PUBLIC MEETING

Hall of States
National Guard Association of the U.S.
One Massachusetts Avenue NW
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Thursday, September 17, 2015
9:07 a.m.

COMMISSIONERS PRESENT:

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ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:07 a.m.]

Welcome, Analytic Plan for the Year Ahead

* CHAIR ROWLAND: Good morning, and welcome to this session of the Medicaid and CHIP Payment and Access Commission. We are pleased to be reconvening after the summer and to have a very full agenda for today.

But, as we open this meeting, we wanted to reflect on and remember Yvette R. Long, a health care advocate who joined our Commission in January as one of our new Commission members and has, unfortunately, passed away this August, on the 22nd of August. Yvette brought to this Commission a perspective that is much needed, that of the beneficiary community that these two programs serve, the challenges in trying to get better access to care for many of the most vulnerable in our society, and Yvette really will be missed here and leaves a big hole in our membership.

I would welcome any comments any other Commissioners would like to make for the record in reflecting on the contributions to improving health for the low-income population that Yvette made. Sara.

COMMISSIONER ROSENBAUM: Well, I have to say, I began my career representing welfare rights, not in Philadelphia, but in the welfare rights organizations in other parts of the country, and so having remained friends with people who continue to work in community legal services -- and Philadelphia is a particularly vibrant community. Welfare rights as a movement has remained quite active in Philadelphia, and people just thought the world of her. Her contributions are enormous, and, of course, we were all very privileged to have her on the Commission.

CHAIR ROWLAND: Andy.

COMMISSIONER COHEN: I admired Yvette for all the things she did other than her service on MACPAC and for her service on MACPAC. I am sure it was not easy to fit in. I think I really admired her work as a MACPAC Commissioner. She listened hard. You could look at her. She was really, really listening, and she spoke so far relatively infrequently, but her comments when she spoke were really thoughtfully considered, incredibly well delivered, and I admire that balance and will seek to emulate it.

CHAIR ROWLAND: And, so, we will also note on our website, we have noted Yvette's passing, and will perhaps

reflect on that in our next report to Congress, as well.

Yvette was part of our discussion at our retreat as we all got together to try to lay out for the staff an ambitious analytic plan for the coming year, and we wanted to just share very briefly the focuses that we will be having as we move forward during this year, the 2015 through 2016 work plan.

We will continue, as we will today, to focus on children's health and the future of children's health coverage. While we know that the CHIP program has been extended for two years, it leaves still open the question of how do we best provide for the coverage that CHIP and Medicaid have been offering to children. How do we assure that children's health is a priority going forward? What are the best ways to organize and finance that care?

So, we're going to be looking at the role that CHIP has played. We're going to be analyzing the implications of moving from a CHIP program to either Medicaid, or to employer-based coverage, or to coverage through the exchange. What are some of the major issues there? What are some of the challenges in organizing that?

And really looking at a fast time track there,

because we need to think about and move forward on what the policies should be in place before 2017 so we don't get up to the brink again with CHIP about to go away and how many children will be lost to coverage.

In our analytic activities, we'll be looking at state-specific actuarial analysis of out-of-pocket spending for children in CHIP versus exchange plans, including those with high health care spending, and especially those children with special health care needs.

We'll also be looking at analyzing the impact of fixing the family glitch on access to coverage and looking at analyzing the various policy options for coverage of children in the current CHIP income range, including the role of Medicaid, use of Medicaid or CHIP to wrap around other sources of coverage, changes to exchange coverage, and focusing on children as a bridge plan between the exchange and between the Medicaid program.

So, it will be a very ambitious analytic agenda and many of the staff -- we have pulled from across the Commission staff to really be able to focus on those.

And then as just yesterday, listening to the Census report come out on the uninsured numbers and the

decline in the number of uninsured, including a decline in uninsured children, we'll continue to look at the impact of the Affordable Care Act on Medicaid and CHIP. We'll look at what the new adult group coming onto the Medicaid program looks like, what their key characteristics are, how they're accessing services, what the differences are in what's going in terms of coverage between the expansion and non-expansion states, but especially looking at what the experience of the expansion states is in terms of utilization and access for the newly covered population.

We'll also be trying to look at how the impact of wellness incentives, cost sharing requirements, and other kind of waivered services are making on the Medicaid population, and we're looking at the impact of some of these expansions on providers, particularly safety net providers.

We do have before us a major requirement from the Congress to report on the DSH program, and we'll be taking up that discussion later this afternoon so that we will be really looking at how the financing of health care services is changing with the Affordable Care Act, especially for those safety net facilities.

We'll be looking back at how the new coverage options and eligibility processes enacted under the ACA are working, especially in terms of the MAGI and the smoothing out of some of the eligibility processes.

And we'll be looking at the impact of newly eligible beneficiaries compared to those who are previously eligible to see what differences there are in their spending utilization and services.

And, finally, we would not be able to continue our work unless we really looked at the fact that it's not just making someone eligible for Medicaid or CHIP, it's how those services are delivered. So, there will be a big focus on improving the delivery system and the payment reforms. This is going on in every state, regardless of whether there has been an expansion or not. This is where the health care is moving, and this is an area where we want to really look at what the best trends are, what some of the best practices are, how is that affecting Medicaid spending, what kind of balancing is going on.

There's currently a lot of new interest in high-cost prescription drugs, which undoubtedly will have to be part of our agenda, as it is of every health care

provider's agenda right now.

And we'll be looking at ways in which Medicaid could potentially be containing costs while improving quality. So, that focus will continue, and our focus, of course, will always be on where are the access gaps, where are the payment problems within the program, and how can we move to help Congress figure out better ways to manage and pay for the services to make sure we get good value and good quality and reasonable access for the poor and those who have disabilities and other challenges that depend on the Medicaid program for their services.

And, lastly, we all know that there are administrative burdens and administrative strains and that the capacity to really manage the program and the capacity to deliver services effectively depends on having adequate staffing and good administrative structures, and so that will continue to be a focus of the Commission's work, as well as identifying where we need data and better information, better information systems to be able to both evaluate the program as well as to run the program itself. So, we will continue to focus our efforts on trying to figure out what some of the better strategies are for

minimizing burden but getting the information that's necessary.

So, with that, I think we have a very full agenda going forward and I hope that we will be able to answer many of the questions that hang out there for the Congress and others about how to improve and manage both Medicaid and CHIP in a more effective manner so that they fulfill the promise that they make to deliver high-quality health services to the populations they serve.

And, any other additional comments from the Commission members on our agenda, or from Anne, as the Executive Director, would be appreciated. Is it a full enough agenda?

EXECUTIVE DIRECTOR SCHWARTZ: I like that you said we're going to answer all the questions.

[Laughter.]

CHAIR ROWLAND: We'll see what we can do.

EXECUTIVE DIRECTOR SCHWARTZ: We'll seek to answer.

CHAIR ROWLAND: Okay. Well, with that, then we will get onto the future of children's coverage and next steps, which is the focus of our discussion this morning,

and I'll ask Joanne and Chris to please join us at the table.

And, as I said, the purpose of this session is really to restart and reset the Commission's conversation on the future of children's coverage so that we can really develop a long-term approach to coverage and our analytic work will support our recommendations to the Congress on how to proceed.

Joanne, are you going to kick it off?

Session 2: Future of Children's Coverage: Next Steps

* MS. JEE: Yes. Today, we're returning to the issues of adequate and affordable children's coverage, and we have three presentations to share with you.

First, we're going to begin the discussion on approaches to children's coverage and lay out for you a general framework to help you begin your consideration.

In the next presentation, we're going to highlight some findings from a recent study on how states implemented the transition of stairstep children, or children with incomes below 138 percent of the federal poverty level, to transition from separate CHIP to Medicaid.

After that, Chris is going to provide some estimates on children's coverage enrollment under different policy scenarios.

In our first presentation, we're going to very briefly review the Commission's work to date, and then talk about the current policy context for children's coverage. Chris will then share with you some data and analyses on characteristics of low- and moderate-income children to help paint the picture of who these children are. After that, we'll kick off the discussion of some broad approaches that, Commissioners, you could consider over the coming months. Finally, we'll ask for your input and guidance on these approaches to help inform our next steps on the analytic work ahead of us.

As you will recall, the Commission's work to date has focused primarily on the immediate consequences to children losing separate CHIP coverage if the program spending were not renewed. It wasn't until April 2015 that the funding renewal occurred. Thus, MACPAC's analyses focused on what would happen to these children if they moved to the exchange, because at the time, exchanges were the likely coverage alternative. And as part of the June

2014 report and recommendation on CHIP funding, the Commission highlighted the need to address affordability and adequacy of children's coverage, including in the exchanges.

Specifically, our analyses included comparisons of CHIP and exchanges in terms of affordability and benefits. We looked at provider network adequacy and likely sources of coverage in the absence of CHIP.

Commissioners have since then indicated that upcoming assessments of children's coverage should consider ways to ensure affordability and adequacy of coverage for low- and moderate-income children and not just those who would lose separate CHIP coverage.

Since passage of the ACA, the Affordable Care Act, the policy context has changed and it now points in a few different ways to the need for a broader approach to children's coverage. First, CHIP funding is renewed through fiscal year 2017, and while this addresses the funding issue for the next two years, the question of CHIP funding will come up again within those two years.

Second, the maintenance of effort for children's

coverage expires at the end of fiscal year 2019, which means that in fiscal year 2020, states can roll back their Medicaid eligibility for children back to the mandatory levels.

And, lastly, CHIP is now sandwiched between Medicaid and the exchanges, and for some children, employer-sponsored insurance, and there are meaningful differences both across states and the coverage sources which may affect families' ability to purchase coverage and get needed care. Areas where we see such differences include eligibility levels, premiums and cost sharing, and covered benefits. Table 1 in your meeting materials, which is behind Tab 2, describes the various coverage sources.

So, we're going to look at an example of state variability and we're going to look at eligibility to illustrate that. So, this slide is a little overwhelming, perhaps, at first blush, but the key take-away here really is that as you look to approaches on children's coverage, to remember that there are different starting points in different states.

So, Chris put together this chart, and it shows Medicaid and CHIP income eligibility levels by age group.

