as we move forward on this one, we come back, again, to the issue of, don't we need to pull out children in foster care and really have a much more intensive look there, because we've now picked that up in three of our presentations. So, I think that was a good suggestion earlier on and would be something that I know there are many in Congress who are really quite concerned about how the foster care program works, how the special adoption programs work, and that we can really look at that.

So, thank you, Chris.

MR. PARK: Thank you.

CHAIR ROWLAND: And, now, we'll move to one of those benefit issues that we have talked about a number of times and that we always know is something that we will

come back to. In honor of our former Commission member Burt Edelstein, we're going to talk now about the fact that the mouth is a part of the body --

[Laughter.]

CHAIR ROWLAND: -- and Medicaid coverage of adult dental services, which is always a sketchy part of the Medicaid program. So, welcome, Sarah, and thank you. We're now at Tab 10.

Session 9: MEDICAID COVERAGE OF DENTAL SERVICES FOR ADULTS

* MS. MELECKI: Yes. So, good afternoon, once again. As Chairperson Rowland stated, this presentation is going to focus on dental benefits for adults enrolled in Medicaid and provide state-level information on coverage policies.

I'll begin today by providing a brief overview of the impact of poor oral health and the dental coverage landscape. I will then discuss current adult dental benefits in Medicaid, followed by an analysis of recent changes in benefits. I will briefly discuss dental care utilization, and I will conclude with a discussion of future Commission work on Medicaid adult dental coverage.

So, we know that poor oral health affects a majority of adults in the United States, with more than 85 percent of adults ages 18 and over affected by dental caries, which are commonly known as cavities. And, adults with incomes below 100 percent of the federal poverty level have particularly poor oral health and are more than three times as likely to have untreated dental caries as adults with incomes above 400 percent of the federal poverty level.

Poor oral health may be both a cause and consequence of several diseases, including diabetes, and may affect pregnancy outcomes. And, poor oral health can have other negative effects, such as pain and tooth loss, which can lower quality of life and jeopardize employment.

Evidence suggests that access to and utilization of dental care increases when a person has dental coverage, and the graph on this slide shows the percentage of adults who have private, public, or no dental coverage by income as of 2012, which is the most recent year for which we have data.

It's important to note that dental insurance benefits, whether private or public, do vary widely. In

some cases, comprehensive benefits are offered, while in other cases, limited or emergency services only are covered.

And, as you can see, people with lower incomes are less likely to have dental coverage than those with higher incomes, and their coverage is more likely to be through a public source than those with higher incomes.

Because adult dental benefits in Medicaid are optional, states vary in the number of and extensiveness of benefits offered. If you look in your paper in Tab 10, there is a chart on page five and six that offers more details of what benefits are offered by State, and there is an additional chart at the end of the brief that offers more details on the limits offered by states. Please note that states that offer emergency-only benefits also differ in their definitions of emergency services as you look over that information.

Because of the vast differences between State benefit offerings, it's difficult to get a sense of what any given State benefit level looks like simply by giving nationwide statistics. However, we do know that states most commonly offer preventive or restorative services, and

there are several states that offer denture or oral surgery services without offering benefits from any other category.

Additionally, states differ in annual financial and service limits. For example, State variation in denture replacement ranges from once every five years to once per lifetime. Some states cover root canals only for front teeth, others for most or all teeth. And, some states cover only a certain number of fillings per year, while others cover all that are medically necessary.

Dental benefits may also differ for different groups of adults in Medicaid. So, some states offer additional dental benefits to pregnant women and certain people with disabilities. In states that have expanded Medicaid, adult dental benefits may vary for the base and expansion populations. And, some managed care plans choose to offer dental benefits beyond what the State Medicaid plan requires.

To date, there is not a standardized system in place to group states based upon their adult dental benefit levels, but several organizations, including the American Dental Association, the DentaQuest Foundation, the National Academy of State Health Policy, and the Center for Health

Care Strategies, are currently working on creating such a system. In the meantime, we have grouped states on this map based on the types and amounts of services offered, but the map does not account for annual limits in terms of dollars or services.

Turning to recent trends in dental benefit changes, adult dental benefit changes are common in State Medicaid programs, and the Kaiser Family Foundation has tracked large-scale benefit changes from 2003 to 2012. There is a graphical representation of these changes on page 11 of your brief, if you are interested.

In all, 32 large-scale changes have occurred among the states between 2003 and 2012. Fourteen of these changes decreased benefits and 18 of them increased benefits. Seven states experienced only increases in coverage, and three states experienced only decreases in coverage. Additionally, ten states experienced both increases and decreases in coverage.

Turning quickly to utilization of dental care, regardless of income level, people are much more likely to see a doctor or other office-based medical provider than they are to see a dentist. In Medicaid specifically, about

21 percent of people enrolled report a dental visit within the past 12 months. And, low utilization of dental services can be attributed to many factors, but for people in Medicaid, two important factors include the fact that many State Medicaid programs do not cover dental services and the fact that few dental providers accept Medicaid patients.

Looking at current work that MACPAC is doing on adult dental services in Medicaid, we're currently working on updating our dental measures in MACStats and looking at changes over time. And, in the recently completed duals demonstration focus groups, which you will hear about at a future meeting, the importance of dental benefits was a common theme.

Looking at possible future work, MACPAC staff have identified several areas that we could look at, including the use of emergency rooms for dental services as compared to State benefit levels and an environmental scan of provider network issues.

So, that will conclude my presentation. Thank you, and I look forward to your discussion.

COMMISSIONER CRUZ: Thank you. I really want to

commend you, because this is a very complicated issue, and I understand this is sort of a draft for our issue brief, which I think deserves a full chapter because of the complexity of the issue. It's not only sort of the epidemiology of the disease, it's the disparities involved. It's the major workforce issues.

But, I think as the brief is important and, actually, timely, because as I understand, next week, there is legislation that is going to be introduced by both the House and the Senate -- I think it's called the Oral Health -- the Dental Comprehensive Reform Act to include oral health services in both Medicare and Medicaid. It's really a rather comprehensive piece of legislation. So, the issue brief at this point could help in some of the discussions while we wait for the chapter.

My main comments are, as I read this as an issue brief, is in some of the way the data is presented and some of the contextual aspect. I think it's important to point out the issues that are caused by oral health, such as the pain and suffering and the loss of work hours. You know, there's something like 165 million hours lost of work because of oral disease. I think there are some other

data, like oral cancer data, the mortality from oral cancer, that is tremendously, specifically among this population, because they have no access to the preventive or early detection of oral cancers. I think there are some factors that are really very important, like, you know, 52 percent of new military recruits couldn't be deployed because of dental problems.

All this to say that as I read it, and maybe that was not the intention, oral health was sort of linked to the effect on systemic diseases, and the important, I think that should be sort of de-emphasized a little bit, just because some of the data is equivocal. Some of the data is just emerging data. It is important data, but oral health is important by itself. It affects the quality of life of the individuals and families. It affects, you know, self-esteem and work and all of that.

So, I have made some written comments that I can send to you in terms of how to sort of put this in context, and a little bit editorial, if you don't mind. Thank you.

COMMISSIONER ROSENBAUM: Yeah. We were talking about this a little bit before, actually. At this point -- I can never remember numbers exactly, but I think something

like three-quarters of all community health centers in the country are offering dental care. It's been -- of all the services they've ramped up over the past decade, this has been, I think, number one, ahead of mental health, which has also been a huge increase.

And, I think it would be very helpful to understand -- because, of course, I mean, I have several colleagues who run health centers that include dental programs and they're drawing patients from as many as three and four hours away. One has a two-year waiting list for adults for appointments. And, I think it would be helpful here to understand the interaction between the coverage issues, which are one level of problem, and the payment issues, that is, how states build their FQHC payment methodology, particularly to take into account oral health. There are a number of states, of course, that cover only emergency care, a very, very limited range of services. But, it might be interesting for us to compare and contrast FQHC -- not just the coverage rules, but the payment methodologies, particularly in safety net providers, and I think it would help a lot to understand, generally speaking, the payment methodologies in oral health care

more generally for private dentists.

I mean, this is -- I don't know enough to know whether the differentials are as pronounced as they are in the case of primary care payment methodologies, but, obviously, all the questions about both incentivizing participation, but also where you have the federal government literally having capitalized a ramp-up of dental practice, which is how to think about the 330 funding here, is there a sustaining financing element that comes behind it, particularly in a practice setting where half the patients are going to be enrolled in Medicaid. So, do we have a sustainable model? You can ramp it up, but then can you sustain it depending on coverage and payment rules, so --

COMMISSIONER RILEY: Just real quickly, this is a great presentation. The future work around the ED is probably pretty interesting, but let me share a painful experience. When I was with the Governor's office, we did a study of claims and found great ED use. The number one ED use was oral health-dental issues, and we were quickly reprimanded by the ED physicians who pointed out that lots of that was drug-seeking behavior and not "real," quote-

unquote, dental issues. So, I think, somehow, we have to split up -- that's a very important issue to look at, but we have got to do so pretty carefully.

COMMISSIONER CRUZ: Yes, it's true, but it's also, if you look at the data in some of the states that have cut oral services, the ED utilization just rubs off. So, we have to look at both.

And, if I may add another comment, the issue of viability. Since there is no mandated service, the states can and do cut as they will. So, that did affect not only the sustainability of programs that may be developed within the State, and it affects also sort of the workforce issues that we are sort of dealing with right now.

So, I think it would be interesting in looking at this viability. I think that charge is really very interesting, how states now do cut according to their budgets and dental is always on the budget cut -- on the cutting budget. And, how does that affect maybe the sustainability of public oral health programs in the State and the acceptability of providers of Medicaid and other public funding.

COMMISSIONER MILLIGAN: I also thought it was a

good presentation. I want to suggest maybe three parts to a potential environmental scan of provider network issues.

One is I do want to pick up on some of what Sara said about the site of care. In my experience, dental services is one of the areas where there's the most segregation of the Medicaid population into sites of care. A lot of it isn't community health centers. A lot of it has become for-profit chains that have been under a fair amount of scrutiny from a fraud, waste, and abuse perspective. And, there's a debate about whether they're meeting a need that isn't being met and they're good programs. But, site of care, I think, is worth looking at, because this is really, I think, an area of a lot of segregation from individuals covered by other payers or private pay, out-of-pocket.

The second is I think it is helpful to look at some of the scope of practice issues that are going on around dental services. There is a lot of debate and some changes nationally and some good examples in some states -- in Alaska, as I recall -- about dental hygienists, dental assistants, and others, and this is an area where scope of practice debates are playing out quite actively.

[Off microphone comments.]

COMMISSIONER MILLIGAN: Yes. And, the scope of practice is really, to me, of relationship to access.

And, the third is I think there is some good literature out there about kind of the elasticity between raising dental fees and whether it has a relationship to increased access, and I haven't seen a lot recently, but I remember seeing a pretty good study out of Indiana where the rates were doubled, but the increase in access was only about ten percent because it was not enough money to encourage dentists who had previously not chosen to participate to change their minds. And, it was really -- it was a good fee increase for the dentists who were already participating, but it didn't expand more slots in offices. But, that whole elasticity point, I think, would be helpful to just not do original research, but I think there's some stuff worth capturing.

COMMISSIONER GOLD: Yeah. Hi. Just a small point. It's a nice job. I don't have comments on the general thing.

I just -- I wasn't sure if you were going to include the figure that compared dental coverage for

adults, private and others, from AHRQ that's in the handout, but not in the brief. If you include it, I was hoping that you could go back to the documents and figure out how they define private health insurance coverage, because this may very well be the right figure. I just looked at it, especially at the 200 percent poverty and up, and I said, gee, that seems high, and I wonder if they just included sort of the surgical, oral surgical benefit or something like that, it would be counted. So, it's just a checkpoint, if you include that, to make sure you put a footnote with what the definition was.

CHAIR ROWLAND: I guess I would ask for an addition to that, because that only goes up to age 64, and I think one of the important things that Medicaid provides for the Medicare population is dental coverage for some of the adults over age 65. So, if we could look at that, that really is a part of the dual --

COMMISSIONER GOLD: That would be the MCBS, probably?

CHAIR ROWLAND: Yes. Then I had Patty, and then I had Sheldon.

COMMISSIONER GABOW: [Off microphone.]

CHAIR ROWLAND: Scope of practice.

COMMISSIONER GABOW: Scope.