So, as you move from left to right across the chart, you have the first group, which are infants; the second group, the one- to five-year-olds; and the third group, which is the six- to 18-year-olds. And within each age group section is a vertical bar which represents states' eligibility levels. The dark blue portion of the bar is Medicaid. The portion of the bars that have the blue diagonal lines represent Medicaid expansion CHIP. And then the green portion of the bar is separate CHIP.

So, what you can see here is that states really vary in how they're covering children, particularly those above 138 percent of the federal poverty level. So, these differences, as well as differences in the areas I mentioned from the previous slide, mean that the approaches you'll be considering over the coming months will have different effects on different families in different states.

Commissioners, you've identified policy questions where our analytic work should focus --

CHAIR ROWLAND: I'd like to say that this is a very complex chart, but it's a very informative one and it really does help you see where the different income cuts

are. So, Chris and Joanne, thank you for putting together something that lets us visualize what we've been trying to talk about as a policy issue.

MS. JEE: As I was saying, you have identified some policy questions to help direct our analytic work. These questions are, first, what policies should be in place before 2017 to assure adequate and affordable coverage for low- and moderate- income children, and there are a number of sub-questions within this question that should be addressed. With respect to benefits, what should the core benefits be for low- and moderate-income children, including medical, dental, and behavioral health? And what policies are needed to ensure that children are receiving those services?

Second, on affordability, how much out-of-pocket spending, including both premiums and cost sharing, is appropriate at different income levels? And for children with high health-care needs, are there any special considerations, for example, with respect to affordability, benefits, care coordination, and access.

And, lastly, on transitions, what are the elements of an appropriate transition plan for low- and

moderate-income children, and as I mentioned, we'll be returning to this topic a little bit later this morning.

The second major policy question that you have identified is under what circumstances should CHIP funding be renewed after 2017?

So, these are big questions and we will be presenting to you approaches on children's coverage that you could consider over the coming months to help get at these questions.

Before we move to those approaches, though, Chris is going to share some data on key characteristics of low- and moderate-income children.

* MR. PETERSON: Thanks. Commissioners, you have asked for information on low- and moderate-income children, particularly those in the income range of 139 to 200 percent of poverty, what we typically think of as the typical CHIP income range. And you have requested that information not to be broken out by --

[Technical interruption.]

MR. PETERSON: So, again, you've requested this information not to be broken out by type of insurance because you want a better sense of who these children are

regardless of where they are getting their coverage. So these are the statistics we want to share today. In particular, we want to look at the attachment these children's families have to the workforce and also how children's health differs across the income scale -- again, regardless of their sources of health insurance.

So, first, let's look at the share of children who have a working parent. On the far left, we're looking at children in the typical Medicaid income range, up to 138 percent of poverty. And even among this lowest-income group, the majority -- 54.7 percent -- have a parent who is working full-time.

It is a significant jump to the next income group in the typical CHIP income range, and the rest of these bars are divided basically based on current exchange policies, so up to 250 percent of poverty, you know, the eligible families receive both premium assistance and cost-sharing reductions for exchange coverage. In the next category, 251 to 400 percent of poverty, cost-sharing reductions are no longer available, but they may qualify for premium credits for exchange coverage. And then above 400 percent of poverty, there are no exchange subsidies

available, and as you see, 95.4 percent of kids in this income range have a parent working full-time.

We also want to know about the availability of employer-sponsored insurance to children, and this slide shows how the percentage of children with a parent offered job-based coverage differs significantly by income. The numbers you see here are a function of two factors: first, as you saw in the last slide, attachment to the workforce increases with income; and, second, the full-time jobs those higher-income parents have are more likely to offer health insurance. Both of these factors contribute equally to the percentages that you see here.

All right. Now let's turn to children's health status. The lowest-income children have the worst health. The highest-income children, above 400 percent of poverty, have the best health. And the children in the middle three groups are pretty similar. For example, looking at the percentage who are in fair or poor health, the top part of the bars, that's a common way to identify the sickest children. And on this measure, there is no significant difference across the three groups in the middle.

So now going to the next slide, Commissioners

have also asked: What are the types of conditions that account for the largest share of children's health care spending? And thinking about your concerns regarding the affordability of coverage, really the question is: Is most of their health care spending on chronic conditions that we can identify in advance and say, well, we know this child is going to need additional cost-sharing assistance or maybe additional benefits in the upcoming year? Or is their spending going to be on acute conditions that could affect any given child and we really can't predict which one is going to have the broken leg, for example?

For children at 139 to 200 percent of poverty, this slide shows that acute conditions make up almost half of their health care spending during the year compared to a third for chronic conditions.

COMMISSIONER GABOW: What's other, if you are not preventive, acute, or chronic?

MR. PETERSON: So that would be care for where diagnoses are not provided with that, and so that could be payments for supplies, equipment, eyeglasses, ambulance services.

COMMISSIONER GABOW: Thank you.

COMMISSIONER COHEN: I'm sorry. Just also on this slide, can you just talk a little bit about acute versus chronic conditions? Does that mean like an asthma exacerbation that hospitalized you would put you -- that would be a chronic condition or an acute?

MR. PETERSON: So I think in that scenario -- actually, I'm not 100 percent positive on that. So let me refresh my memory on that before I answer. I feel like that's going to be chronic, but I would want to double check that.

And on this last slide, for my part -- and then I will turn it back over to Joanne -- finally, you've requested information on family budgets. Across children's income groups, where do families spend their money? And above each bar, you see the total amount spent by households with children on average, and not surprisingly, the more money they make, the more they spend. You also see in the dark blue portion at the bottom of the bars is that lower-income families end up devoting a larger percentage of their income to basic living expenses, even if that dollar amount is less than higher-income families.

So, for example, the lowest-income families are

devoting 83 percent of their spending to basic living expenses. That's compared to a lesser percentage, 69 percent, for those above 400 percent of poverty. But even so, the lowest-income families are spending $25,546 on basic living expenses, and that's less than half of the $63,816 spent by families above 400 percent of poverty.

So there are more details in your memo, Commissioners, but we hope that this gives you some additional insights on these children's characteristics, and with that, I'll turn it back over to Joanne.

MS. JEE: Thanks. So now we've heard about the policy context and some of the characteristics of low- and moderate-income children, and we will go ahead and just talk quickly about some broad approaches.

We've identified five broad approaches for providing affordable and adequate coverage for low- and moderate-income children that you could consider over the coming months. They're listed on your slide, and I'll just quickly run through them for you.

The first is enhancing exchange coverage, and this could be done through such as providing additional subsidies or by addressing benefits in the exchanges.

The second is expanding the minimum Medicaid eligibility level for children, so rather than 138 percent of the federal poverty level, a new minimum could be set at a higher level, such as 200 or 250 percent of the federal poverty level.

The third is replacing CHIP with the new bridge program that would help smooth out the differences between Medicaid and exchange coverage in terms of cost sharing or benefits, or both.

The next approach is to extend CHIP permanently, and the last approach here on the slide that you might consider is to retain current law with no changes. This would mean that CHIP funding would expire in 2017.

There are several considerations for assessing the approaches, some of which are listed here. For example, how many children would be covered under any of the approaches and how many would be left uninsured? What is the adequacy of covered benefits within the approaches? What is considered affordable? What are state and federal operational issues that should be considered? How would financing be structured? And how much state flexibility is appropriate and within which areas? And, of course,

Commissioners, there may be several others that you would identify.

This slide simply brings the approaches and considerations together so you can see how they fit. To inform your evaluation on each of the approaches, we plan to bring you analyses and information on the various considerations which we just listed. We plan to provide you the information as they become available over the coming months, and, in fact, later today Chris will be sharing some estimates on children's coverage under some hypothetical scenarios which might help us begin to fill in this grid.

So today we've really just begun the conversation on the approaches, so for today your input on the approaches, and specifically whether these are the right ones, whether some others should be considered, or whether there are any hybrids of the approaches, would be very useful as we, the staff, move forward.

Additionally, input on the considerations would also be useful. Should any of the considerations take priority? And are there others that we should be thinking about? Your guidance will help us in our ongoing work to

provide you the information and data for your consideration.

Thank you.

CHAIR ROWLAND: You know, I would think that one of the other considerations we might want to add is the delivery system that would go with any one of these, because the way in which care is delivered could affect the way that option works or, you know, it may be to create a managed care package that works for children in different settings.

And now are there comments?

COMMISSIONER RILEY: Thanks. I thought the approaches were great until I read the next section, where we see that even when you do those approaches, you leave significant numbers of children uninsured. So it strikes me there might be some hybrids or some additions if we recast ourselves around how will we -- rather than CHIP, how will we cover kids? How will we make sure kids are covered?

One area that I'd be intrigued to have us look a little bit more at, especially when you look at the access to employer-based coverage for CHIP kids, 60 to 70 percent

of kids have access to employer-based coverage. We know there's a requirement for child-only plans even though they're not really child-only plans. But, you know, what kinds of strategies would work for employer-sponsored coverage? Because that is still an option.

And another option I would think about is, especially when we get into our later work, how could we convert the CHIP funding to additional subsidies to make a program affordable -- you know, admittedly we have to deal with the benefit itself, but to make it more affordable? So I think those two issues, ESI/child-only and thinking through could you convert CHIP funding to be a stronger subsidy.

COMMISSIONER ROSENBAUM: Yeah, I just want to echo Trish's point. I think that we might -- and I had the same reaction, which is that when I read the later materials, then I was sort of struck by the hill we have to climb here. I think that everything -- I think that for working-age Americans, at least in our heads, employer-sponsored coverage remains the default.

Now, I know, certainly at my own employer and I know from everybody else in the world who has employer-

sponsored coverage, that employer-sponsored coverage for dependents is on a tremendous downward slope. From the work I did with Jenny Kenney last year, just charting the 30-year decline was an eye-opening experience. And I think as the Commission, in approaching a child health policy, we need to start by asking ourselves the question of whether we think it's a good idea for purposes of reaching children and reaching children with good coverage to try and keep this as the default -- keep employer-sponsored coverage as the default for children and working families.