COMMISSIONER RETCHIN: Just a comment on the scope, and then going back to a point Chuck made. But, I think this is a workforce issue. The dental schools, now, they are starting to proliferate. There are new dental schools opening. But, the workforce is really -- it's really a supply and price issue.

But, I did want to mention, and Chuck, you said that there were for-profits, but I believe all those are pediatric, aren't they?

COMMISSIONER MILLIGAN: [Off microphone.]

COMMISSIONER RETCHIN: Yeah. Okay. I don't think there are any for-profits in this space. There's no money.

COMMISSIONER CHECKETT: Is that true? Pro Dental?

COMMISSIONER RETCHIN: Oh, yeah.

COMMISSIONER CHECKETT: Is only pediatric?

COMMISSIONER RETCHIN: Oh, I don't know about that one, but I don't think there are -- I think they're all pediatric.

COMMISSIONER CRUZ: In the -- yeah, they're all pediatric.

In terms of the workforce issues, the scope of practice is a workforce issue and I think it could be sort of seen as maybe looking at some of the, what they call, Medicaid dental reforms, or they have different names, because one of the issues of the new dental schools is that it is a very sort of expensive way of treating disease in underserved populations and not necessarily creating more dentists are going to solve the issue.

There is not only the issue of the number of dentists, it's the maldistribution of dentists. Dentists don't want to practice in underserved areas. I mean, you have them -- in New York, you have them all practicing in Manhattan, but there's none to be found in Upstate New York. Just recently, actually, we heard of a pregnant woman that had a tooth abscess and actually lost her baby because she couldn't find a dentist. She had to drive two hours.

But, cases like that are sort of a bigger umbrella beyond the scope of practice. It's education. It's rates. It's reimbursement rates. In New York, the

Dental Association sued the State and won and the rates were hiked, I don't know how much, but they were pretty high, and it did not increase -- no, it did not increase the number of dentists that participated. It made a lot of dentists that are actually already participating in Medicaid richer, but it didn't increase the actual accessibility, so --

COMMISSIONER GOLD: Just a note that, like with physicians, it's not just payment and supply, it's also -- especially when supply is tight, you know, concern about missed appointments, concern about language barriers, concern about where people are. There's a lot of reasons why people might not get the care they need.

COMMISSIONER ROSENBAUM: Well, Gustavo and I were talking about the fact that, actually, there's some slack in dental use right now --

COMMISSIONER GOLD: [Off microphone.]

COMMISSIONER ROSENBAUM: Exactly. I mean, this is the part that is so complex, I think.

COMMISSIONER CRUZ: It is. When you look at -- I was looking at a study recently where you see the individuals that have private dental insurance, that have

had dental insurance for a while, the utilization is actually coming down and it's actually because of a lack of perceived need. So, there is a -- while there is this huge buckets of the population that have no access and do need but do have no way of accessing it. So, I think -- Peter was saying before that, you know, dental caries is a disease of the poor, and it's largely also big oral health issues is also a disease of the poor. So, a lot of the people that actually have dental insurance have had it for many years, can pay for it, and don't feel they need it because they don't have any issues. So, usually, those that need it the most have the less access to care.

COMMISSIONER GOLD: You know, I would ask you to check the numbers on that and see if some of the results, and maybe I'm using myself as a poor example, one. We always say not to do that. But, dental insurance has real limitations. It often doesn't cover a lot. It has a price out of pocket. Where it has a network, that network may not include people's doctors. So, there's a lot of out-of-pocket cost, and even people who have more money may still have trouble affording dental care. And, I certainly -- I mean, maybe the kids coming up don't have any cavities, but

all the people I know had plenty of cavities, so I'm not quite sure that it's just a disease of the poor --

COMMISSIONER CRUZ: Sure. It's definitely multi-factorial. It's not -- they claim it's perceived need. This is the data that comes from the ADA. But, it is definitely out-of-pocket cost. It's network. It's -- yeah.

CHAIR ROWLAND: Okay. Well, clearly, we want to look at dental issues, both these for adults, but also we have to be reminded that one of our big charges is also to look at access to dental services for children and some of the differences there in their accessibility versus that for adults.

This has always been a benefit on the adult side that's obviously an optional benefit under Medicaid. It's the first one cut when states have to save some money. It's sometimes counterproductive to cut it, but they do, and I think the look that you've had at kind of where it's available and digging deeper on some of the challenges there, combined with raising the workforce issues, because I think the twin side -- it's not really payment, as we've just talked, it's often just availability and who's willing

to see these populations.

And, I'm struck by remembering that whenever you look at some of the free clinics that are available for people without insurance, the biggest need that comes through the door there is not actually medical care, but it's dental care.

So, thank you, Sarah. This is the first time Sarah has briefed us and she's obviously done a great job.

So, with that, we will ask if anyone in the audience wants to make any public comments to us. We always encourage those who listen to us to also comment in writing if, after you get back to your offices, you discover that there was some point that we really missed that you'd like to clarify or some additional information you'd like to provide.

PUBLIC COMMENT

* [No response.]

CHAIR ROWLAND: Well, then we will stand adjourned until tomorrow morning. Thank you very much for weathering the weather to be here.

[Whereupon, at 4:48 p.m., the proceedings were adjourned, to resume at 9:30 a.m. on Friday, February 27,

2015.]

PUBLIC MEETING

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

Friday, February 27, 2015
9:39 a.m.

COMMISSIONERS PRESENT:

DIANE ROWLAND, ScD, Chair
MARSHA GOLD, ScD, Vice Chair
SHARON L. CARTE, MHS
DONNA CHECKETT, MPA, MSW
ANDREA COHEN, JD
GUSTAVO CRUZ, DMD, MPH
PATRICIA GABOW, MD
YVETTE LONG
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
PATRICIA RILEY, MS
SARA ROSENBAUM, JD
PETER SZILAGYI, MD, MPH

ANNE L. SCHWARTZ, PhD, Executive Director

Session 10: Medicaid Shared Savings: An Approach to Addressing Spending Growth
Alan Weil, JD, Editor-in-Chief, Health Affairs.....265
Mark McClellan, MD, PhD, Senior Fellow, Brookings Institution.....275

Session 11: Themes from Administrative Capacity Roundtable
Moira Forbes, Policy Director.....327

Public Comment.....360

Adjourn Day 2.....362

P R O C E E D I N G S

[9:39 a.m.]

CHAIR ROWLAND: Good morning, and welcome to the Medicaid and CHIP Payment and Access Commission's Friday morning session, and we are delighted to be able to begin this session with a discussion of Medicaid shared savings programs and other approaches to look at spending growth. We've brought two highly knowledgeable experts to join us who have each talked about this option, and they're going to both reveal their thinking not only on this option but any of the other things that we choose to ask them questions of. So I want to welcome Mark McClellan and Alan Weil and ask you to do miraculous things in the ten minutes Anne has given each of you to talk, and then we will have lots of time to engage in conversation afterward. And I'm not sure who was planning to go first.

Well, it's great to have you both, and thank you for joining us.

Session 10: MEDICAID SHARED SAVINGS: AN APPROACH TO ADDRESSING SPENDING GROWTH

* MR. WEIL: Thank you, Diane, thank you, Commissioners. It's really a pleasure to be asked to join

you today. It's also a pleasure to know that someone actually read an article that I published in Health Affairs a few years ago called "Promoting Cooperative Federalism through State Shared Savings" and --

CHAIR ROWLAND: You only wanted to make sure the editor of Health Affairs knew that occasionally we read it.

MR. WEIL: Yes. Needless to say, I was not the editor at the time the paper was published.

It was my effort to lay out a concept for a future for the program, but I think any discussion of Medicaid reform has to begin with the goals of that reform. And it seems to me that given the size and cost of the program and the rate of growth that people have experienced and expect to experience in the future, cost savings are an inherent part of any agenda around Medicaid reform.

Since the Institute of Medicine tells us that as much as a third of the spending in the health care system provides no added value, it's enticing to believe that you could just take a third out of the Medicaid program and everyone would go merrily on their way with no negative consequences. I don't think it's quite that easy. No one has actually figured out how to take that third out

anywhere, but Medicaid has a few features that make this particularly challenging, starting, of course, with the already quite low payment rates relative to other payers, which then translates into financial strain on providers, many of whom have limited access to capital that they would need to use to invest in reengineering systems to reduce the cost of care.

Of course, a large portion of the cost of the program are associated with long-term services and supports and the needs of those who need those services. Many of those costs are not medical, so any analysis of sort of waste in the health care system doesn't really speak to the social needs.

Which, of course, brings the next issue, which is, given the population served by Medicaid, there's this very complex interplay between the social and health needs of the population served by the program, and so looking at health spending in isolation from social spending is, I think, going to lead us to perhaps some erroneous conclusions about where the money can be found.

The program serves, as you all know very well, a very heterogeneous set of folks, but it includes some

extremely vulnerable, medically fragile, socially fragile enrollees where, if we make mistakes, the consequences for them are particularly high.

And, by the way, Medicaid is the largest player in managed care. While the private sector has had this love-hate relationship with it over the years, it's actually quite mature in Medicaid. And so, again, when we talk about redoing financing, we kind of already did that in Medicaid.

So all of this is to say that even if we accept the existence of excess spending in health care, figuring out how to modify Medicaid in a way that contains costs without having negative consequences is, I think, more challenging than for the health care system as a whole.

I was asked to reflect of where I think savings could be found, and I guess this is -- I don't know if this is helpful. It's probably the same list pretty much anyone would come up with.

It does seem to me that one of the drivers of Medicaid costs is the high prevalence of chronic conditions that really should be and could be addressed through public health and social interventions, that would reduce the

burden of disease and, therefore, reduce the costs associated with those chronic conditions.

You know, these are like one-sentence -- like they'd be easy to do, and I want to acknowledge that they're not. But since I was asked where you might find it, that's a place.

CHAIR ROWLAND: But when you finish, we're going to ask you to --

MR. WEIL: I thought you might.

Of course, there are also high-cost patients with very complex needs who are suffering from poor coordination of services. There's a lot of attention paid to dual eligibles, which is good, but remember that duals are only a subset of the high-cost complex populations, and I feel like in the public discourse, the equation of duals and high cost is made, and it's erroneous.

I think there's tremendous opportunity for robust patient engagement. I don't just mean financial incentives, although maybe they're a part of the picture, but I'm talking about true clinical and social engagement with patients, community-based case, team care, self-care. And there's tremendous opportunities throughout the health

care system for clinical reengineering. Again, we're part of the way through this. The patient-centered medical home model is rolled out, health homes, integration across mental health, oral health, physical health. These are approaches certainly not unique to Medicaid, and, in fact, they're probably most likely to be successful if they're done in conjunction with broader reengineering in the health care system.

So I know it's a long frame, but it's very hard to talk about reform without talking about why you're doing it. And I think it's very -- and yet often I feel like the proposals are made without any sense of the reasons behind them.

So what I tried to do in my proposal was create an environment that I thought was hospitable to the kinds of savings associated with efficiency gains without creating incentives for savings that come at the expense of enrollees or providers just by cutting benefits or rates, which is something we all know how to do, but we also know the consequences.

The premise of the proposal is really very straightforward, which is that in a matching structure with

shared federal-state saving -- sorry, shared federal-state spending, the matching structure is inherently and intentionally expansionary; that is, the marginal cost of expansion is less -- of a dollar's worth of expansion is less than a dollar to the state as they make the decision because they share the cost with the federal government. So it was designed to encourage states to expand the program, and in essence, what my shared savings proposal tries to do is create, if you will, the equivalent of an enhanced match for programmatic savings that don't come at the expense of enrollees. So it's basically deleveraging the program. And, frankly, the details that I propose are less important than the concept. The fundamental concept is to try to deleverage.

So in the few minutes that I have remaining, I just want to set forth five design features that I included and explain why they're there and hopefully that is -- again, why they're there is more important than how I address them.

So the first is the proposal I made, shared savings on Medicaid, CHIP, and the premium tax credits through the Affordable Care Act, and the idea was to focus

on items that are under the state's control, which if a state runs its own exchange, it has a lot -- even if it doesn't, it has a lot of control over premiums in the exchange.

There are other proposals out there that share savings on total health care spending in the state. I think that's a lovely idea, but I don't think it's under states' control. You're talking about Medicare, you're talking about employer coverage, which states have extremely limited authority over, in some instances none. So the first design feature is reward states for things that they can do something about and don't hold them accountable for things they can't.