The problems are not just the affordability of the premiums, obviously. We are now quickly at my own employer, the largest private employer in Washington, moving toward a world in which families are going to have easily $12,000 deductibles. And so even if there's an argument for trying to maintain children in their family's plan, we end up potentially with an illusion of coverage for anything but preventive benefits.

And so I think in unpacking our options, we have to back up and demonstrate for Congress where dependent coverage is going generally, and then lay out the choices, including, as Trish points out, the choice of trying to

repair employer coverage or have that on the table as part of the mix along with switching over more or less to public coverage. And if so, then how do we do that?

CHAIR ROWLAND: But I'm thinking that it's also important to keep that slide that you showed, Chris, of the family budgets and really to have -- it's not just the $12,000, but it's what that $12,000 does at a different income.

COMMISSIONER MILLIGAN: I thought the data was great. I appreciate the work you all did since the last time we saw you. Two quick comments.

One is I think when we say one of the approaches is retain current law, I think we just need to be very explicit what we mean by that, because I think part of what we mean by that includes the current optional coverage under Medicaid, not just sort of the baseline assumption maybe that CHIP is going to sunset or something. But I think we have to keep in mind that the current law also gives some options to states about expanding Medicaid for kids, because I don't -- I want to be careful that CHIP isn't -- that we in some ways unpack CHIP as a program and CHIP as an enhanced funding source, because states have the

option to expand Medicaid and address a lot of the problems about benefits and cost sharing. It's just not with enhanced funding. And I think we need to be very explicit about what we mean by the current law.

And the second thing is that one of the considerations I would add to the bulleted list about considerations is equity or variability across states or something like that, because I do think the bar chart that you highlighted was very helpful and very good. And I think one of the notions about CHIP that is often lost in the discussion that that chart highlights is where CHIP programs are now in many states is based on where Medicaid was in 1997 in many states. And I think we need to have as a value or as a consideration the fact that a lot of the rest of the publicly financed insurance framework in the ACA and otherwise has removed a lot of variability, and that the considerations for CHIP we need to, I think, keep an eye on the equity and variability piece of this, too.

COMMISSIONER GABOW: Thank you for the report, and I'd like to echo the issue of uniformity and equity. I think it's an issue that we haven't dealt enough with, with Medicaid, particularly expansion/non-expansion, and, you

know, are we one country or not? Is everybody an equal citizen? Is everyone an equal person? I think that's important.

The other thing I'd add to the grid is simplicity. Does it drive us towards a more organized structure and simple approach to health care for the country?

The second area of comments I want to make gets back to this chart, which I think -- of basic living expenses, which I think is really important not just for CHIP but for Medicaid. And I think we should maybe think of doing something to expand on this because I think there's a bigger story. This chart's important, but there's a bigger story to this chart that, as we think about cost sharing, premiums, we need to look at it. And I would say there are a couple things I would like to see added to this picture. One is, as you look at these income levels, what other resources do these families access in order to survive. So if you're under 138 percent and you're spending 83 percent on basic things, are you also getting SNAP? Are you also living in subsidized housing? I mean, there are -- what does it take to live at this, and

what other things are you accessing?

And I think the other part is -- and maybe this data just doesn't exist. What is the savings that people have? Because this group, the poorer you are, the more often you have an unexpected expense. You know, you have a terrible car, so it breaks down. You're living in a poor house, so the roof leaks. I mean, it just seems like you're always kind of on the edge. So some way of assessing how precarious things are in these income levels, you know, how often do they get evicted -- I don't know. It's just we need a better picture, I think, as we look at what's happening with cost sharing and premiums and really understanding what is affordability if you're at 200 percent of federal poverty.

And I also think it's always worthwhile, when we publish anything with these scales, to put some reference point that what is 200 percent of poverty if you're a family of four. I mean, probably everyone in this room knows it, but I'm not sure all of our readers of reports know that. And it's a startlingly low number.

CHAIR ROWLAND: Patty, I think you raise -- I mean, this is an important piece of our consideration for

children, but I think you're raising an even broader request that would be very important, I think, for the Commission's work, which is to really look at low-income families and all the challenges, whether they're on Medicaid or on CHIP, whether it's a family with children, because certainly we see some of these same things in the newly eligible population of adults that's coming on to Medicaid in terms of their ability to afford some of the cost sharing they may have to face. So we'll just add that to Anne's analytic agenda, but we'll also keep that focus here in the CHIP discussion.

Sharon is next up.

COMMISSIONER CARTE: Well, I have to begin by saying that, as a sitting CHIP director, how truly grateful I am that Congress made the decision last April to continue funding so that I'm not faced -- in a state where our CHIP families would be faced with a lot of uncertainty at this time. I'm really grateful.

I'd like to really thank Joanne and Chris for these charts and the data. They really start to help us look at different ways we could take a slice out of the apple. And I'm anxiously awaiting the ACS data that will

be out to the public next month because I think -- I know that for our state, as a state that had a Medicaid expansion, we did bring in many additional children. I'm interested to see how many states might be at 95 percent or above in their coverage of children right now. That would be an important question, because I think many states will be at near-universal coverage. But of course, we do face these challenges of affordability for families.

And I think that Patty raises an important question about health equity of children, so we have a lot of work ahead for us, I think, on CHIP.

COMMISSIONER RETCHIN: Thanks. Chris, could you go back to the slide on basic living expenses and just -- since a number of Commissioners commented. Yeah.

Just so I understand, the definition of basic living expenses must come from the Consumer Expenditure Survey?

And can you just sort of list or just give a sense of the multiplier effect of 25 to 64? Is there any sense or definition there? Because this is a pretty important slide.

Well, so basic living expenses, people are

obviously spending more as they earn more, and yet it's a lower proportion. I understood that, anyway. But just in terms of definition -- because this really gets at the very issue or sort of the myth that the poorest poor make these utility tradeoffs, that instead of a copay, they may be purchasing something that's not needed. And yet if you look at the lower end, I mean, those really are -- just sort of in terms of definitions, I think that's an important part of the slide, because this really hit home for me looking at the less than 138 percent of federal poverty, how great a proportion of the income that is for just basic living.

And I think Patty's point about catastrophic or less than catastrophic events, that can really tip somebody over, and yet faced with a -- what it really brings home for me is like a $5 copay to go to a non-emergent visit to the emergency room and how that can really tip somebody over.

The other point or comment, I guess, I would make is, as I read the materials, what came home to this internist, not knowing enough about pediatrics, Peter, is it's almost like a policy canary. That here we are, the

Medicaid program by far is the most complex government-sponsored program for health care, and then the subset for children, for insuring children, is by far the most complex fragmented. And it seems to me with the clock ticking on us over the next two years, if we do anything, it would be to simplify, get out some of the seams, fix the family glitch, the stair-step problem, because this seems to me the most -- it was clearly complicated in terms of policy choices.

CHAIR ROWLAND: Sheldon, I think that this reflects what you can get from the Consumer Expenditure Survey. When one does analysis of family budgets, when you go to a family and say, "Show me how much you spend on this, how much you earn," we've never been able to get those budgets to add up. They always have some debt, and I think that looking at sort of the debt factor in these low-income families is also important.

COMMISSIONER RETCHIN: Well, just to expand on that, I think that's such an important slide to get to especially the lower bar when directionally at 83 percent -- so it's 80 percent, but directionally, it really is a powerful slide.

CHAIR ROWLAND: Peter, you're up.

COMMISSIONER SZILAGYI: Yeah. First of all, thank you for both the systematic and thoughtful approach and the very helpful data. Actually, I had many points that were already stated, but I just want to emphasize a couple of new points.

CHIP is one of the programs that have been the most well -- that's poorly stated -- the best studied, and not only has CHIP reduced the number of uninsured, but it has really improved quality of care and health outcomes. It's just been better studied than many other programs in children.

So for me, it's not an approach, but kind of a principle. There's a principle in medicine called primum non nocere, "do no harm." And so, to me, this is kind of a policy approach that given a health care delivery system that has been shown to be quite effective, we should come up with the multiple approaches or the hybrids that do no harm for this level of population.

Second point is I'm struck by kind of the juxtaposition of this slide and your slide that showed the chronic, the percent of kids with fair or poor health or

good health. Multiple studies, several that I've done and others have done, show that there's a little bit of a stair step in terms of health or unmet needs, but for the most part, there's nothing magical about 100 percent of poverty level or 138 percent of poverty level. If there is a drop-off, it's much more at around 400 percent -- or somewhere between 300 and 400 percent of the poverty level.

So if one of the measures that you might consider looking at is called unmet needs, these are measures in many of the national datasets, and it reflects very much a patient-centered approach where people ask parents what are the health care needs, very specific, then oral health, medical health, mental health, and have those needs been met.

If you look at unmet needs, in this graph you will find that they're very similar up to about 400 percent of the poverty level; somewhere between 300 and 400 percent. So my point is that the health care needs, the chronic diseases, the unmet needs, they don't go down at one of these levels until you get way to the right-hand side of the slide, near 3- to 400 percent of the poverty level. So we have to do something to reduce those unmet

needs and to take care of the population, and I would strongly advocate for making that cutoff, if there's going to be a cutoff, significantly higher than 138 percent.

Maybe my final point is many people, very smart people, are arguing that old-fashioned designation of the federal poverty level should be changed, and if you include -- I won't get into details about how the poverty level is defined -- and it goes back way many, many decades ago, but there is a strong argument that the federal poverty level should -- actually be much higher than it is right now, which would basically mean that far more children are poor than we are designating as poor.

CHAIR ROWLAND: Marsha.

VICE CHAIR GOLD: Yeah. There was a lot of discussion of CHIP when I was not on the Commission, so pardon me if some of this doesn't match.

But I do think it's important to not get so expansive that we don't deal with the policy dilemma Congress has, which is what happens if CHIP goes away in 2017. I do think it's important that we look at all children, but all children within that context, and we have existing programs out there. We have Medicaid. We have

the exchange. We have employer-based coverage. And I think if CHIP goes away, one thing, this is maybe minor, but it was in the context of some of the writing and the text we saw, not in the presentation. It acts like it's just the standalone CHIP programs, but that's not it. It's also the Medicaid link, which is even more substantial. Maybe it doesn't happen right away. Maybe it's 2019. Maybe people do other things to cut coverage.