Second of all, I propose savings against a baseline defined in advance. This is in contrast to two approaches that are out there. One is sort of the waiver negotiations that are done state by state, where you negotiate the baseline, which I find lacks transparency and creates serious problems for really whether or not the savings are credible.

It's also in contrast to a block grant approach or even a per capita cap approach. People tend to think,

oh, a block grant is simple. Well, actually, if you're going to do a block grant, you have to figure -- you have to go a few years back to get credible data. You have to trend it forward. So you're already off by a few years. Presumably, you're going to want to have some safety catch for hep C, new treatment, or HIV/AIDS or something like that. And it actually turns out that matching dollar for dollar is incredibly simple compared to almost every other proposal. And so the second feature is to have the savings measured against something that is defined in advance and not have this sort of constant negotiation about what the savings really are.

The third design feature is to try to create incentives that are strong but not too strong. You know, whether I got it right, of course, other people can judge. My view is that a block grant creates too strong incentives for savings that can come at the expense of enrollees and providers, that basically you want to, as I say, deleverage but not make it so that if you can just get another dollar out of the system, you keep that whole dollar to spend on other priorities.

The fourth feature that I included, which would

certainly be hard to take in a broader legislative environment, is that I propose an optional program, just like accountable care organizations for Medicare. My view is that in order to generate and document savings, you have to have a huge investment in a data infrastructure, quality infrastructure and cost infrastructure. And many states haven't made that, and if you make it mandatory, you're basically asking states to do the impossible, or you're forcing states to achieve results that they have no infrastructure to measure or achieve.

So I'm a big believer in letting the leaders lead. If you think you can do this cheaper, then you have to have the infrastructure to do it and to show that you've done it. And in that sense, making it optional I think serves that purpose.

And, finally, again, in a completely arbitrary way, I included a lock-in period, three years, borrowing from the ACO model. You have to acknowledge that any system of transformation takes time, that there's a life cycle of investment, probably increased costs in the short run, but hopefully a positive return in the long run. And there are too many opportunities for gaming.

So fundamentally my goal was to align the state and federal desire to control costs in the program, to deleverage the highly leveraged program as it exists today, but to do it in what I unabashedly would call an incremental way. I think that unraveling the matching structure, capping the structure, totally redesigning the structure has potential negative consequences that are very large. This may not go -- it obviously doesn't go as far as some people would go, but I think it creates an opportunity to give states an incentive to be creative about health system transformation within Medicaid and to align it with health system transformation more broadly.

That's what I propose, and I hope that explaining the rationale will help you think about where you should go with your own recommendations. Thank you.

CHAIR ROWLAND: Thank you, Alan.

Mark?

* DR. McCLELLAN: Diane, thank you, and thanks to the Commission for the opportunity to talk with you all this morning.

I'm going to try to hit some points that Alan didn't already cover. I agree with just about everything

he said in terms of the challenges and the directions for solving those challenges that a shared savings program in Medicaid could address. I just want to provide a little bit more or a little bit different perspective on context.

A lot of the focus, understandably, has been on coverage expansions in Medicaid, but this is occurring at a time when there are some concerns not only about rising costs but about quality of care as well. And in Medicare and commercial programs, kind of a long history of trying to keep costs down by restricting access to services or cutting payment rates. Just ask the physicians about how well that works in the Medicare program.

The interest behind accountable care organizations and a lot of these alternative payment models is to shift the focus away from -- just limit -- trying to limit the volume and intensity of services that are traditionally covered in health care and just change the game. You know, change to delivering care in new ways and providing support for doing that. And you heard from Alan earlier about some of the many opportunities to potentially get better quality care without increasing cost in the Medicaid program. I'd say that, you know, given the

vulnerability of the populations, the prevalence of chronic or multiple chronic diseases, and other factors that influence health outcomes but that are not very well addressed through the traditional health care system, I think the opportunities for these kinds of care improvements through new mechanisms of delivering care are probably greater in the Medicaid population than any other part of the American public. So it's more opportunities for managing chronic diseases effectively, more opportunities for using specialists or mental health/substance abuse services in a more coordinated way, greater patient engagement. As Alan mentioned, I'd highlight that there are a lot of interesting things going on around trying to integrate social and community-based services, family services, early childhood programs. These are not very well or extensively developed yet, but seem to be showing some promising results. And they just don't fit very well into the traditional Medicaid model of funding streams that go for traditional services or as the support for these other programs are separate.

So I think there's some steps happening, but not in Medicaid perhaps as much, and the Medicare ACO program

or other commercial programs to try to move away from paying for specific services that are covered and others that aren't and getting into a more individualized, perhaps broader but more targeted set of medical and non-medical treatments that work best for particular patients.

Now, there is no reason that can't happen, and it is actually happening within the traditional Medicaid context. Some of this is happening through things like the so-called DSRIP programs, a lot of federal support for trying out these new approaches to care delivery and preventing complications and improving health while not increasing costs, or maybe even saving money. This has been a big part of many of the waivers, which is most of the way the Medicaid program in 30-plus states with comprehensive 1115 waivers in place that are clearly moving -- trying to move away from traditional mechanisms of financing and delivering care.

But as Alan said, one problem with the waiver approach is that it's not very transparent. It's very individualized, and so it's hard to draw conclusions about what's really working in terms of saving money and improving outcomes.

One of the things that's a hallmark of all of these kinds of movements in care delivery towards accountable care, towards payments that are more at the person level and tied to better results as well as lower costs is that it tries to reduce that lack of transparency around what we really want in health care, which is better health outcomes, better care experience, and lower overall costs together.

So I know a lot of the motivation for this session has been about cost reduction, but I think that's missing sort of the biggest -- you know, one of the biggest opportunities for accountable care reforms at the state level as well as within health care organizations, which is better quality of care.

If you look at some of the early results from these kinds of shifts in provider payment systems in Medicare and the commercial sector and so forth, they do save some money, but the biggest impacts are typically on getting to better results in care because it becomes easier to put funding streams together, to target services, to get outside of the traditional mechanisms of funding care that tends to focus on, you know, again, volume and intensity of

services and not results.

So the reason that our proposal focused on Medicaid shared savings was because of this very big opportunity. This actually grew out of a collaborative effort that Brookings had sponsored, the Bending the Curve Initiative, with support from the Robert Wood Johnson Foundation. This was made up of a group of collaborators from kind of both sides of the political aisle, a broad range of experts. We issued a report in the spring of 2013 that included participants like Tom Daschle, Donna Shalala, Mike Leavitt, Glenn Hubbard, David Cutler, Mark Pauly, so people who have been -- you know, don't always write or see political issues or policy issues in the same way, but did come together behind this one.

The idea was to make this focus on better results and lower costs at the same time, a more explicit core feature of Medicaid. And I think this could work, as Alan was saying, as an option for states to take instead of waivers or other more traditional approaches. But because states would have an opportunity to share in some of the savings, it could provide some additional support for states to undertake the steps that are needed to make this

program work, and I'll come back to that in just a minute.

I would also add, as Alan mentioned, that, you know, while there have been a lot of partisan issues around Medicaid reform recently, this area of trying to help health care policies, whether it's in Medicare through payment reforms or the private sector through value-based insurance initiatives and the like, it is an area where there is a fair amount of bipartisanship in terms of support in other areas outside of Medicaid. Maybe that could come here. We also thought about proposals in our group for doing kind of broader ways of sharing savings with the state. I think as Alan mentioned, though, if you're going to start somewhere in terms of engaging states, this is where the biggest part of the state budgets are, more than 20 percent of spending. This is where the biggest state concerns are about rising costs, and this is where the biggest state control is in terms of potentially influencing care delivery.

It is true that the federal government exerts an awful lot of control over how Medicaid operates in terms of benefit requirements and other minimum standards. But the program is actually on the front lines administered by the

states and giving them more resources and more opportunities for developing an infrastructure to lead to better care that the opportunity for shared savings would provide would, we think, really help with that.

In terms of the details of our proposal, I think for our purposes today, they're not too different from what Alan has already described. The key parts in terms of an infrastructure, key elements of a shared savings program generally, are, first of all, you have got to come up with a mechanism for determining if there are savings. That means calculating benchmarks. This can be challenging since there are different component populations in states.

DR. McCLELLAN: In our proposal, we talked about ways to break down the overall Medicaid population into its different subsets, so childless adults, non-elderly disabled, duals, and so forth, and ways of getting some standard approaches of calculating per beneficiary baselines for each of these.

I should say, too, that our proposal focuses on getting savings at the per beneficiary level, so it's not to provide too strong incentives to get costs down by just restricting enrollment in the program or participation in

Medicaid. But, with a benchmark for spending, where it is and where it could be, and doing that in a comparable way and publicizing it across states, we think would be healthy from a transparency standpoint more generally, and also could help guide further waiver discussions for states that did not opt for the shared savings approach.

But, then you also need benchmarks for performance measures, and this is an area where, frankly, Medicaid has been behind in terms of what's available publicly to understand the quality of care being delivered. CMS has been focusing on trying to make progress on better measures and supporting states in implementing better measures in Medicaid. There's a core CMS measure set, at least for the non-elderly Medicaid beneficiaries. There's work in other areas, for dual-eligible Medicare and Medicaid beneficiaries. The Medicare side of quality measurement programs have developed some better measures.

But, compared to, say, the Medicare ACO program, where there are now 33 measures, many of which are very much population outcome oriented -- diabetes control, prevention of readmissions, things like that -- measures in Medicaid have not been that well developed, nor, because

they're voluntary, have they been that extensively adopted. So, that's an area where, as this program got off the ground, some support from CMS, from the federal government, would be very helpful.

In the implementation of the program, the idea would be to get a baseline set of measures, both financial performance, so that's a cost benchmark by population, and a baseline set of quality measures, with the recognition that the quality measures may not be ideal, or anywhere near ideal, to start with. That's not a reason to not go forward. The way that a lot of these reforms have worked outside of Medicaid is that you kind of start where you are, maybe in a limited way, so a limited version of shared savings until, perhaps, states get better performance measures in place.

Maybe there could be some support for putting those performance measures in place. For example, in the Medicaid DSRIP programs now, all of those come with expectations that you're going to measure the impact of the program on performance. Unfortunately, there aren't really widely available consistent measures that are used for those DSRIP pilots, even in areas where you're dealing with

similar populations.

So, I think there are a lot of tools that CMS could use to help make more consistent measures available that would really add to the confidence that these programs are doing what's intended in terms of impacts on quality of care and access to care and the like.

So, with those features in place, I think both our program and Alan's highlighted that you would look at the comparison of financial performance and have a minimum standard for improvement in quality, in these quality measures, at the same time. If states beat their trend in financial performance by far enough, and when these programs are typically implemented, there's kind of a wedge or corridor that the actuaries think of as being random variation that you don't want to necessarily pay out in a different way for, so there might be a corridor around which states don't share savings. But, if you beat that corridor, say, savings of more than one percentage point or something like that, then beyond that, the State would get a share of the federal savings.

The program can be more or less incremental, depending on what the share of the federal savings might

be. If it's a small share of the federal savings, it is truly incremental from where we are today. And, for people who are reluctant about going down this road, that might be a place to start. It at least would provide some incentives and get CMS and the states used to thinking about the program, not only in terms of sort of their existing reporting requirements around minimum benefit standards, but, again, this shift towards better outcomes and more flexibility in how they use funds and combine funds to get to those outcomes and put these quality measures and access measures more front and center.

Or, it could be a larger share of savings to the states, which would provide more incentives for them to undertake efforts to get to improvements in quality and reductions in cost at the same time.

I think in both our proposals, we talk about how a 50 percent of sharing between states -- of the federal savings with the states might be a good place to aim. That would mean that, say, for the childless adult recent Medicaid expansion, states would get more support, more financial savings, than they would with a core Medicaid population, or a core Medicaid population where the State's

share is larger to begin with. But, that might offset some of the concerns I know Alan and others have raised about, in the current models, with very high contribution rates by the federal government might not provide states with as strong incentives as you'd like to be accountable and limit costs. But, again, this is a design choice in how much you want those savings to be shared.

From the states' standpoint, this does -- these kinds of efforts do require more infrastructure than just paying the bills or signing a capitated contract with Medicaid managed care plans. It requires identifying and then tracking a set of performance measures. Depending on how the program is designed, those might be consistent across states, which would allow for more comparability and more transparency and more learning about what's really working in these care reforms. But, states could get more financial support for making investments in that infrastructure because they're sharing in the savings.