So I think we do that, and one of the things I'm wondering is instead of just saying, "Here are these neutral criteria, and we're going to look," whether we should be a little more normative about what we're trying to accomplish. And it seems like if CHIP were to go away, we want to limit the impact on coverage within some sense of a budget constraint. And I don't know how we put this in because Congress will have a budget constraint. How do we take into account the differences in relative need across children on the income scale so that we're dealing with all children, but maybe the subsidies are geared towards the lower income?

I think we want to reduce the state variability, especially from the bottom up, by raising it.

We want to minimize the transition problems across, when people cross them, and I think that's probably analytically more at the lower income scale. But I'm not sure that's an analytical question.

And we want to consider, assuming any kids were going to be in the exchange, how to make the exchange coverage work a little better for children because it wasn't really considered that way.

And so it seems to me that while we may have all these different options, this hybrid that people are talking about is likely to be, if one had some normative sense, where we'd get up to. You'd raise the Medicaid level at some level. We'd made the exchanges better for kids, make the bridge programs if states want them, can do them. I don't understand as much about them as other people.

So I'm thinking how do we avoid making it so theoretical that we don't come down to the real issues that Congress is going to have to deal with as it struggles with what happens in 2017 because I don't think they're going to take a totally new program and create it, but they have an existing reality they have to deal with, and we have some

existing programs that could be changed.

CHAIR ROWLAND: And we have to keep Patty's simplicity in mind as we go forward with that too because we're trying to streamline, not to create more complications.

I have Andy, Chuck, Donna, Steve.

COMMISSIONER COHEN: I'll be quick, but I also really want to compliment you for just a crystal-clear presentation and just sort of way of engaging us in this conversation. There's a lot of, obviously, really meaty issues in here.

I just want to echo Diane's comment about the importance of having the sort of impact on delivery system as a factor for consideration and evaluating the various options, and I think that we just have to recognize that for pediatric care, public programs are really sort of -- are dominant payers. I mean, it's really significant.

And changes in whether or not a significant group of children are going to be served by Medicaid, which in most states is a very low payer or in a more commercial plan, it will have an impact on the delivery system.

I don't remember, actually. It might be nice to

get a little bit of a review of sort of like the specific access literature on kids in Medicaid and other things, but I just think that factor is extremely important and may be more important for this population than for others.

COMMISSIONER CHECKETT: Well, again, I will echo everyone's compliments on great work, and my brain is reengaging this week on CHIP again and Medicaid and last from important policy issues.

A couple of these are really minor points, but on slide 9, I am looking at the title, and it says -- if you could go to it, it says, "Most low-income children have a working parent." I just want to question when we're showing a graph of up to 400 percent of poverty. Do we really want to be saying low-income or perhaps low-income and moderate-income?

MR. PETERSON: Well, this was just to --

COMMISSIONER CHECKETT: Or am I misreading it?

MR. PETERSON: -- provide the whole landscape, and our focus was on the lower income side of this income scale. So this chart actually shows all incomes.

COMMISSIONER CHECKETT: Right, right.

MR. PETERSON: And so our point was just to say

some may have some different "a prioris" coming into this that the lowest income families don't have a working parent. I mean, I think we all would kind of expect above 400 percent of poverty, you're going to have working parents.

COMMISSIONER CHECKETT: Right.

MR. PETERSON: And so the point was just to bring home the message.

COMMISSIONER CHECKETT: You're -- or trying to counter an assumption that people -- that low-income kids don't have parents who aren't in the workforce. Okay. Sorry for the --

CHAIR ROWLAND: Actually, it's most children have a working parent, and even low-income children have a working parent.

COMMISSIONER CHECKETT: Right. It threw me a little bit, but if I'm the only one, now that you're explaining it in front of a whole group of people, it's fine with me, so great. I probably need more coffee.

And so I'm going to ask another question because maybe I'm just being dense again this morning on this. So on slide 13 -- and if I am, then I'm not going to raise my

hand the rest of the day, which will be extremely unusual. When we're saying households with children devote -- it might be the same thing -- devote larger share of spending to basic living expenses, so is it only? I guess I'm having trouble with households with children, or all these households have children or -- okay.

MR. PETERSON: Yeah. What we are looking at here --

COMMISSIONER CHECKETT: And none of the households on this chart have children.

MR. PETERSON: All of the households in this chart have children.

COMMISSIONER CHECKETT: Okay.

MR. PETERSON: All of them.

COMMISSIONER CHECKETT: All right. And so --

COMMISSIONER ROSENBAUM: But we don't have the comparison.

COMMISSIONER CHECKETT: We don't have the comparison. Maybe that's what's lacking.

EXECUTIVE DIRECTOR SCHWARTZ: I think what you're picking up on, Donna, is that we were trying not to -- we have a mix here of titles that say what you will find on

this chart and things that are trying to sort of make it have a takeaway, and we probably need to be a little bit more careful in doing that.

COMMISSIONER CHECKETT: In what the -- yeah -- the takeaway is.

EXECUTIVE DIRECTOR SCHWARTZ: Right. Right.

COMMISSIONER CHECKETT: Oh, okay. Thank you for --

EXECUTIVE DIRECTOR SCHWARTZ: Yeah.

COMMISSIONER CHECKETT: Because to me, this was -- I got what you were saying, but it didn't actually say that the only households on here --

EXECUTIVE DIRECTOR SCHWARTZ: Yeah.

COMMISSIONER CHECKETT: -- are households with children.

EXECUTIVE DIRECTOR SCHWARTZ: And it's a fair point to make because we do put these slides up on our website for people who don't come to the meeting, so it's important that they are accurate and someone can look at the slide and understand what it means, whether it's what this chart is about or a takeaway.

COMMISSIONER CHECKETT: Right. Okay. Thank you.

And for the record, I am on Pacific time and so now just now waking up. Chuck might be there with me, so thank you very much.

MR. PETERSON: Right. So really we needed more words here, which is households with children who are lower income devote a larger share of spending to basic living expenses relative to those with higher income.

VICE CHAIR GOLD: Or else it's just basic living expenses account for a large share of the spending of households with children.

COMMISSIONER CHECKETT: Right. And I do appreciate you -- my question -- people really look at these slides, so I just want to make sure we're being real clear about the points that we're making, so thank you so much.

CHAIR ROWLAND: And I do think what we're trying to do here is not to -- our previous analyses have focused mostly on CHIP kids and what happens to the CHIP children and who they are and where they go, and what we're trying here is to take a broader look at children across the income spectrum and the differences that we may see for low-income children that need to be taken into account as

we develop policy to account for changes in the CHIP program.

And you're right. The titles always are the hardest.

Patty.

COMMISSIONER GABOW: Donna's question raises another question about this slide. You can see this slide has raised a lot of interest, but this is for families of three. And I think I've asked this question before. When we look at CHIP and Medicaid families, what is the average family size? And what happens -- I used to think that the number of FTEs to take care of two kids is not double what it takes to take care of one kid.

CHAIR ROWLAND: This slide is not about a family of three. This slide is about households with children. What you've got here is the poverty level for a family of three.

COMMISSIONER GABOW: A family of three.

CHAIR ROWLAND: But this includes families of all sizes.

COMMISSIONER GABOW: I see. So I think would be -- well, that confused me, but I guess I'm like Donna, not

enough coffee. But what happens -- I mean, what is the average family size? Do we know? And what happens if you go from one child to four children? It just seems like, as we're trying to think through this, we do need to know what are the family sizes that were actually average in this group, and where does that put you? I mean, it would seem that it takes more of your income if you have four kids than if you have one kid, but maybe -- I don't know.

MR. PETERSON: I will continue to look because we have that number. We have that number --

EXECUTIVE DIRECTOR SCHWARTZ: We have that number, and I think it's like 2-point something, something like that.

And I think again here, Patty, what you're picking up on is you have now put the fear of God in all of us to make sure that we always have the measure of what the poverty level is for some family size on the slide, so you know what it means. But this -- if I'm understanding it correctly, this is for families with households with children, which could be of variable sizes. This is the average at that poverty -- at that poverty level, which would be different, depending on how many kids in

households.

So providing more information seems to have somehow made it more confusing, and I think on the next round, in the spirit of continuous quality improvement, we can keep working on that.

COMMISSIONER GABOW: I'm sorry.

COMMISSIONER WALDREN: So, I agree. I think you guys did a great job. I also like the data visualization. I think that's very, very powerful and helps us quickly look at a really complex set of data and make some good interpretations. So, I applaud you in doing that work.

On the slide that talked about the conditions, one thing that I think we may want to look at is what are the types of services being delivered, meaning how much of that chronic is inpatient versus outpatient, how much of that acute is the same, how much is NICU versus ICU versus the regular floor, so we kind of understand what services are being done.

And the reason I say that is I'm also struck that it's almost like if we're talking about, you know, trying to afford a car, that we've been talking about coverage, we talk about kind of the financing. Well, how should we

finance that? We really haven't talked about how do we make the car cheaper and still an adequate quality.

So, if we start looking at some of those services, the other thing would be, is, well, what are some care delivery modalities or innovations that would actually lower the cost and make it more affordable without putting more money into the system, which we know is already a challenge for the system and for us as a nation going forward.

But, again, I think you guys did a great job on this.

COMMISSIONER MILLIGAN: So, I guess I mainly wanted to comment about Patty's comment and tying it back to Peter about poverty level and just make one comment about that. In some ways, I'm less focused on the average family size or the variability of family size. I think, really, what it gets back to for me is the poverty level is tied to household size. The issue is whether the poverty level -- the way it's measured and defined and determined, which dates back, as Peter said, to the 1950s, and based on how much it costs to buy groceries alone, whether that is the right way -- whether that elasticity of poverty level

matches the elasticity of actual cost incurred for another kid and then another kid.

So, I just -- mainly, I wanted to tie back to, to me, the issue it raises is this affordability and basic living expense pieces if a third member of a household or a fourth member of a household, in fact, the basic living expenses marginally increases it by $10,000, but the FPL goes up by $8,000, to me, that's the challenge. So, I just wanted to comment on that.

CHAIR ROWLAND: Well, as we've gone around, obviously, the poverty level and how it's calculated and how it varies across the country, even though we use a uniform national poverty level, it's a substantial issue, and many have argued that some of that variability you see in where states set the income eligibility level for CHIP is because the cost of living varies so widely across states and even within states, obviously. So, I think, that's another factor to really look at. I mean, what does it mean to live on 150 percent of poverty in Iowa versus what does it mean to live on 150 percent of poverty in New York City.

Peter.

COMMISSIONER SZILAGYI: One other new point, and this piggybacks a little bit on Steve's point, as we're trying to grapple with how we improve or maintain access and quality and reduce costs, it may be helpful to show some data about what proportion of children account for what proportion of costs.

So, I've seen one study suggesting that five percent of kids accounts for half of all children's health care costs -- no surprise, because those five percent are the ones that are extremely sick. But it makes you think about, okay, then if half of the costs are already taken up by only five percent, and that's not that different than the young adult world, you know, how can we save costs on the other 95 percent, or do we focus more on delivery strategies for the five percent and try to maintain or improve quality and reduce costs at the same time for that.

So, as we're kind of thinking about delivery systems and also access and quality, it might be helpful to kind of show that data, not just for hospitalizations, but in terms of what about the proportions of children, and that data would be available to you.

CHAIR ROWLAND: Andy.

COMMISSIONER COHEN: I hesitate to say this, but along the lines of Peter's comment, I did also sort of have this urge to understand a little bit better as I was reading this. You know, we talk about children as a sort of single group of zero- to 18-year-olds, everywhere except in the eligibility slide, where there's obviously significant variation. The lumping is a little weird there to me. It's, like, zero to one, one to six, and then six and up. But if you think about children and the life course and the kinds of health care interventions that they need, they're really different across that course, and I would -- and the lumpings might be a little bit different, and I would defer to real experts to say what they are. But, I mean, it's sort of young children, maybe school-age children, and sort of teens and adolescents and young adults.

So, in terms of, like, both expenditures, needs, and really focus, there's really significant differences among those groups and that sort of goes to the question of what's a good delivery system for them, what are the benefit needs, those sorts of things. So, it's another bit of complexity to sort of throw into the analysis, and yet I

think it's kind of important. I almost hear myself saying that maybe policies might be different depending on age. That seems like a scary result of what I'm saying, but I think it at least has to be a little bit a part of our analysis.

CHAIR ROWLAND: Patty just stared at you.

[Laughter.]

CHAIR ROWLAND: Well, I think this has been a very good start on looking at a framework. Obviously, there is a lot to consider, but I think the information you've started us with today both piques our interest in more information, but we don't want to get to where we're so data-heavy that we can't see the forest through the trees, and I think you're helping to really put us on a pathway where we have a framework that's realistic to begin to analyze the choices.

And, since this is only the beginning of our morning on CHIP, we're going to move now to really look at some experience that's out there in terms of transitions, which is a big issue for the future of the CHIP children, and this is to look at some analysis and work that the Commission staff and their contractors have done on state

transitions of children from separate CHIP to Medicaid, the so-called stairstep children. And, Joanne, you're still on.

Session 3: Analysis of State Transitions of Children from Separate CHIP to Medicaid (Stairstep Children)

* MS. JEE: So, this morning, I am going to highlight for you some key findings from a recent study that we had a contractor do for us on the transition of stairstep kids.

Recall that the Affordable Care Act included a provision that set the minimum Medicaid income eligibility threshold for children at 138 percent of the federal poverty level effective January 2014. This meant that states that had been covering these children had to transition their coverage from separate CHIP -- states that had been covering these children in separate CHIP, excuse me, had to transition their coverage from separate CHIP to Medicaid. And when the ACA was passed, 21 states fell into this category, and the states that transitioned had different transition dates.

So, this stairstep transition was a large-scale transition of children's coverage and it should provide

some useful insights to help in thinking about future transitions in children's coverage as we consider the approaches.

So, really, our goal in this work was to better understand how states approached these transitions. So, we engaged Mathematica Policy Research to assess how states did this, any practices that facilitated the transitions, as well as any challenges that the states experienced.

Mathematica interviewed Medicaid and CHIP officials, children's advocates, provider associations, and health plan issuers in ten states, which are listed on the slide here: Alabama, Colorado, Florida, Mississippi, Nevada, North Carolina, Oregon, Pennsylvania, Texas, and Utah. So, it's a varying -- there's a variety of states.

Overall, those who were interviewed for this work thought that the transition went pretty smoothly. So, this morning, I'm going to just highlight for you some of the strategies that were used by the states in the transition as well as describe briefly some of the challenges. As Diane said, this information is provided for you in Tab 3 of your meeting materials. It includes the contractor report, as well.

The first strategy I wanted to highlight for you was working proactively to address continuity of care. Interviewees in the states that did this described two main approaches. The first was to identify children with CHIP primary care providers who also were Medicaid providers and then to help those children enroll in Medicaid health plans in which those providers participated. That way, they could stay with the same provider even if they had to change plans and coverage sources. Other states reached out to CHIP providers who were not already Medicaid providers and encouraged them to participate to help address this -- to help maintain continuity for those kids.

A second strategy was to engage in early and coordinated planning. States told us that they generally began the planning process for the transition six months prior to it occurring. And critical to the planning was ensuring close coordination between the state agencies and departments who were involved in any way with the transition, and this included ensuring that the right technical staff and experts were present, including experts in information technology, eligibility policy, benefits, and program finance. An example of the way this occurred

was through cross-agency work groups that met on a regular basis.

Another strategy was to have early and clear communications with families. States provided between one and three mailed notices to families between January of 2013 to March 2014, so you can see that the communications started before the transition and continued after the January implementation dates. Interestingly, mailings were the predominant method in all of the states, although some of the states did say that they also used web-based announcements.

Some of the interviewees said that targeted outreach to families who would be subject to the transition was more effective than a broad-based outreach effort, such as what would occur over radio and television ads, and they thought that it helped to minimize confusion by other families who actually wouldn't be affected by the transition.

The last strategy I wanted to highlight for you this morning is that of engaging a variety of stakeholders. States engaged groups, including consumer advocates, as I mentioned, health plan issuers, and provider associations,

and really leveraged the expertise of those groups and their relationships with their constituencies. Stakeholders were involved in things as transition planning. For example, some third-party administrators and health plan issuers helped think through some of the technical aspects of the change or helped to analyze provider networks.

Another way that stakeholders were involved was in educating families and providers about this change and disseminating information about it. In some cases, stakeholders reviewed some of the communications that states had planned just to -- and provide any feedback on the communications to help make it more clear.

Stakeholders also helped inform states along the way with any sort of on-the-ground feedback that they could provide in terms of issues or challenges that were coming up that the state might not necessarily know.

Although stakeholders were generally satisfied with the way they were included in the transition planning, some thought that if they were included earlier in the process, it would have been more effective.

Although the transition generally was thought to

have been a smooth one, interviewees did identify some challenges, which is probably not such a big surprise. The most common one was getting information systems and technology ready for the transition, and this included making needed changes to eligibility systems.

Secondly, while states were implementing the stairstep transition, they also were simultaneously implementing numerous other ACA provisions at the same time. For example, the states were in the midst of the first open enrollment period for the exchanges, which was a very big lift. Other changes included, in some states, the expansion to the newly eligible Medicaid adults and the conversion to the MAGI eligibility system for calculation.

Finally, educating families and providers about the transition was also a challenge. They sometimes had some difficulty ensuring that everybody understood sort of what the change was and what it meant for them, particularly with respect to their coverage, and that, in fact, they were not losing coverage, that it just was changing. In some cases, there were delivery system changes, as well, that sometimes was confusing for families.

And despite the efforts of the states, some of the interviewees expressed concern that there were -- some families did experience some disruption in care.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: Thank you. What's -- there are three things that strike me about this data that I don't think was in your control to change, but I think the conclusions are, one, once again, we see no uniform approach to how to do this, and that is just all over the map.

Secondly, I think there is no data tying a given -- and this isn't your problem but this is an issue where the data was not available -- there is no data tying an intervention to an outcome. So, I mean, you know, to say, well, our state did X but we have no idea what that really quantitatively did, is -- leaves us with no idea of what really works.

And the third observation is, related to that, is that we live, for better or for worse, in a time in which there is a lot of knowledge about behavioral economics, marketing, and how to reach people, and it doesn't seem like any of that knowledge is put to work when we try to do

this. So, for example, we did a study years ago that showed sending letters to this population is about the least effective thing you could do. First of all, the address you have may not be wrong. Secondly, they tend not to read the mail about this thing.

And, so, given that we live in this world that knows a lot about how to reach people and how to market something to a whole range of populations, it doesn't seem like these methodologies, techniques, were utilized and that we have this whole behavioral economics out there that is not being used as we try to enroll people or transition people and there's some disconnect about we're still sending post letters in 2015.

COMMISSIONER CRUZ: Thank you. I just have two quick questions. I didn't see here a -- I saw as one of the strategies to proactively try to keep their PCP, but there was no mention about other adequacy of provider networks, such as oral health or behavioral health. Is that a concern, or is that addressed?

MS. JEE: Uh, yeah. That was certainly raised as a concern, specifically behavioral health, and I believe dental health. But if I recall correctly, the primary

focus was on primary care providers so that those children could be linked up to those same providers when they changed health plans, if they had to change plans.

COMMISSIONER CRUZ: And another question. Some of the CHIP programs run on a fee-for-service scheme and in Medicaid on managed care. Was there a problem in terms of families sort of adapting from the fee-for-service or managed care, trying -- having to see a primary care provider for referrals and stuff?

MS. JEE: I don't have specific data on whether they were able to access the service. I think that, certainly, there was some confusion where there were delivery system changes involved as a part of their transition.

COMMISSIONER ROSENBAUM: Thanks. This was great and very helpful. I have one question and one observation.

The question, I'm sitting here, you know, we just have such a deluge of information, I can never remember anymore what we know -- or somebody knows out there, not me at the moment.