We'd recommend another step that the federal government could take to support states by providing them some more systemic guidance and exchange of best practices. So, if you look at the ACO programs taking place around the

country today, some of the things that CMS has announced recently in terms of Medicare payment reforms, you know, they're supporting mechanisms for sharing best practices, learning networks, things like that, resources that can help providers and organizations move towards these more innovative ways of delivering care. That could be a feature of this program, too.

So, this can be -- I think Alan is right in describing this as not a fundamental change in the Medicaid program, but a potentially important one nonetheless. It can be more or less incremental. If the shared savings is very small, you're not going very far away from where we are today, just adding, maybe, some transparency and some emphasis on consistent ways of calculating spending benchmarks and quality of care. You could go very much further in the other direction and provide stronger incentives for states to undertake efforts to really reform their health care systems, maybe align with some of the other efforts that are taking place on the commercial side in Medicare to support bigger reforms in care.

But, I think the main thing to emphasize is that this shifts the focus. This is a great way of explicitly

shifting the focus from just being about costs and access to coverage in Medicaid, important as those two considerations are, to costs and what we are getting for it in terms of results for the populations that we're intending to cover and support through these increasingly large and important programs in the United States. Thank you.

CHAIR ROWLAND: Well, thank you both.

Could you talk a little bit about how the demonstrations going on around dual-eligibles fit into a shared savings concept? I mean, is some of the structure of those demos getting toward what you would be talking about, or are they not there yet, or -- because they do have performance standards. They do have integration of care, between two big federal programs, actually, as a goal. And, they do have shared savings, or savings targets, at least.

MR. WEIL: Yeah. I would say, structurally, there's a lot to learn from each other. I don't think I am currently sufficiently close to the detail of how those are designed to take the question much further. But, there's a whole second set of issues, as you know, in those, which,

as you say, it's two big programs and there's rule alignment and payment method alignment and figuring out how to -- and alignment around the enrollee experience and rights to services and lock-ins and all of those kinds of things.

But, I think, conceptually -- and I think this is really following on Mark's last point --

CHAIR ROWLAND: I think I was referring to it more as a model --

MR. WEIL: Yeah --

CHAIR ROWLAND: -- of how you could potentially do a shared savings demonstration as opposed to --

MR. WEIL: No, and that's really where I was going to close, is which I think Mark's final point, that this is really -- if we can view this as an opportunity to shift the focus toward results, the whole notion that structuring those demos is based on an expectation that there will be quality measurement and reporting and standards as opposed to just financial reporting, I think that's a huge step forward, and in that sense, I'd certainly see it consistent.

DR. McCLELLAN: I agree with Alan. The programs

themselves, I think many of them are still pretty new, and Melanie Bella has been working hard to get them off the ground, but there is a lot of alignment that needs to take place. You know, I think what -- while it fits with the kinds of proposals we've been describing, the nice thing about a framework like this is that I think it would make it an easier fit to develop these kinds of reforms. Right now, they're very much individual hard work to put each of these together. There's not a clear set of measures to draw on, not a clear understanding from the states of what they would actually save if these programs work. You know, it's not as well established a track for actually supporting reform, but I think it's, you know, just like the DSRIPs and the other individual programs, yeah, these are all moving in the right direction, but they're not get a systematic push or support for moving in that direction yet.

CHAIR ROWLAND: Okay. I have Marsha, and then Sara.

COMMISSIONER GOLD: I wanted to sort of -- I've been looking at managed care for a long time, and I wanted to say something about how I see Medicaid in relation to

others that may be different from you, but also put it in the context -- this Commission has written a lot about the nature of the Medicaid population, and in some ways, what the Medicaid population has is a lot of people that -- or services that don't fall in the Medicare and they don't fall in the commercial sector. And, that's where a lot of the costs are and that's where the care management challenges are that are kind of unique that don't necessarily exist -- don't exist in the commercial market, or at least are invisible, because no one pays attention to them. And in Medicare, you get them with the duals and with certain other groups.

But, it seems to me, if you look at Medicaid, Medicaid has actually been ahead of the game in terms of trying to manage care for kids and moms and that stuff. They're not always perfect. The measures may not be as great and there are some other challenges. But, they've used managed care quite effectively in the non-managed care states. They were some of the leaders with medical homes and other things.

And, so, I'm a little bit concerned with characterizing Medicaid as behind and needing to learn from

commercial and the Medicare program. I think where the Medicaid program has the biggest challenges is where they can't learn from those other programs because no one's doing it. So, how do you deal with the disabled? How do you deal with the HIV? How do you deal with the kids with the special needs and those sorts of things? And that's where a lot of the costs are.

So, I wonder if you could talk about how you think your proposals fit within that context -- and feel free to disagree with me if you don't think that's an accurate way of laying things out.

DR. McCLELLAN: I think you're right, that there are a lot of innovative approaches taking place in Medicaid managed care now. I guess I would just say that these kinds of reforms seem like they would reinforce and support that movement, hopefully more systematically and extensively than is the case now. There are, as you know, a number of states that are increasingly relying on managed care. There are some states -- Oregon, Minnesota, others -- that have taken more of a regional approach. I think depending on the State's circumstances, the best way to go may be different, but I think it definitely helps to have

this kind of more explicit focus on performance measures. If we can get to more comparability of those measures across programs, it would help a lot.

There is some good work, very good work, reflected in some of the studies on the HIV population, other special needs populations, and starting to be some work on integrating social services more effectively, community-based services, though some of that is happening outside of the traditional Medicaid managed care plans, too.

So, I don't disagree with you. I just think that if we had more of an emphasis on getting to better results for this population, it would actually help us learn more quickly from the programs that are doing something well and help expand them more widely, in a faster way, too.

MR. WEIL: Yeah. As a general matter, I share, Marsha, your sense that, in many respects, Medicaid is ahead of the game, and it's why, when I was talking about the barriers to savings in Medicaid, the dominance of managed care actually has created some looseness around financing that I think you don't tend to find in other areas.

I do think, however, that there are places where commercial plans have been able to make investments, perhaps in things like predictive analytics, where Medicaid may be behind. It's an empirical question of -- and I'm sure there are some behind and ahead and generalizing is risky.

I completely agree that there are few models for the most complex populations, and yet, again, around the country, there are states that have adopted them.

So, I go exactly where Mark did, which is that what's lacking is any sort of national endeavor to develop and embrace a set of metrics that are appropriate to the complexity of the population. I was on the AHRQ subcommittees that set the children's and the adult Medicaid quality measures. The statute required that we use measures that were already in use. And, of course, as is always the case with measure sets, you want them to be relatively small, and they're optional, and we don't have a lot. The deeper you get into the complexity of the population, the less we have. And, then, remember that the statute that created those measures also created a process for developing new measures.

So, I think there's an understanding that this is an evolving art. What's missing, and I'm glad Mark said it in response to the duals issue, is that, again, we're sort of doing this all one by one. I mean, Sara, you're the leader in examining states' relationships with managed care companies and Medicaid, and, you know, the old contracts were about network adequacy and now there's robust quality reporting, and it's been a long evolution through a combination of advocacy and more sophisticated understanding of the metrics, just more computing power, but also changed expectations of what managed care is supposed to do, because it used to be we just thought all it was an access panel, where access was what mattered.

So, I view these -- I mean, in response to the framing of your question, my reaction is very much the same as Mark's, which is these proposals are consistent with the evolution that's occurring. Whether Medicaid's ahead or behind, in exactly the right place, I don't know. I'm sure -- I know it's variable. But, it's consistent. And, to think about at a national level that we want to judge what we're getting for this investment in addition to just what we're spending on it seems to me a framework that could be

very positive for those who are trying to do this work.

COMMISSIONER ROSENBAUM: So, I'm thinking -- I think a fair amount like Marsha on this, and I'm also trying to imagine turning these ideas into legislation. Would it not make sense, actually, and would it not be sort of an efficient way to get to the point you both want to get to, to simply go back and revisit the 1997 Balanced Budget Act managed care provisions? Those provisions were really meant to take us from a very slow evolution of Medicaid into what we see today. And, yet, there are a lot of constraints on the use of managed care.

And, so, it has always struck me that if what we want to do is speed up an evolution, that might be the way to go, especially since built into the arrangements are shared savings. I mean, as you know, it's obviously an element of managed care. CMS sanctions specifically shared savings arrangements. And, what you both are really talking about is allowing the delivery system to evolve further. So, that's one observation.

And, another is we're a year away now from the State Innovation Waivers, and so I'm wondering whether it's not worth our thinking about what you're talking about in

two pieces. One is an immediate effort around the BBA managed care provisions, and then the second is to actually get a little bit more ambitious with the State Innovation Waivers under certain circumstances, because those waivers, I think, much more than people realize, are pretty constrained. I mean, you can deal with your Medicaid and you can deal with social services and you can deal with this, but you can't touch these other things here.

And, so, I think in a federalism era, the question is whether, under certain circumstances, we would want to allow states to engage in innovations that they otherwise could not. Or, for example, in a State that had a commitment to ensuring everybody in the State, do we, in fact, allow the State to have a certain kind of relationship with self-insuring ERISA plans that we do not permit in other states? Do we allow the State to take the lead on certain aspects of Medicare that we normally wouldn't allow?

I don't see how we get to innovations for the very toughest cases unless the State can actually think delivery system overall and not have certain payers essentially retreating into their own corners, you know,

when the going gets tough here.

And, so, I'm thinking -- as I'm listening to your excellent presentations, I'm thinking about, couldn't we -- you know, could we think about breaking it into sort of two stages, some immediate work on Medicaid and then some more ambitious work on system-level change.

DR. McCLELLAN: I think that makes a lot of sense. I need to take a closer look at the BBA managed care, Medicaid managed care provisions. It does strike me that while that has helped a lot with giving states the opportunity to implement Medicaid managed care reforms -- and some of them have been quite successful on the lines that Marsha was talking about earlier -- the key things that we've seen in a lot of delivery reform efforts are you need the flexibility and opportunity to do it and accountability for -- this involves a shift in accountability towards results, but the financial incentive smatter too.

While some of these Medicaid managed -- or many of these Medicaid managed care reforms have been implemented in the context of big 1115 waivers that in effect set something like a baseline and gives states some

shared savings below it, it doesn't really strike me as a systematic, clear, transparent, predictable, long-term approach, where if a state is going to think about some serious investments and do I need to do something more in my Medicaid agency other than have a few staff who are overseeing managed care programs, do I really want to invest in better tracking capabilities and start moving towards that more systematic approach to supporting reforms in care in a state, it would be helpful to have that long-term predictability about payoffs coming back to the states in terms of better controls of costs going along with the demonstrated improvements in results. So that seems like a fairly big difference between some of the more effective accountable care programs elsewhere and what's in the law now.

It would also add in terms of extending out in a broader way. I agree that there may or may not be some real opportunities to support this work through the state innovation provision. It also strikes me as something where, just like the waiver process, a lot could potentially be done in the name of some statutory provisions that are kind of vague and kind of broad, and

that it would behoove everyone to have a clearer, more certain pathway and ideally with some bipartisan support for how reforms could occur.

If you think the waiver -- Alan, if the waiver process for Medicaid is complex now, just wait till those waivers start coming in and in terms of transparency, predictability, and so forth. And I really haven't seen much work done at all to lay a foundation for how that's going to go forward.

So, again, I think this kind of framework would be helpful in starting to get there.

MR. WEIL: Let me react. This was a very interesting set of comments.

I do think there are probably ways to build from BBA. I don't actually think the big problem right now is that there are huge impediments to using managed care. I think the real issue is what's inside the black box of managed care, and that's where I think the thinking has evolved a great deal. It used to be sort of, well, you know, as long as we're getting the financial protection of the capitation rate and we can measure sort of access adequacy, then we kind of figure they have all the

incentives right. And now, increasingly, payers are saying, "Actually, it turns out they aren't doing all the things we think we want them to do, and so we're going to go inside the black box and push enhanced payments for primary care and participation in different structures and the like.

And I don't know that I see the federal statute as impediments to that. To me, the problem with that approach is that any savings that the state generates are then subject to the standard match rate.

Well, yes, I think changing the match rate would feel to me like more than just amending the provisions.

COMMISSIONER ROSENBAUM: Just mostly trying to figure out where lawmakers should train their vision.