[Laughter.]

COMMISSIONER ROSENBAUM: Do we know generally

what the congruity is between pediatric participation in separate CHIP programs and pediatric participation in Medicaid? Do we know what the gap is, how many pediatricians who participate in one don't participate in both?

MS. JEE: I don't have that number. I don't know if we know that.

COMMISSIONER ROSENBAUM: We don't know that, oh, good. It wasn't just me. I thought maybe -- yes, I mean, I think this becomes -- and, of course, the third piece would be how many also participate in subsidized exchange plans.

MS. JEE: I will say, though, in some of the states, you know, the people who were interviewed, the state officials, did say -- they were able to note, "We do have a lot of overlap in our providers." But I don't know that any sort of hard numbers on that --

COMMISSIONER ROSENBAUM: And it's really going to be an issue, I think, more for adolescent medicine. I mean, this is -- the children who are -- the stairstep children are somewhat older, if children can be old.

But the other thing is just an observation --

CHAIR ROWLAND: You know, Sara, that pediatric participation is the highest in Medicaid of --

COMMISSIONER ROSENBAUM: Yes, generally, that we do know, and that's why I thought maybe there isn't -- may not be such a huge group of doctors who would be in one and not the other, because they're already in the program that's the lower payer.

But the other thing that's an observation, I'm sitting here listening to this, I'm thinking, well, wait a minute, this is a constant problem for children. Yes, there was a moment in time when we have attached a moniker to them called "stairstep children," and sometimes I think we sort of get carried away with the monikers here. But I could imagine going through all of this in the next month, the mom gets, you know, a $10 a month pay increase and then she comes back in CHIP.

And so I'm just trying to figure out what we learned from this study that adds to the challenge of, in fact, a much more constant movement. I mean, how many of these folks going into this said, you know, we don't have to have special meetings about it because we're having to move children every minute of our lives; they're moving

between two programs. And yet here in the study, it sort of emerges as the separate moment in time, and I'm wondering if we're not dealing a bit with a Potemkin village here, that it was a separate moment in time because it was a moment on a piece of policy paper, i.e., the law. But in reality, this doesn't help us understand what's going on about the much deeper problem, which is that next month your child is, you know, potentially out of one insurance system and into another insurance system.

And so I'm just wondering whether any states -- I don't know how to ask this politely, but like do any states sort of jaw-drop and say why -- I mean, this is -- we deal with this all the time, why are you treating it this way as sort of a thing to study?

MS. JEE: No. I think --

CHAIR ROWLAND: Sara, I think that what this was looking at was specific of if you end a program and have time to prepare for a transition, what elements should be part of that. But I don't think it speaks to the broader issue of churn because there's little preparation, but it could help know some of the things you should try to take into account.

COMMISSIONER ROSENBAUM: So the benefit to us from this is literally when one thing ends and another thing picks up.

CHAIR ROWLAND: And, remember, we undertook this at the point --

COMMISSIONER ROSENBAUM: It doesn't tell us about-

CHAIR ROWLAND: -- when we thought there might be an end to CHIP itself, not an extension to 2017, and what would you need to know about how to transition children to another source of coverage.

COMMISSIONER MARTÍNEZ ROGERS: You kind of answered what I was going to say, but the one thing I did notice, because Texas did not let people know ahead of time, and we had over 200,000 kids. I mean, that's -- you know, they gave -- of course, they blamed the federal government for that. But, you know, I just -- you know, the transition couldn't have been that smooth. And, really, when you talk about, you know, that you sent letters that are clearly understood, by whom? I mean, there's so many illiterate people. Who understood it? They understood it or did the consumer understand it? You

know, that's something that -- just a comment.

CHAIR ROWLAND: Okay.

COMMISSIONER CARTE: I'd like to speak to Patty bringing up the issue about data. While I really appreciate the descriptiveness of this study, it would be nice to have data in a few areas. But I'd just suggest to you that, you know, CHIP programs scrambled as best they could to make sure we addressed this issue, and I felt like in my state that we did because we saw few problems. But the three areas where I think it was important that, Joanne, you've really alluded to in the study are, you know, the effectiveness of communication to CHIP families. We did both direct letter communication as well as website and involving communications with community partners.

The second issue that was a concern to us was the one that you brought up, the PCP acceptance of Medicaid or the numbers of our members for whom that would be a problem or an issue. And we tackled that by doing a provider file match of our CHIP program with our Medicaid program, and we communicated to those providers to assure that those families would not -- would have help if they needed in making changes.

And, thirdly, there was a question of the disruption of any services that were ongoing, and obviously there we were concerned for children who might be undergoing a long course of intensive treatment services or particularly behavioral health services. And it would be good to know, you know, what data or effectiveness around those three issues when we're making these transitions in the future. But, unfortunately, it's hard to both do it and collect the data at the same time.

CHAIR ROWLAND: Yes, several of you have talked about using a letter to communicate with the beneficiaries, but isn't that a requirement of the law that beneficiaries receive written notification?

COMMISSIONER CARTE: Yes, and in our state we received a follow-up review by our legislature where we were asked to show the documentation of what we'd done.

CHAIR ROWLAND: So to pick up on Patty's point, maybe one other issue one could look at is are there other more effective ways of trying to communicate with beneficiaries in an era in which many of them have other modes than receiving mail to get messages.

COMMISSIONER COHEN: I'm not sure if I'm beating

a dead horse or sort of pulling a few things together here, but I do think this issue of transition -- so churn and transition are a little different, but the issue of transition happens in the Medicaid program constantly. In every state, some population is being moved from one form of coverage to another or one network to another. I mean, it's constant, and CMS often has to weigh in, I think, and sort of look at kind of what the transition plans are. And my sense is that there's an incredibly sort of ad hoc response or sort of set of directions that go out and that it's not typically standardized. There are some things in law and regs, but it's really not standardized and it is really far from state of the art, is my impression. I don't know. Maybe we stumbled into state of the art, but I sort of have my doubts. But I do think that this kind of case study does not help us really understand this larger issue, and it is going to be a big issue if there is going to be a -- you know, it is a large change if CHIP is going to go away or change in a substantial way.

So I guess I would just say I think it is worth it for us to think about ways to invest in standardizing and maybe getting to the sort of next level of what we know

and understand about what a good transition is, and I do think this is not the right method to do that.

And I guess the other thing I would just throw out there is I happened to learn that the administration did an executive order a few days ago about the importance of using behavioral economics throughout social service programs and otherwise, and it's developed an expert committee and this and that. So, anyway, I do hope that some of those principles and learnings can be applied here, because this really does seem like efforts are -- but they just feel incredibly old-fashioned and not data-driven at all.

CHAIR ROWLAND: But I want to remind the Commission members again, as we ask for something different than what this study was, if the study was created because you asked what the experience was with the transition from CHIP to Medicaid for the stairstep children. So I think we need to be fair that this study has addressed a concern you had. Now you're raising a broader one.

COMMISSIONER COHEN: Well, I think it's a question of how -- addressing how, and it's not a critique.

This is what is sort of like available within a budget. I'm not sort of second-guessing the decision. I think I'm saying looking at what we got, it really indicates the need to go about it maybe another way. You know, I'm not second-guessing --

CHAIR ROWLAND: But I'm pointing out that you're asking for a different study.

COMMISSIONER COHEN: Well, it's -- it's adding, I think, a data and an outcome -- for one thing, a data and an outcome, you know, sort of component, not connected to the actions as opposed to looking at data and outcome in two states and looking at sort of activities in a lot of states.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah, I mean, we'll see what we get in Part 2, and just also we're still working on the data use agreements and getting the data from two states that have been, I think, incredibly generous in their willingness to do it, but it's still -- it's sort of the lift to do that is considerably more. So we're hopeful that this is going to provide sort of a valuable next picture. Again, it will be a smaller number of states because it's a bigger task to do the data

analysis, but also, you know, did it actually work out okay? Are the kids getting the services they need? Which I think is sort of the ultimate measure. So stay tuned.

COMMISSIONER SZILAGYI: Just a very quick question, because I think the horse is dead.

[Laughter.]

COMMISSIONER SZILAGYI: Is Part 2 going to be an analysis of utilization data? Because I think that's what would be really helpful. You know, I think there's two issues. One is answering the question of the stairstep children, and that is probably best answered in a multidimensional type of way, adding qualitative information, which they've received very well from one component, not from parents or families but from providers and the health care delivery system. And then the other is the quantitative data, which would, you know, it's not -- probably not that difficult to get utilization data on preventive service utilization or acute utilization and were there gaps.

MS. JEE: Right. So while the first part of the study looked at sort of the transition planning process and how it was implemented, there is a second part coming up

where they will look -- they're going to look at the stairstep kids in -- Mathematica will look at stairstep children in two states, Colorado and New York, assuming that all the data agreements can be made and gotten, and look at sort of before the transition, what their utilization looked like, and access to services and then after the transition. So comparing what it looked like in CHIP to what it looks like in Medicaid just from this population. And it will be limited. It's just two states. But it's a start.

COMMISSIONER SZILAGYI: And for these ten states, did they have information about the reimbursement under CHIP versus Medicaid? And was there a lot of variability in the states, and did they find differences in responses there?

MS. JEE: Yes, there were some differences in the states. I don't believe they collected a lot of detail on the payment rates, but there certainly were some differences.

CHAIR ROWLAND: Chuck.

COMMISSIONER MILLIGAN: I'll pass.

COMMISSIONER CHECKETT: I'm going to actually

pick up on another issue, which is, I think, a discussion about communicating with beneficiaries in general. And I certainly don't want to go back and redo anything here, or I don't even think my comments are necessarily germane just to Part 2. I think the staff and the Commission going forward might want to start to add to our questions: What other ways are states communicating? Who is using whether it's texting or other types of electronic communications, e-mail? I think that providers are doing a fantastic job. How many of us get, you know, "Press 4 if you're going to show up tomorrow" notices or text messages, that type of thing? And I know they're doing that with Medicaid beneficiaries. I know a number of the health plans are doing similar initiatives. But when you think about states communicating information about eligibility, the very state Medicaid agencies who, frankly, are struggling to, you know, have an update to their MMIS system that's 20 years old and eligibility systems are old, I suspect we're not seeing a lot of digital and local technology from them. I think it's a really great point, and I would just suggest that we start to incorporate that into thinking and surveys going forward.