MR. WEIL: Got it.

COMMISSIONER ROSENBAUM: When we have these very broad ideas, which are tremendously important, and then you're sitting there as Congress trying to think, "Well, what do I do with this?" -- and it strikes me that what you're really talking about is delivery system innovation with an opportunity to do things that aren't done today for populations that don't happen.

You don't really have to change the benefits. You don't have to change the eligibility rules. What you really have to change is that part of the statute that deals with state authority over the delivery.

MR. WEIL: Yes. So if that's the way you meant to build on it, then I completely agree.

I still think you need a financial component, which is I think what Mark said.

With respect to the state innovation waivers, the risk I have in relying on that, in addition to the issues that Mark raised, is that if I understand the provision correctly, there is an opportunity for a direct payment model, meaning the state gets the money that the federal government would have otherwise given in the form of subsidies. That is a very high-risk proposition.

So I feel like what the innovation waivers create is two options. One is sort of a very traditional one, and the other is give the state the money, and they're on the hook dollar for dollar. I don't want to call it a block grant because this is very different, but the marginal incentives for states are identical to a block grant because the amount the federal government gives them is

capped, and then every dollar they save, they keep.

So it feels to me like it creates two extreme options. One is status quo, and the other is block grant, and I think what we're trying to do is create an option that isn't either of those extremes.

Your final point about -- and the comment you just made about this is really about delivery system, I agree, but this is where I sort of go back to Marsha's point, which is there are two -- to simplify, there really are two tracks here. One is the multi-payer reorganization of the traditional mainstream health care system, what ACOs are trying to do, what patients in medical homes are trying to do, all of that.

The other is the Medicaid-targeted delivery systems that provide services and treat patients who are almost unrepresented in commercial plans out there, and the strategies for doing those two are very different. So what I worry about sort of calling it, part of a global delivery system reform agenda is that there are subcategories of that, that I think have very different texture.

COMMISSIONER COHEN: Diane, I'm going to drive you crazy because I have a two-part question again.

Actually, one of them is really just a -- hey, compared to Patty, I am efficient. But one of them really is a clarifying question, and I'm not quite sure I understand.

Do your proposals assume increased regulatory or statutory flexibilities for states, or do they assume that the incentives will encourage states to use the flexibilities that they have in a more effective way? So that's my clarifying question.

MR. WEIL: I will admit that I finessed that a bit.

COMMISSIONER COHEN: Oh, so I caught that.

MR. WEIL: Right. So it's a good question.

COMMISSIONER COHEN: So maybe yes, maybe no.

MR. WEIL: I mean, the answer is I think it has to be paired with that, but I think the boundaries of that are perilous.

Again my goal was to sort of say let's think about it this way, and if we could agree -- I don't want to go on, since I said I finessed it. Now I'm going to box myself in the corner.

Again, I am gravitating towards a comment Mark made, which is this is a balance. So as our ability and

confidence in our metrics, particularly our quality performance metrics, grows, then I think our willingness to accept flexibility should also grow.

But my personal view is that we're at a pretty basic level right now in that area, particularly as it pertains to the Medicaid population, and so my personal willingness to let all of the constraints go is quite low, but I think that you have to -- it's a consensus process to figure out how much of the one you need to make the other happen.

DR. McCLELLAN: Yes. The constraints are in place because the expectation is that by having those constraints, you are going to assure better access to needed care and get better results.

To the extent that we can actually more directly assess whether innovative approaches to delivering care are delivering those results that we want, which, frankly, in many cases, may not be getting delivered right now, despite the requirements in place, maybe there's some room for agreement on getting to more flexibility. But in our discussions, there's a very similar point to what Alan made, which was that the more confident you are, that

you're really tracking what matters for these populations, the more flexibility you'd probably be comfortable in allowing in terms of how to get there in care delivery and benefits and so forth.

COMMISSIONER COHEN: Got it. Okay. Thank you. Thank you. That was very helpful.

I have the same instinct as Marsha and Sara, which, of course, I'm tickled that I have the same instinct as Marsha and Sara. It doesn't always happen that way.

But this concern that we have been talking about, whether or not there are sufficient quality measures, performance measures for the populations that Medicaid takes care of and spends so much money on, DD, behavioral health, long-term care, and other things, and so I kind of want to ask this question based on your respective experiences sort of in government, thinking about the health care system changes and things like that rather than sort of experts on this financing proposal.

I understand that if you are going to incentivize performance in all sectors, you have to take some leaps, and you have to create a structure and some incentives before you are 100 percent confident in the measures.

But I guess my question is, how can we really try to focus on improving -- testing and improving those measures? Because it has been a long time that we've sat around this table. Actually, it's sort of like -- that's actually a relatively shorter time, but a long time that people have been observing the lack of good measures in these areas. And the fact that Medicaid spends so much money on it, the fact that there is so much pressure on financing and all the things. It did not seem to have really moved the ball forward very quickly.

And I would also say this relates to the challenge of the data systems. I live in New York now, and New York has an incredibly complicated DSRIP system, which is really taxing even a pretty deep Medicaid program there, and that's really only looking at acute care. I mean, it's really not looking much beyond that at all.

So I'm just sort of wondering from your perspectives, what are some steps that either we as a Commission could take in terms of our recommendation or exploration? How can we move this area forward in terms of really pushing both performance measures and good data analysis and collection?

I know it's a hard question. You can be brief.

MR. WEIL: Yeah. Well, I mean, I want to reiterate what I said in my opening, which is, fundamentally, now that I don't work at NASHP anymore, I can say if you do this in a voluntary way, it's not going to happen. And I mean measurement. It's expensive. There's a lot of resistance, and if it happens, it will be -- you won't have consistency across sites, which is what you need. The whole point of measurement is actually, of course, to be able to benchmark and improve -- or at least one of the goals.

A huge portion of my desire to promote something like this was to say, "Okay, states. You think you can do it better for less. You've been saying it forever. So if you believe it, the onus is on you to show it. So if you want some savings, you have to invest in the data infrastructure to demonstrate that you had savings at the same time that you were able to retain or improve quality."

So it's to flip the formula, and again, it's sort of where we've used access, we've used access to a guaranteed set of benefits as a proxy for quality, and we know that that's a terrible proxy, and yet it's the only

one we've had.

Sarah, when you mentioned BBA, I was thinking one of my favorite party jokes -- or I should say one of the reasons I'm so popular at parties is I tell people about the 75-25 rule, and no one believes that that ever was in place. I go to great parties. I should get out more.

[Laughter.]

MR. WEIL: SO the point is we have this proxy for quality that we know is inadequate, and what I was hoping in proposing this -- and again, it's consistent with others -- is to basically say to those who feel so confident that they can do better, then the onus is on you.

Mark knows more, I'm sure, than I do about various efforts that have occurred in Medicare to basically pay for reporting before you pay for outcomes. I have enough familiarity to know they exist. So that's really fundamentally it for me, is that you have to tie it to a business case, and if you're running a state Medicaid agency with 8 million things that you have to do and a lot of financial pressure, investing in voluntary quality metrics is not going to rise to the top. And so it doesn't happen.

So I think trying to create a framework where there is a business case for doing it as opposed to just a belief that we should is critical.

DR. McCLELLAN: First, I am probably not going to go to Alan's party.

Let's say you're a state like New York that wants to do something in terms of improving quality and lowering costs at the same time, and what you have to do now is go and apply to a bunch of disparate brands, go through a very long waiver process on top of that, try to make it all fit together when there is not really any set of measures or standard expectations that you can lean on for how you're designing these kinds of reforms. So that's a lot of work.

And then on top of that, you've got to actually negotiate out on a one-off basis what kind of savings you're going to get, can you get something that's beyond just the state's share. And some of that is in the new New York waiver, but it's been a long process, and it's not a very predictable roadmap, and generalizing from the New York experience -- and either it's DSRIPs or its waivers -- is going to be really, really difficult because all these features are so unique. The measures that are being used

are kind of unique and not necessarily representative of what will be used in other states.

This is a federal program, and what seems to work best is when there can be something in it for the federal government and something in it for the states. So if you're going to ask the states to do more in terms of accountability on some standard, truly meaningful measures or more standard, truly meaningful measures of quality, I think they are going to understandably want something in return, which would be a faster way to get these reforms in place and an expectation in more -- not just short-term DSRIP, but long-term predictability that they can make these investments and reforms in care and there will be a long-term payoff.

The problem with a DSRIP, just like a problem with some of these other pilots, it is three years, five years, some short period of time, and then what? How do you make those care reforms sustainable?

Medicare is having some of the same issues with some of its CMMI pilots where people have demonstrated, "Hey, you gave us some money up front. We were able to reform care and lower cost, but what do we do now?" There

is no payment system for that or no standard model for that reform and care to fit into to make it sustainable. So this is really about making the kinds of things that states are trying to do more sustainable, more effective, and in return, I think what the states are going to have to show is more accountability for the results as opposed to a lot of -- maybe a shift away from so much emphasis on the traditional kinds of standards around benefits and so forth.

CHAIR ROWLAND: For the benefit of a few of our Commission members, could you just clarify what DSRIP is?

DR. McCLELLAN: Delivery System Reform. These are Innovation Pilots that are intended to support the tons of good ideas out there for doing better than we're doing in getting better health outcomes at lower costs for particular kinds of Medicaid beneficiaries, and many states are implementing a number of these. They are being done as sort of pilot programs under this sort of CMMI authority that came with the Affordable Care Act. And --

COMMISSIONER COHEN: And incentive payments that come along with performance.

DR. McCLELLAN: And incentive payments along with

them.

COMMISSIONER COHEN: Incentive payments to provider systems.

DR. McCLELLAN: Right. Right.

But again, these are one-time pilots, and I think a very important question, as with any pilot programs, is what do you do next? The law on the Medicare side gives CMS the authority to expand the pilot that they think works nationally. That hasn't happened with any yet. I guess we're still early on since the 2010 law, but again, unless you've got a more systematic framework of being able to pay for and support and reward states that are improving quality and lowering cost, I think it's going to be hard for a lot of these efforts to really be sustainable.

CHAIR ROWLAND: And for the record, I am going to have Anne just explain what the Commission is actually doing in DSRIP.

EXECUTIVE DIRECTOR SCHWARTZ: Yes. We are finishing up a project on DSRIPs right now with the help of NASHP, and I think maybe at the next meeting and certainly at the next meeting in May, we will be bringing to you what we have learned in that project with some description at

different levels because it is so complex about how these things work and how they work in different states, so stay tuned for that.

COMMISSIONER GABOW: Thank you both for coming. I think we all know that Medicaid has done some remarkable things, but to me there are three issues that I think are worth thinking about, and I was wondering how what you're proposing might help or further complicate these issues.

The first one is the tremendous lack of uniformity of what you get if you're poor and vulnerable in one state versus another, unlike Medicare, which is no matter where you live, this is how it works.

The second is the tremendous administrative complexity that exists within the program for the states to have to administer.

And the third is something that, Alan, you alluded to, that this population has much of their problem in the social determinants of health, not in the health care system.

So how do we know that shared savings would go back into actually dealing with the social determinants of health, which ultimately will influence the cost of this

population and their well-being, and not go back to make providers have bigger bank accounts or put new roads in or whatever? And is there a way that in one of your criteria the shared savings could be stepped up in some way if it were, in fact, directed to those things that determine many of the problems in this population?

MR. WEIL: Let me respond. I mean, I don't think the first issue you raise is addressed through these. In some respects, the more you give states a path -- and I suggest that it's optional -- it could actually increase disparity across states in their approach. Obviously, lack of uniformity in eligibility is something that this is not designed to address, and talk to the Supreme Court about that.

With respect to the second, administrative complexity, I mean, this is something that Mark and I both referred to. To the extent that we can create a statutory pathway that is not based on one-off waiver negotiations -- I'm not suggesting waivers are the root of all administrative complexity in Medicaid, but they do create a particular type of complexity about resources, about time, about transparency, and placing this structure in a more

uniform formal way I think is a big win. But it doesn't really address some of what I'm sure are some of the other things you would think of as complexity.

With respect to the social determinants, I mean, this goes beyond this paper. I think that shared savings and the whole sort of ACO performance movement is a facilitator for the health care system to come to its senses and realize that a lot of the money that's being spent in it could yield better outcomes if it were spent elsewhere, and if you get to keep some of the savings, you now have an incentive to do so.