And I would point out the managed care regs also had a big requirement about a lot of paper, and there's an animated discussion with CMS on at what point does it become ridiculous to start mailing people provider directories when we don't know where they are, et cetera.

Thank you.

VICE CHAIR GOLD: Feel free to correct me if you think I'm analytically wrong on what we know, but I sort of think that I'm listening to people who are suggesting that if we just got more knowledge of the literature, it would tell us what to do. I don't think the research is there. I think it's really hard to study administrative processes and figure out what to do, and there is some variability across states in how the interest groups coordinate with people, what capacities are there. And so what works in one place may not work in another. So that's just a caution.

The other thing, on behavioral economics, I'm trying to puzzle through how you'd apply it here. I mean, the most -- most of the things either you automatically enroll someone so it's a decision to opt out rather than opt in, or you use payment to do things, some of those

conflict with laws on these programs. So I don't quite know how it -- I'm not sure it has a magic bullet that's here. It's worth looking at. It's also worth looking at the experience with express eligibility and getting people into Medicaid. When Medicaid went to managed care, how did they learn it? You could probably do an environmental scan. It would be soft. It's going to be the same qualitative data you say you don't like now, but that's all there is.

And the other thing is states don't have all the information. I don't think states have e-mail addresses. They have that address, and it's probably wrong, and they probably don't have a phone number.

So a lot of these things are the constraints people are working under, and I think in a lot of cases, they try and work with interest groups who do have an ability to have a more personal relationship with people. So, you know, it's not rocket science.

CHAIR ROWLAND: I'm thinking how nice it would have been to have Yvette sitting here at our table to be able to respond to all of these issues.

COMMISSIONER COHEN: I do just want to make the

point, though, that -- I take your point, and you know much better than I do what is achievable in terms of research, and especially research that MACPAC can afford. But I just want us to think bigger. We have the ability to make recommendations about what the law is. We have the ability to make recommendations to an agency to -- you know, it doesn't mean they're going to take them -- to prioritize a deeper look at the issue where we don't have to get data agreements from states and do the research ourselves, but, you know, can say this is an issue that comes up again and again and again and again, and we recognize how much we don't know. Somebody who doesn't have to get an agreement maybe is the one to sort of do this work.

So I just want us to think creatively. In some ways, the states -- we're not judging the states and what they did here. They're under incredible constraints. But I think what we're saying is we have the ability to sort of envision different requirements or a different look at requirements, and we don't have to do all the research ourselves if it's really hard to do, which it is. And, again, that's why I'm not second-guessing the study either. We just sort of have to think about our niche and what's

enough evidence and importance to us to sort of recommend that the entity better able to do that research, really engage in it, and not -- we're not as constrained by what is. We can sort of think and recommend bigger. And, of course, we have to pick our battles.

CHAIR ROWLAND: Okay. Well, thank you, Joanne.

We're going to take a 10-minute break and reconvene at 11:00.

* [Recess.]

CHAIR ROWLAND: If we could please reconvene. The break is over.

We are going to continue our discussion of children's coverage, and as one could gather from our last session, this Commission and the Commission members like data and numbers and information, and so we're moving in this section to look at the estimates of children's coverage under different policy approaches. And we've got Chris back at the table to guide us through this discussion.

Session 4: Estimates of Children's Coverage Under Different Policy Approaches

* MR. PETERSON: Thank you.

Earlier, we presented five broad approaches along with characteristics of children and how they vary by income. At future meetings, we'll explore these approaches in greater depth and the considerations that you've been discussing for some time already, talking about coverage, benefits, affordability, spending, and others.

In this session, we want to provide some estimates along one of those dimensions, and that is coverage. The estimates we're presenting today are from the Urban Institute and build on those in our March report.

Our purpose is simply to give you orders of magnitude of the effects on coverage of a few hypothetical examples to give you some concrete estimates to react to.

Our estimates in the March report showed what would have happened if separate CHIP coverage ended in 2016. Today, we want to build on those estimates and show what would have happened if separate CHIP coverage ended and if some other policy interventions had been put in place.

First, what would happen if exchange coverage were enhanced, in particular, by fixing the so-called family glitch? As a reminder, you're generally ineligible

for exchange subsidies if you are offered employer-sponsored coverage. But if your employer-sponsored insurance is deemed unaffordable, then you can qualify for exchange subsidies. That affordability test, employer-sponsored insurance is deemed unaffordable if you face self-only premiums that exceed 9.5 percent of income, but that's only for self-only coverage. The cost of family coverage, which is generally much higher, is not included in the test; hence, the shorthand term "family glitch."

As you'll see shortly, fixing the family glitch by itself doesn't reduce uninsurance as much as you might expect because to obtain exchange coverage, many families would have to pay a much higher amount out of pocket relative to CHIP. That's still a barrier.

So as another alternative under enhancing exchange coverage, we just wanted to test making exchange premiums cheaper, going so far for this illustration to eliminate premiums for children in their state's current CHIP income range. In reality, that approach may be practically untenable, but we wanted to test the extreme case of having children who lose separate CHIP coverage to face no premiums if they qualified for exchange coverage.

Another set of example scenarios we looked at was, rather than looking at it from the exchange angle, what if we instead tried to address the loss of separate CHIP coverage by expanding Medicaid? And here, we tested expanding Medicaid for children up to 175 percent of the poverty level, which is $42,438 for a family of four, and also to 200 percent of poverty. Again, these are just illustrations of what could have happened in 2016. Of course, CHIP funding has now been extended through 2017, so we will end this session with some discussion of our next steps, including moving these projections forward to later years.

So now turning to the pie chart, as a reminder, in the March report, we showed that 3.7 million children would have lost separate CHIP coverage if funding ended in 2016 and -- in response to what Chuck had said earlier -- and assuming that states did nothing else. So, yes, they could have -- they could have expanded Medicaid to cover that, but these estimates were just assuming separate CHIP ends, and it goes just like that.

Of those 3.7 million, this pie chart shows exactly what we had in the March report: 1.4 million were

projected to obtain subsidized exchange coverage; 1.2 would have enrolled in employer-sponsored coverage; and 1.1 million would have become uninsured. And remember, all 1.1 million of those uninsured children would have been eligible for something, either employer-sponsored coverage or subsidized exchange coverage, but they would have not enrolled in that coverage.

So now we move to the first bar chart. This chart is focused on the 3.7 million children projected to have separate CHIP coverage in 2016. Then the second bar shows exactly what was in the last slide in the pie chart. So without separate CHIP, we go from the bottom up, 1.2 million in employer-sponsored coverage, 1.4 in exchange coverage, and at the top of the second bar there, 1.1 million uninsured.

Now, the new piece, this third bar, looks at if you fixed the family glitch, that is, if the ACA's affordability test for employer-sponsored coverage also took into account the out-of-pocket cost for family coverage, that's what this third bar shows.

As you see at the top of the third bar, even with fixing the family glitch, 1 million of those former

separate CHIP kids would be uninsured.

This 1 million -- this is not in the slide, but I just want to take a second. This 1 million basically consists of three groups. First of all, even with the affordability test, there are kids who still don't qualify for exchange subsidies, and they make up about 40 percent of this amount. They were ineligible for exchange subsidies before. They're still ineligible. They're offered employer-sponsored coverage. The family premium is less than 9.5 percent of income, not eligible before, not eligible now.

The second group is about 37 percent of the total. They were eligible for exchange subsidies before, and they didn't enroll. You fix the family glitch. Nothing has changed for them. They are still eligible for exchange coverage. It still costs what it cost. They're still not enrolling.

The third group is the remaining 23 percent who with the redefined affordability test, they do become eligible for exchange subsidies, but in the context of this 1 million uninsured, they still don't enroll in that either. So they move from being eligible for employer-

sponsored insurance that they don't enroll in to also being eligible for subsidized exchange coverage that they don't enroll in. Remember the family still has to pay between 3 percent and 9.5 percent of family income out of pocket for exchange premiums.

So to remove the barrier presented by these premiums, we said, "Well, let's test what would happen if children in their state's separate CHIP income range faced no premium for their exchange coverage," and the last bar shows this scenario. Zeroing out their premium cuts the number of uninsured in half relative to the prior bar, but still, relative to continuing CHIP, leaves half a million children uninsured. And it's worth noting actually that of that 500,000 drop in insured we see going from the third bar to the last bar, 300,000 of those were already subsidy-eligible. So it is simply that now there are zero premiums, they are taking up that coverage. So regardless of your fix to the family glitch --

COMMISSIONER ROSENBAUM: I got to just ask. So you're saying that free coverage would still leave half a million uninsured because?

MR. PETERSON: Because --

COMMISSIONER ROSENBAUM: Because?

MR. PETERSON: Some of them are still un-eligible, ineligible for exchange subsidies.

COMMISSIONER ROSENBAUM: Because the affordability, because of the affordability test. So you'd have to lift that plus lifting the affordability test. I've got it.

MR. PETERSON: Right.

VICE CHAIR GOLD: Higher income, right?

MR. PETERSON: What's that?

VICE CHAIR GOLD: Higher income. That's why you're --

MR. PETERSON: Yeah. The premiums relative to their income still don't exceed 9.5 percent of income. They still aren't eligible for exchange subsidies. They find ESI unaffordable.

CHAIR ROWLAND: They might be working in a place where the premium is low because the benefits in the coverage are low.

VICE CHAIR GOLD: Oh, okay.

CHAIR ROWLAND: So it's the relationship of premium to income, not just income.

COMMISSIONER GABOW: I still don't understand who's in this group and why they aren't enrolling. I'm confused about that.

MR. PETERSON: So, first of all, let's talk about who became insured under this last scenario. People who now face zero premiums for exchange coverage, they enroll. So they're covered.