I do not believe that that facilitator is all that we need to get to where we should be in terms of rebalancing our resources toward the social elements that affect people's health, and I very strongly would argue for direct interventions that move resources and invest.

I'm enough of a state person and enough of a government administrator to be nervous about something that creates different shared ratios, depending on whether the service is medical or social, because I see gaming and I see administrative complexity and I see lots of ways that that goes wrong. And so to me, the approach is to

facilitate, and then if you want to directly target resources through another initiative, I would do so. But I personally get nervous about using the shared savings model to then also create, if you will, differential match rates for different kinds of services, although that's obviously a time-honored tradition in Medicaid.

DR. McCLELLAN: Just a couple points. On the lack of uniformity across states, I agree we probably will see more differences in approach, at least initially under this kind of model, but hopefully what would happen is reduction in differences in results. Right now, I think one reason there are so many varied approaches is that there's just not that much clarity on what kind of impact they're really having on the outcomes that we care about.

And I think, again, one of the big things for me, when I was at CMS and starting, the forerunner of the Medicare ACO program was just to shift the focus to what really matters, you know, something like patient experience with care and outcomes and getting to lower costs. So even if you don't make a fundamental shift, you know, putting all of the money into this new kind of payment system right away, even if it is truly incremental, at least emphasizing

that I think could help add to the momentum behind what's right now, as Alan was saying, a pretty complex DSRIP program, pretty complex waiver processes, which are all intending to be about getting to better results, but, you know, not providing as much clarity and, therefore, as much speed and support for states and doing what really works, given whatever resources they're willing to spend to have the most impact on these populations.

In terms of the social determinants, I think more match rate -- you know, higher match rates, things like that would be nice. I think the biggest challenge is it's just really hard to get these different kind of funding streams aligned and then shift the resources from one to the other in a way that works.

I can tell you from, again, back in my days at CMS, any proposals that talk about non-medical spending leading to an impact on medical spending coming from states are looked at with a very high degree of skepticism, you know, having seen a lot of, like, school transportation programs and, you know -- but that's because this is occurring in the context of what states view as kind of an open-ended, often very favorable matching rate program.

I think the only way -- the only way -- you're going to really get significant support from Medicaid funding streams for coordinating those kinds of services is through a program like this where you can, you know, tell actuaries with a straight face that just because we're adding in this funding stream doesn't mean funding is going to go up, and it really is going to lead to some worthwhile changes for those to work.

As you know from your experience in Colorado, it's not just a matter of saying, okay; we want to spend more on social services. You need a coordinated approach to how you're spending that money. You need to target it to the right people. You need to track the overall combined spending and have some accountability for keeping that spending down. That's what this kind of approach is about, and I think the fact that we're not seeing as much movement in terms of combining these funding streams effectively while keeping costs down, you know, still a lot of skepticism in Medicaid waivers to try to do this is because we don't have enough emphasis on results and encouraging states to make some hard changes in the way they run their agencies and the way they work together to

actually achieve better results for beneficiaries.

COMMISSIONER MILLIGAN: I'm tempted to ask if the state procurement process, Alan, would even fit inside of your three-year timeline.

I want to test a little bit of the boundaries about whether this should be a Medicaid-focused or an all-payer or total-payer, total-funding focus. Medicaid grew a lot because states saw an advantage and others saw an advantage in bringing into a leveraged financing arrangement things like child welfare and special ed. and lots of things. Some of the doors have closed over time.

Deleveraging I think would have maybe some of the salutary effects that you're talking about in terms of public health and how much Medicaid has taken over the financing for behavioral health and other things.

But I want to test sort of the permeability of this and the cost shifting and sort of the social pieces, because presumably in a shared savings model, there could be effects to other payers and other covered populations if the state achieved savings through provider rate reductions or other kinds of benefit limitations or reducing support for uncompensated care or other kinds of things. And the

spillover -- and I'm sort of picking up, I think, on some of what Sara was getting at. Some of the spillover could be into not only Medicare but on the commercial side, and then the spillover could be into accelerating the adoption of high-deductible plans and accelerating an employer's approach to sort of keep its premiums managed through shifting to employees and some of the sort of defined contribution instead of defined benefit model.

So that's all by way of asking how in your view would the unintended consequences outside of wherever you would draw the boundary of analysis, how would you address the cost shift or the shift across that boundary line into the non-Medicaid populations and non-Medicaid areas of the delivery system?

MR. WEIL: There have been a number of shared savings proposals made that are on total state spending, and they're designed to basically draw the circle broader so that you can't get outside of it. As I said, conceptually I love it, but I don't think we can either measure it, nor do I think states have the appropriate controls.

To be totally honest, I'm just not too worried

about Medicaid shifting costs outside of its boundaries any more than it already has. I don't see a lot more leverage to do that, and I think the political constraints on that are more relevant than some federal-state financial constraints. But I obviously could be wrong.

I do want to say, you know, when I wrote this paper, I was much more focused on the dynamics than on the specifics. The context of this paper for me was a fear that with states making decisions every day on things that the federal government is paying 100 percent for, whether that's the Medicaid expansion or the exchange subsidies, that over time state flexibility would be eroded as the federal government, taking a close look at the cost of these programs, started to say, wait a minute, we don't like how much they cost, we're going to tell states what to do.

And so I was trying to find a way that would create a dynamic of alignment around shared savings, truly the shared side. As Mark said, it's a lot easier to do these things when both the state and the federal government see that they have something in it.

So that's really the context I was working in. I

was much more worried about the state-federal relationship than the notion that the state is somehow going to shift costs outside. It's a totally reasonable question, but it's actually not the one that motivated my --

COMMISSIONER MILLIGAN: And, I'm sorry, if I could just -- my emphasis might have been misplaced, because partly I was getting at that issue, but partly I was getting at the issue of isn't it in the public interest to try to have whatever the shared savings in a sense to sort of raise all boats, whether it's adoption of health information exchanges or all-payer reform. So I wasn't solely focusing on the cost-shifting piece, but I was trying, I think, to elevate to the broader public interest being advanced by whatever the shared savings model would be.

MR. WEIL: So I could not agree with you more. The problem is I'm trying to figure out the accountability pathway. So it certainly would be better if we could save everyone something, but my concern is those individual actors, whether it's states or delivery systems or enrollees or whoever, they're faced with their own piece of it. And I just can't find a way to add up all the pieces

and say we're all in it together; therefore, we'll all take the approach that is best for all of us. What we're all going to do is take the approach that's best within a context, and I'm trying to align those contexts. And some of it I can do, and some of it I think it just gets too complicated. But maybe that's the next iteration.

DR. McCLELLAN: Maybe there's some really suggestive evidence from Medicare about these kinds of concerns. The same kinds of issues arise there, you know, if Medicaid does something -- Medicare does something to control costs like cut physician or hospital payment rates, that's going to end up putting more pressure on providers, because their costs of doing business are effectively shifted elsewhere.

You know, Medicare is farther down this road of at least talking about and starting to implement more systematically and nationally these changes in payments, both in the Medicare managed care plans and the performance measures used there and in the ACO programs and the other pilots and initiatives that the administration is undertaking administratively. And if and when the physician SGR legislation is ever fixed, that's going to be

a big further shift to these kinds of more accountable payment models. And the main motivation behind that is to give -- to provide an alternative for cost control other than just squeezing down the rates and shifting the costs and getting stuck in this vicious cycle of having to do more fee-for-service payments.

So it may not be easy, as Alan is saying, to come up with a comprehensive way of getting Medicare, the commercial insurers, and the Medicaid programs together, but directionally, what we've talked about here is, I think, similar to where Medicare is already heading and where many of the commercial plans are heading as an effort to avoid restrictions and reducing provider payment rates and things like that in order to keep costs down.

CHAIR ROWLAND: Well, I thank you for giving us such a broad and wide-ranging discussion that I think leaves a lot of room for continued thought and action by the Commission. And I'm going to ask you -- I mean, I think one of the things we are very interested in is knowing what kind of metrics would be important to measure, and one of our charges is to look at what data and information states should have and be developing. And so

if you have further thoughts around what we might do to stimulate in the short term through our recommendations better investment in both the data and the performance measures, we would appreciate receiving that so that we could act further on your wise counsel. But thank you both for coming today.

DR. McCLELLAN: Thank you, and we'll follow up with Anne on that.

CHAIR ROWLAND: Great. Thank you.

And now, since we're talking about states and state capacity, one of the issues that we have had on the Commission's agenda is do states have administrative challenges and the administrative capacity to move forward on many of these kinds of reforms, and we sponsored a roundtable on that, and I'd like Moira to come up and review that with us.

And think about performance measures and a state's ability to implement those as you talk.

Session 11: THEMES FROM ADMINISTRATIVE CAPACITY ROUNDTABLE

* MS. FORBES: All right. Good morning. Yes, that last session was a very good setup to this.

So I'd like to give an update on our administrative capacity work. In our June 2014 report to the Congress, the Commission included a chapter on administrative capacity, and that chapter, just a quick recap since some folks are new.

We covered the range of responsibilities that states have, some of the challenges they face in meeting the regulatory requirements, improving quality of outcomes, and integrating Medicaid and CHIP into sort of larger delivery system reforms.

We also talked about the innovative approaches developed by states and CMS and private organizations to help states strengthen Medicaid administrative capacity.

We noted that while there is certainly a general consensus that Medicaid, as a large public program, should be seeking value and seeking high performance, there were few clear standards to assess these objectives and little evidence on best practices.

So we noted the next steps for MACPAC would be to examine how administrative performance should be measured and identify which strategies are most effective in helping states to develop that capacity.

To help inform those activities, we convened a roundtable of experts to gain insight on the needs of state Medicaid agencies and identify some additional opportunities and strategies to develop capacity.

We invited a diverse group of experts to come to MACPAC's offices here in D.C. for a day earlier this month. The group included current and former state Medicaid directors and CMS leaders, representatives of other large public purchasers, such as the Federal Employees Health Benefits Program, consultants and researchers, performance measurement experts, and representatives from organizations such as the Medicaid Leadership Institute.

And Trish was one of the participants, and I don't know if you wanted to -- I know, unfortunately, there was weather, and a few of the folks had to actually be on by phone, couldn't make it to D.C. that day, and Trish was trapped under the snow in Maine. But I don't know from the part -- that you were able to hear, is there anything you'd like to share?

COMMISSIONER RILEY: The part that I was able to hear, I did participate, and Judy Moore was also there and had some very focused comments, I thought. But I thought

it was a challenging conversation and kind of went in circles a little bit, and I think the issue of measurement is a really tough one, and we can tell from at least the part of the conversation I heard that people really struggled with -- is that the place to focus our attention.

MS. FORBES: We met for a full day. These are the questions that the group was asked to focus on, and we did have professional moderators. MACPAC staff were just observers to the conversation.

In the morning, we focused a lot on the state strategies for recruitment and staff development. We've heard a lot about how hard it is to staff a program, especially when you're trying to pursue innovation. We talked about the different approaches states and other organizations have taken to develop or supplement state capacity, and in the afternoon, we actually spent a lot more time talking about performance measurement specifically, and we also discussed the federal role sort of broadly as well as MACPAC specifically, that participants talked about current federal efforts to help states and their suggestions for what might be done in the future.

In the morning, the group discussed staffing. There was a lot of discussion about the different types of staff needed to run an effective Medicaid program, not so much the specific skill sets needed, but more the sort of mix of leadership and management and frontline staff, and the differences in how you recruit and you train and you retain and you develop staff in each of those groups.

The participants, again, they represented a sort of diversity of perspectives, but they talked about a lot of different ways that states can get access to the breadth and depth of staff that they need to run a program. They talked about different measures to recruit, to train. They talked about hiring contractors to fill specific skill needs or to provide surge capacity. They talked about partnering with state universities. There was sort of a large menu of alternatives for states that are trying to get the expertise and the levels of staff that they need to be effective.

The group did talk about frontline workers a bit, which is not something that the Commission focused on a lot in our chapter last year, but certainly, with all of the changes that have happened in eligibility processes and

policies over the last couple of years, the role of the frontline worker is very important. They talked about strategies to involve frontline workers more in identifying opportunities for performance improvement and then implementing those, both as a mechanism not just to improve the program, but to help with the morale and with retention and with identifying future leaders. So that was an interesting sort of part of the conversation.

What we heard from the discussion is that there's a lot of models in the states to address all of these issues, and there's a lot of lessons that we can learn about what works in what context and in what circumstances. What we did not hear was sort of a consensus on an approach that would be applicable nationally. There's a lot of variation in the states.

We certainly heard that additional federal support for things like training, maybe expanding the reach of the Medicaid Integrity Institute, things like that would be welcome, but the group didn't come to some sort of consensus on this is the model that every state should be encouraged to adopt. There's a range of things that states have found to be effective, and publicizing those but not

necessarily requiring or incentivizing any single strategy, I would say was the takeaway from that, from the morning.

The group spent a good portion of the afternoon discussing performance measurement and how we can measure Medicaid performance for accountability improvement. This really echoes the conversation that we just had.

The participants identified a number of different dimensions in which performance measurements are important, and they sort of bucketed it into the day-to-day Medicaid operations, how quickly and accurately a state processes eligibility applications or how quickly and accurately a state processes claims.

They talked about the measures that you want to have as a purchaser of health care services, the quality and outcome measures, the percentage of kids that are fully immunized or the percentage of people who are admitted as an inpatient and then readmitted within 30 days of discharge.

And then they also talked about sort of metrics around Medicaid's strategic goals or Medicaid's role in seeking value, and some of the metrics that were identified were things such as the proportion of payments that are

made on the basis of value rather than volume or the proportion of payments for long-term services and supports that go to services provided in the home and community as opposed to services that are provided in an institution.

However, outside of -- and again, this echoes what we just heard -- outside of HEDIS and the core adult and child measures that CMS has been working on for the past few years, a lot of what folks were talking about were very state-specific measures that either the state itself has chosen to measure and report or requires its contractors to measure and report or that CMS has tied to a specific waiver or to a specific grant or initiative. We didn't hear about a lot of consensus around national measures.

The group did talk about the challenge of comparability among states and comparing states. Some raised the concern that if states do use consistent measures, they are going to be compared to each other and they are going to be stacked up. What folks in the roundtable sort of suggested was that part of developing measurement, sort of consistent measurements from Medicaid, is also developing a way to allow for appropriate

adjustment for the differences among states, who they cover, what they cover, that sort of thing, that that context is really an important part of having a measurement system. And there were several people in the room that definitely emphasized that point.

I would say we heard agreement among the participants that consistency in performance measurement is preferable to inconsistency, but we did not hear agreement around how we should get to those measures. There were some folks who very strongly believe that this should come up from the states, that they are in the best position to know what to measure and how to get that done. There were some folks who said this is the appropriate role for CMS: they have the national perspective, they've got the resources to invest in coming up with a measure set. And there were some folks who said the private sector, the research community, if they had good data, they can go out and really look at it and think about what should we measuring, what should we be focusing on. We did not hear consensus from the participants around how to get to the bidders.

So a lot of the --

CHAIR ROWLAND: Maybe that's an area that MACPAC can try and give some guidance.

MS. FORBES: That would be good, and I will come back to that in a second.

At the end of the day, we asked about federal policy opportunities, and I should point out that Judy Moore was one of the experts we had in the room, and several times, she kept trying to get the group to come back to what can MACPAC do or what can the federal government do.

CHAIR ROWLAND: For the new members, Judy Moore is a retired member of MACPAC.

MS. FORBES: Yes.

CHAIR ROWLAND: She had this issue as one of her main issues while she served as a Commissioner.

MS. FORBES: And she had been at CMS and was one of our experts for bringing that perspective.

What the discussion came back to when the group talked about the federal policy opportunities, one of the things that the participants sort of kept raising was this issue that Medicaid -- they acknowledged that Medicaid is jointly administered and funded by the states and the

federal government but pointed out that the states have tremendous flexibility in how they design and operate their programs.

And it's very difficult to define high performance in terms of access or quality or efficiency, given the enormous variation in coverage and payment and state organization and delivery systems. But in the absence of consistent measures of performance, of course, it's difficult for states or the federal government to know how any state's performance stacks up against other states or to determine which state structures and policies are effective.

So this is a challenge for some of the other potential federal policy opportunities that the group identified, which included providing a federal clearinghouse of effective practices, hoping to create the justification or I guess the business case for investment in administrative capacity, providing bonuses as an incentive for states to improve performance or achieve high level of performance, having a way to measure that performance as an underpinning to all of those policy solutions that the group identified.

Again, this echoes an earlier conversation and what we heard last month from the folks who reported on the Medicaid Listening Institute.

I know that we often fall back on anecdotes about which states are high performing. It was a struggle when we were working on the chapter last year. A lot of the information we have is based on stories about the outliers that were at one end of the performance spectrum on the other, but we don't really know where most states fall.

So while MACPAC has certainly highlighted a lot of these challenges in data and measurement, we have put a spotlight on this, there's still not much for anyone to work with. So in terms of follow-up from the roundtable and what I would sort of ask the Commission, is there something we can do to further this discussion? Is there any work, particularly in the area of the performance measurement, which might help move the conversation from "this is a problem" to "is there something that someone can do"?

CHAIR ROWLAND: Thank you.

Trish, then Sharon, then Andy.

COMMISSIONER RILEY: It's sort of where I was

left with the Alan and Mark discussion, thinking about the sort of fundamental rethinking. I wanted to ask the practical question of even if we could do the shared savings, where's the capacity in the state to stop, think, thoughtfully approach this? We don't reinforce that. We don't pay for that. We don't allow that to happen. So any kind of major reform becomes a full employment program for consultants, which is not a bad thing, and you certainly need them, but it strikes me that there is a very rich area for MACPAC here, both in bringing all the parties together around measurement, of which I think is less a priority, then real investment in training and support for the management of Medicaid agencies, with the recognition that Medicaid directors turn over every two years. You've got to build real capacity within those agencies.

We build capacity to go after fraud and abuse, and we don't build the same capacity to help states administer themselves, and it seems to me recommendations around a congressional activity and change in the statute that would have a parallel activity to the fraud and abuse work at the 90-10 with the college of fraud and abuse -- I forget what it's called -- and the sort of equivalent on

the administrative side is where we should put our eggs in that basket and less so in measurement, although I do think it's an appropriate role for us to bring all those parties together and begin to look at that.

CHAIR ROWLAND: Sharon.

COMMISSIONER CARTE: Moira, I thought the comments on the slide you have for what the MACPAC heard about staffing are kind of interesting, and they seem to belie what we hear informally from states and Medicaid officials, where you say they have many options to get access to the breadth and depth of expertise needed, but it's just been my experience and observation that just oversight of managed care, for example, takes a lot of expertise, very specialized expertise.

I heard the Deputy Commissioner for the State of Virginia, for example, say in conferences, national conferences, that really states need to have people, staff that have MBAs. They need to be able to read the prospectus of the company, the corporations that they're dealing with, know what those companies are doing across states. And frankly, I just do not see that kind of expertise in the states. I am just throwing it out there,

but I'd be surprised if more than a dozen states have that kind of expertise.

I've seen in my own state, Medicaid commissioners struggle with vacancy rates. Yes, they might. I mean large vacancy rates of more than 20 percent. I am disappointed in this response.

The other thing I wanted to ask you was if there was any discussion about Medicaid programs needing to have or wanting to have an office of an actuary or an ongoing actuarial contract.

In my state, the public employees program has one. The CHIP program has one, but Medicaid, the largest payer, has none. I mean, go figure.

MS. FORBES: So actuarial expertise was one of the specific areas that the states talked about, and I may have oversimplified. It wasn't that the folks in the room didn't say that they had struggles. It was that they did identify a wide range of ways to solve the problem, but they certainly all experienced the challenging in finding folks. Actuarial expertise was one of them.

I think a lot of states have hired that, but we did hear from a few states where they have had to make the

case to be able to get exemptions like the salary rules, to be able to hire that kind of expertise, and I think those states are -- the ones that we heard from in this meeting -- are states that have made a significant investment in managed care as a delivery system reform and used that to justify the investment and get the permission to do that. Whereas, I don't know that every state that implements a managed care program makes the whole sort of corresponding shift in how it staffs its own program that would sort of relate to that.

CHAIR ROWLAND: I think this goes to the issue that we have tried to work with before of what's the skill set that a state needs to either have in-house or ongoing contracts with to be able to manage Medicaid in a modern world, and certainly, we hear that there's real data and health information technology needs. There are real actuarial services needs. There's contracting health. So I think that is an area where we need to keep pushing as a Commission on, as Trish likes to say, what does it take to run a modern Medicaid program?

I have Andy next and then Donna.

Sharon, were you finished?

COMMISSIONER CARTE: I just wanted to add it's not only managed care. I currently have a utilization review nurse who is retiring. Just the time that it takes to recruit someone new -- and I'll be surprised if I can get someone who has her certification in doing health claims review.

The time and, as Trish said, to be able to thoughtfully manage and plan for your program is very dependent on your capacity.

COMMISSIONER COHEN: Moira, I wanted to ask a little more about who was there and whether or not -- were most of the people who were there consultants and researchers and performance measurement experts within health care or not within health care?

MS. FORBES: Primarily within health care. Several of the consultants -- and we had a few current state Medicaid directors, and some of the consultants and researchers who were there were former state Medicaid directors.

We purposely wanted to have a diversity of opinion. We had some folks who are involved in thinking about performance for public programs generally, of which

Medicaid is one but not the only, and we brought in folks who think about public value, like from the IBM Center on Excellence in Government, those kinds of folks, who again are not as Medicaid focused, but more thinking around how do government programs operate effectively.

EXECUTIVE DIRECTOR SCHWARTZ: I think this was a struggle here because we specifically tried to find those sorts of people I was only there for part of the day but among the people in the room who were sort of the outliers, the conversation kept sort of swirling back to their expertise and their ability to contribute, and I think in some ways, the folks who are Medicaid-centric, the current and former folks, kept zeroing in on something that was sort of hard to weigh in on, kept comparing themselves to the highway department. That's what we heard a lot about.

So I don't think we probably were as effective as we could be, although we certainly were trying just that, to bring in those other cross-sector experiences.

CHAIR ROWLAND: While your summary is helpful, as Marsha just raised, I think it would be more helpful to the Commission next time to also have the agenda and the participants of the roundtable included in our materials.

COMMISSIONER COHEN: Agree.

VICE CHAIR GOLD: Did the person who did this prepare a summary for you of the session that you used that would have more detail that we could look at as to what people said or not?

MS. FORBES: Our contractor is preparing a final deliverable. We just held this. This was like two weeks ago.

VICE CHAIR GOLD: Oh, okay.

MS. FORBES: We don't have the final deliverable yet, but we wanted to not wait another month.

VICE CHAIR GOLD: Sure.

COMMISSIONER COHEN: I am struck. This may be something that all of you have heard before, but I have to say when I heard it for the first time, I thought, "Ha," and I have applied it in many different contexts. So there is this sort of the traditional sort of made-up tale, I'm quite sure, about if you had asked people 100 years ago, what do they really need to sort of make their work go better or more productively, they would say they needed a faster horse, and it was because they could not envision that coming along -- this was more than 100 years ago --

we're going to be in cars, so they were very focused on, "I need a faster horse. I need a faster horse. How can I make my horse faster?"

And I think sometimes it's very hard to get answers about how to improve the system from people who have very immediate sort of like needs and incentives and other things who are working within the system when they work under the constraints that they work under, and most systems are sort of, as the saying goes, designed to get the outcomes -- or get the outcomes that it was designed to get.

So I'm really glad that you tried to get people outside of Medicaid to sort of think about comparisons and other programs that may have faced similar challenges. I mean, basically, this is a management -- I mean, it's management issues, and it's management expertise that's probably needed, but both within the organizations and external to think about it.

But I am sort of struck by the last panel too. So I asked the question. God, our work on performance measurement in certain areas is just so weak and so behind, and so how do we move that along? Basically, Alan's answer

was you design a system that rewards it or punishes it and says if you can't measure it, you can't get any benefit, and then people will focus on it. I guess that's part of what I'm thinking. Maybe we can move things along a little bit by being crystal clear about what the outcomes should be or what the processes even should be of a Medicaid system, like really identifying the areas that are the most important and encouraging CMS or recommending or whatever, whatever we want to do, say you have to -- whatever the tools are, require, incentivize, reward, or punish if these things aren't met.

I feel like we are a bit circular here. We sort of have this big sense that there is a lack of capacity, but we haven't prioritized what are the most important areas, what are the biggest areas of deficit, and only once we, I think, are clearer on that can we say, okay, developing a system that makes states really focus on this. I mean, if you were going to lose one point of FMAP, I assure you the state would do something to get you a good nurse, and I'm not suggesting that that is the approach or the right sort of level of penalty, but we got to make this a bit more concrete with incentives, I think.

COMMISSIONER CHECKETT: Well, I'm so glad to hear that this is the start of more substantive and focused work in this area, given, I think, its great significance. And, in fact, it's linked to, you know, not just the discussion earlier today about what can we do to control the cost of the Medicaid program, but in many ways to all the work we do, because the Medicaid agencies are the ones who are making the final decisions -- along with Congress and CMS, the final decisions on how these programs work, what they focus on.

You know, I was so struck by Moira's presentation and a little saddened by some of it, although I think perhaps Andy's analogy is so accurate that you don't know what you don't know, and you don't know what the future could bring.

Last summer, I went to my 50th state -- a cause for celebration -- and I would say I've been probably close to 40 of those doing some type of Medicaid business with some hat I've worn through the years, and the range is startling. There are extremely sophisticated states. They are functioning like, you know, incredibly well-educated, sophisticated purchasers of health care. And there are

some that are just kind of woefully just understaffed and undereducated and under-everything.

So there's this huge range, and I really think that this is very important work for the Commission. And I have no solution, although I have thoughts, but I think the Commission has got to focus on something we can do to incentivize Congress and to incentivize the states -- and it may be the linking of managing the program, moving the program forward by doing that to ensure that the states have the capacity that they need. And we've talked on and off for the past couple years. I mean, is it a standard of, you know, you should have these types of functions or you should have these capabilities? But I just really -- I just think that we have got to address this. I guess I would close there, because the implications of not -- and I guess I would just close by saying I think it's sad in some ways that they couldn't get over the -- you know, we're not like the highway department and they treat us like one, although that is an issue because I've been there. But this is a really big issue.

And so I would just urge the Commission that we have to really dig in this year on this if we want to make

meaningful change in this program. Thank you.

COMMISSIONER GABOW: I would second that. I think it's really important for us to develop some template about what it takes to run a highly efficient, high-value program of this magnitude in Medicaid. And then I think the other part is how you then attach carrots and sticks to that is very important.

The other point I wanted to make relates to Andrea's comment about learning from other industries, and excuse me if I go back to my passion of lean, but, you know, at Denver Health, when we started putting Toyota production systems into health care, initially what we heard -- and we were at the front of that -- "We're not an automobile company. We are so much more complex. That's an assembly line thing. How could you possibly apply that to the operating room?"

Well, I will tell you, the operating room is an assembly line, and managing large enterprises, there are a lot of things that could be done by learning from a process like lean that reengineers the work flow, let's the front-line people have the power to solve problems, give them the tools to do it. And, I mean, we realized almost $200

million of hard financial benefit, had the lowest mortality rate of all 117 academic health centers, and 85 percent of our employees said they understood how this helped us do our mission. It hits the target on all those things.

So we have to get over this issue that what we do is so unique that it can't -- that we cannot use the tools that others have used to effectively improve how we do our business. And, I mean, we really have to get out of that mind-set in all of health care and all of government, or we'll never get to hitting the target on quality, cost, and employee engagement.

So that's my sermon for today.

CHAIR ROWLAND: You know, Patty, I'm reminded of the fact that for years we were told you couldn't do things electronically in medicine, but you could go to a bank anywhere in the world and put in your bank card and out would come some money in the right denomination from your account. So I think that is a really important point, that you can't always just look inward. You have to look outward and apply other principles. But Marsha had her hand up.

VICE CHAIR GOLD: I'm a little bit -- I wanted to

see if I could clarify a little bit the discussion on performance measurement, because I think there were several concepts mixed in, and I'm not sure what they were saying. I mean, one of the issues is the operational effectiveness, and I think people here were talking about what it takes to run an effective program. And here it seems the measures for the federal government is sort of minimum expectations. I mean, if you're going to get this money, you need X, Y, or Z, or something like that, as well as whatever help can be done to help the states do that.

I think if one does that, one has to realize that different states will get that expertise in different ways. Some of them can use the insurance departments effectively to get actuarial skills or some managed care; others bring that in-house; some use a consultant. There are different ways to get it, and I think states need flexibility for what works for them to do it. But some minimum expectations are important.

But I was a little bit concerned, Trish, with saying performance measurements weren't important. I think maybe what you were talking about is operational effectiveness, because the performance measurements we were

talking about before in the earlier session I think were less management ones as how do you create tools that can be available to states and people for measuring care for the kinds of people we need. And I see it more as a technical assistance measurement thing that ultimately could be used for accountability, probably initially within states to help them get better programs. You know, there's a whole lot of risk adjustment to compare states in terms of performance, and I see less immediate value there. But it seems that for other reasons of administrative capacity, those things, a lot of states don't have the capacity to develop it alone, and there are a number of areas where it was -- it's important that some central people, whoever they are, help do things.

And so I was a little bit concerned with why you thought performance measurement wasn't -- I mean, was it just that you were talking about different performance measures or--

COMMISSIONER RILEY: No, I think it's a less important priority than giving the equal attention to the administrative needs of agencies that we do with fraud and abuse, that we spend money up front helping people do their

jobs, getting training, getting help, getting assistance. I think that's a much, much, much more immediate need. And I am a measurement skeptic because I think we spend so much -- not that it isn't important. It is. But we spend so much time and energy trying to come up with measures and who decides and what are they.

That said, I think there may well be a role for MACPAC to bring the parties together to think about some few set of measures that would really test and measure what a quality, effective, efficient Medicaid agency is. But I do think there's much more need up front maybe as we think about what those measures should be.

VICE CHAIR GOLD: To what extent are some of those problems created by state-specific authorities and labor markets and pay raises? I mean, they're real problems, but to what --

COMMISSIONER RILEY: But that's exactly --

VICE CHAIR GOLD: -- extent are there ways to deal with that?

COMMISSIONER RILEY: Well, 90-10 reimbursement, we give 90-10 reimbursement to go after fraud and abuse. We give 90-10 reimbursement, but very little on the

management and administration side and the planning side. We have very little capacity for states to go off and get training for their staffs. We have very little capacity to do data analytics. We spend almost no attention on sort of the nuts and bolts of how do you manage these enormous systems.

CHAIR ROWLAND: Let me ask you, Moira, when Chuck and the other Medicaid directors came and talked with us, one of the things they did raise was the fact that the FMAP was unequal and that the administrative match is just 50 percent. They also talked about whether statutory language that would allow them to go around hiring practices and reimburse at a higher rate for certain kinds of skill sets could be included. Were those topics discussed at this forum?

MS. FORBES: The participants mainly focused on, to sort of Marsha's point, the state-specific flexibilities that they have been able to get in place and the challenges around -- it was more around state pay rules and, you know, state capitals being located in undesirable places. I think a lot of the things that they brought up were not areas where -- they didn't speak so much to those kinds of

areas where a difference in the federal incentives might matter.

COMMISSIONER RILEY: Well, but all the more reason -- all the more reason, exactly right, because Augusta, Maine, is not an attractive place. Lansing, Michigan, may not get the same people that Boston does. But all the more -- Jefferson, Missouri. But all the more reason to have the capacity to have a College of Medicaid Knowledge. You know, we've got a place where people can go to learn how to go after fraud, but we have no place where people can go to prevent it.

CHAIR ROWLAND: I think that that's an important point, and I think looking at the match issues are part of what we as a Commission recommending to Congress -- those are steps Congress can take to try and improve the resources. states may have many work-arounds they can use, but I think our responsibility is to say what impediments are there at the federal level that keep states from being able to develop the capacity they need.

COMMISSIONER COHEN: Can I just make a pitch, though? Again, channeling maybe Alan Weil and Mark McClellan. We can say that -- we can point out that the

match rate is unfair, and we can say that the match rate should be different and states would, you know, have more money available to hire. But in this day and age, would we not be making a better, a stronger kind of case to Congress if we said here are -- do this in a package that says here's five measures that go along with it and show us that you're going to do better on those. In other words, link extra money to some outcome that we help to identify, and by -- or measure that we help -- and by identifying what the priorities are, it feels a little bit less like just, you know, a cost shift from one government entity to another. And I'm not saying there's anything wrong with that, but to something that you can show there will be a value add at the end of it as opposed to just a cost shift. And I feel like that's something that potentially we could do, at least identify the areas of priority or the areas of substandard performance that could be linked to a bump in payment, instead of just talking about the bump in payment.

EXECUTIVE DIRECTOR SCHWARTZ: And I believe that the match rate -- and I'm probably going to get myself in trouble here, but Moira can bail me out. On the eligibility and enrollment information systems, it was not

just report your expenditures on that line item, but it must have these types of criteria. Correct?

MS. FORBES: Yes, there were characteristics -- they did more to tie the additional match for updates to eligibility systems to specific standards that those systems had to reach, in terms of interoperability and being modular and things like that, where previously money had not been tied to sort of quality goals like that.

CHAIR ROWLAND: Or like the CHIP performance bonuses.

COMMISSIONER CHECKETT: You know, in the vein of just brainstorming and as part of this discussion -- and I think we've talked in the past, but saying these are the skill sets, now you can get them through consultants, you can get them through staffing, we don't so much care where you get them, but these are the things that any entity that is responsible for managing the care of, you know, millions of people and the costs of their health care, these are the skills and functions you should have. And I think, you know, in a report to Congress or some type of brief or something, I think that could be of value.

Frankly, I was meeting with legislators in one

unnamed state, and they actually asked for that, because they were saying, "Is there anything like that?" Because they're trying to figure out why they're having trouble managing their Medicaid program.

And, you know, it is surprising in some of the states just the lack of sophistication -- not surprising, but the lack of sophistication. Why? Because this health care industry has grown so quickly. You know, in the company I work for, it's a race for talent. We can't hire fast enough the brightest, best people that we would like to have because everybody else is trying to get them. So, you know, a state Medicaid agency trying to compete with that is just very challenging.

So I think a service could be done. I love Andy's idea about even linking it, but I'm in the more basic of I think we just need to educate lawmakers, state and federal level, and others, this is the basics of running a program this big, because I can assure you, many states are not there.

CHAIR ROWLAND: I'm sorry Chuck had to leave, because I also remember him saying that every Medicaid agency was a training ground for the consultants who came

back and charged seven times as much to work for them.

MS. FORBES: And one of the roundtable participants suggested that that was a recruiting tool. Tell them it's their golden ticket.

CHAIR ROWLAND: Okay. Well, this has been a great conversation, and I think this is clearly an area where the performance standards, the training, the capacity, a lot of good ideas here, but this has to be an area where we continue to focus. So thank you.

And now if there's anyone from our audience who would like to offer any comments, please feel free to come forward.

PUBLIC COMMENT

* MR. JONES: Hello. Good morning.

CHAIR ROWLAND: Good morning.

MR. JONES: Hi. My name is Tim Jones. I'm the Director of Government Relations at Altegra Health. Our company helps Medicare Advantage, low-income beneficiaries enroll into Medicare savings programs. We act as an authorized representative. And so I'm sorry I wasn't here to comment at the end of the day yesterday. I had to leave early. But I just wanted to go back to your session

yesterday and thank the staff and the Commissioners for all of your interest yesterday in highlighting some of the difficulties associated with enrolling low-income beneficiaries into Medicare savings programs.

As you may remember, a couple months ago we sent a document for your review that highlights some of these issues. So we're happy to work with you in whatever way possible moving forward on this issue, because at the end of the day I think we're all committed to helping those who are eligible but not yet enrolled enroll in these programs as efficiently as possible.

Thank you very much, and have a good day.

CHAIR ROWLAND: Well, thank you, and please continue to share any information with the staff and with the Commission.

Now, with that, we will adjourn this meeting, but I want to remind everyone, especially the Commission members, that the next meeting is March 24th and 25th. That is a Tuesday and a Wednesday, not a Thursday and a Friday, so please come on Tuesday and Wednesday. And it is going to be held at the Washington Convention Center, so please don't come to NGAUS. Please go to the Washington

Convention Center.

EXECUTIVE DIRECTOR SCHWARTZ: We will remind you multiple times by e-mail, but just the more times we can reinforce that, maybe your motor reflexes will put you in the right place.

[Whereupon, at 11:40 a.m., the meeting was adjourned.]