Who's left out? Those who are left out are those who are not qualifying for this new free coverage under exchanges. Who are they? They are those who are offered employer-sponsored coverage, and they have to pay out of pocket for that coverage. And it is, by definition, their premium contribution is less than 9.5 percent of income, but it's still 9.5 percent of income or less. It's not zero, and therefore, they do not take up that employer-sponsored coverage. So that is essentially who remains in that last group.

CHAIR ROWLAND: Well, let's be clear here. This is not actual experience. This is a model of how people would fall out, and so there are assumptions built into this model about what percent will take up, what percent will not. And we should just be clear --

MR. PETERSON: Yes.

CHAIR ROWLAND: -- that it's modeling. It's not actual data.

Sharon?

COMMISSIONER CARTE: And to that point, too, Diane, the fact that this is modeling data, I think another area we need to account for is to look at actual data for children in the exchanges and how it trends. In 2016, I think we should look at that because it will relate to the affordability issue, and as premiums have escalated, whether there's a drop-off. It's going to be critical to see that.

MR. PETERSON: Yes. So we'll talk about that in a minute, but all of the estimates that we have heretofore were based on what was in the March report. That was based on the world forecasting what the exchange premiums will be.

COMMISSIONER CARTE: Right. I understood.

MR. PETERSON: The new estimates we're going to be having will reflect the latest changes, what we've seen in exchange coverage, and the newest data where individuals are enrolled. So we're trying to get all of the latest

information, including what we know about CHIP enrollment, to be reflected in the modeling. So these numbers will be changing, undoubtedly, because we'll be looking to future years and reflecting the latest data that we have.

Okay. So let's see where we were. In this last bar, I also want to point out the number at the bottom here, the bottom right. That if separate CHIP went away and the family glitch were fixed and eligible children faced no exchange premiums, 737,000 children, former CHIP kids would enroll in employer-sponsored coverage. Okay. That's the way to think about that number.

I just want to point out when we're looking at the enrollment in employer-sponsored coverage here, moving from, for example, the second or third bar to that last bar, we're not talking about crowd-out. This is not crowd-out. Crowd-out is when kids -- people move from employer-sponsored coverage into public coverage. In this slide, we are talking about children enrolled in separate CHIP and what happens under different scenarios. So I just want to make sure that that is clear.

But it does still raise policy questions when we see these different numbers.

COMMISSIONER RILEY: Chris, could you spend a little time comparing the second bar, why 1 million -- when we fix a family glitch and account for families, what is the difference between the 1 million and 737?

MR. PETERSON: Yes, exactly. They get free insurance in the exchange. So that is the point. It's not crowd-out, per se, but nevertheless, the policies that one could put in place are going to have other effects, and so now children -- you know, these families say, "Oh, my gosh. We were in CHIP. The kids were in CHIP, and now we can put them in exchange coverage, and it's free. I'm going to do that rather than put them in employer-sponsored coverage."

COMMISSIONER ROSENBAUM: But that group, for that group of 737,000, they're making that choice, even though, technically, coverage is not affordable for them, because if it were affordable for them --

MR. PETERSON: Or it may be affordable.

COMMISSIONER ROSENBAUM: -- they may be barred, and they'd be up at the top.

MR. PETERSON: Yes.

COMMISSIONER ROSENBAUM: So they're struggling to get into their employer plan because they've lost their

benefits, as best I can tell -- would be a way of thinking about it. Otherwise, they couldn't get the free coverage in the exchange if coverage were affordable through their employer plan. They would be in the top group, but this is a group that when hit with the notice, not realizing that they actually could go to the exchange and get free coverage, are nonetheless, I think, struggling to pay their family premium. I don't know how else to understand it.

CHAIR ROWLAND: They might not be eligible. They might not be eligible for coverage.

COMMISSIONER ROSENBAUM: But if --

CHAIR ROWLAND: They may have higher income.

COMMISSIONER ROSENBAUM: Oh, there may be some who have higher income, so we've got two people in there. One is that they are exceeding -- but how many states have CHIP programs that exceed 400 percent of poverty?

MR. PETERSON: Well, this is all among the 3.7 million kids, and none of them go above 400 percent.

COMMISSIONER ROSENBAUM: Right. So that --

CHAIR ROWLAND: Yeah. But if you're already eligible to be covered by your employer and you don't have -- you don't fall into the family glitch, then you're not

eligible to go into the exchange.

MR. PETERSON: So they take up the employer-sponsored coverage for which they are eligible, and there is no alternative for them to go into exchange coverage.

EXECUTIVE DIRECTOR SCHWARTZ: When you fix the family glitch, there still is an affordability test.

COMMISSIONER ROSENBAUM: Well, that's what I'm --

EXECUTIVE DIRECTOR SCHWARTZ: It's just a more expansive affordability test.

COMMISSIONER ROSENBAUM: Yeah. I mean, there's some relationship between the number at the top and the number at the bottom. The number at the top are the people who, even with free premiums, can't get into the exchange because they have affordable employer coverage. The people at the bottom are people who go into their employer coverage. A few may be people who couldn't qualify for the free premiums, period, but it seems to me -- and maybe it's important to understand this -- that you have a number of people in there, a bunch of people who are buying insurance they can't afford.

MR. PETERSON: Yeah. And I think, really, it's the middle bar that's critical. I mean, it's the exchange

coverage, right? It's as we move from the third bar to the fourth. We're going from 1.6 million enrolled in exchange coverage to 2.5 million.

COMMISSIONER ROSENBAUM: I'm worried about the Patty problem; that is, that they've come up with money that they really can't afford because their incomes are lower, and yet they've gone after their employer coverage.

MR. PETERSON: On the other hand, though, the decline you see going at the bottom, going from the 1.1 million to the 737,000, is a reflection of people saying, "Yes. I was eligible for exchange coverage before even though I had this employer-sponsored coverage. I wasn't going to take it up before. Now I am." So that lowers, on the margin, the enrollment of employer-sponsored coverage, but is that an okay thing, given the fact that it's now more affordable to them? That's not a question that a model is going to answer for you.

COMMISSIONER COHEN: I have a question. This only looks at separate CHIP, and I guess my question is, are we comfortable -- that means that there is an assumption that there's no effect on those that are in the Medicaid-only programs, and I know there's the hold

harmless. But are we comfortable there would be no effect of this family glitch and of whatever states do for the budget constraints on the uninsured? And I'm wondering whether the modeling needs to be expanded to take into account the Medicaid segment of the CHIP program and how it's affected by CHIP going away.

MR. PETERSON: Well, first of all, the children who are enrolled in Medicaid and Medicaid expansion coverage would not be affected by a fix of the family glitch, because Medicaid and Medicaid expansion CHIP trumps exchange eligibility. So if you are eligible as a child for Medicaid, you can't say, "Oh, you know what? I'd like to take up the option to go enroll in exchange coverage and get those subsidies." That option is not available to you.

However, and we'll talk about this in a minute, as we look forward to our estimates going out to 2020 when the MOE ends and thinking about the possibility of states rolling back their Medicaid coverage to minimum levels, then we will be capturing that as well.

But then, thirdly, the slides that are coming up also show the impact of this on children overall, not just for the separate CHIP kids, but for now in these slides,

we're just looking at the separate CHIP kids.

COMMISSIONER MILLIGAN: Yeah. Sorry. We're all jumping in on you now, Chris. I'm piling on too.

So I think one of the things I want to raise is that the 476 also might be going back to what Sara said in the earlier discussion about affordability. Premium levels might be getting sort of more moderated, but deductibles and other forms of cost sharing are going up a lot. There's a lot more high-deductible plans on the employer side to begin with, and so that 476 might reflect people who have access to affordable coverage when measured by premiums but don't have affordable coverage when measured by total out of pocket. So I just think we need to keep our eye on the ball about affordability not being synonymous with premiums.

MR. PETERSON: Okay. I have more detailed spreadsheets here, and just FYI on that 476,000, 403,000 of them are not subsidy-eligible. So it's 74,000 who are falling into that group. I mean, it's 15 percent of the group, but there it is.

COMMISSIONER ROSENBAUM: Because under the law, as affordability is defined in the law, which

unfortunately, going to Chuck's point, which is correct, is only the premium, so most of that 476,000 group is a group for whom the premium was technically affordable.

CHAIR ROWLAND: Okay. Let's just make an assumption here, which is what we do in modeling, that these are showing us relative changes with regard to different policies, but the actual numbers are highly dependent on what the take-up rates are and the other assumptions. So, let's not treat this as trying to figure out every person who fell into the 476,000, but generally what the trends are as you try to put these policies into place.

MR. PETERSON: Thank you.

[Laughter.]

MR. PETERSON: So, now, going to this next bar chart, so, now, what happens if separate CHIP ends for these 3.7 million children, but instead of doing something with exchange coverage, Medicaid is expanded. The first two bars are exactly the same as before. We're talking about the 3.7 million separate CHIP children and where they end up without that coverage.

But if Medicaid were expanded to 175 percent of

poverty, again, about $42,400 for a family of four, but it varies by family size, 1.3 million of them would obtain Medicaid, but 717,000 would still be uninsured. So, what about expanding up to 200 percent of poverty, which is $48,500 for a family of four. Two-point-two million would obtain Medicaid, with about half-a-million uninsured. It's interesting that the number remaining uninsured here is similar to fixing the family glitch with zero premium for eligible children.

Besides reducing uninsurance, you also see at the bottom how expanded Medicaid eligibility would lead to some who lose CHIP enrolling in Medicaid rather than employer-sponsored coverage. Again, if the premiums and cost sharing are so much lower in Medicaid, then rather than employer-sponsored coverage, they're making a choice that this is better off for me as a family on the affordability front, even if that change on the margins doesn't reduce the number of uninsured. And again, not crowd out, but still a consideration in thinking about where children end up, the affordability of their coverage, and, of course, the cost to the federal government.

So, that's essentially it for the hypothetical

options model. These next two slides show exactly the same options, except rather than looking only narrowly at the 3.7 million children in separate CHIP, we know you want to see how these changes affect all children, and that's what you see here in this slide.

Among all children, you see in the bottom left, very bottom left, that 3.7 million in separate CHIP, and they make up a pretty small share of the total. The elimination of separate CHIP coverage in the second bar would have increased children's uninsurance in 2016 to four million, so an increase of 40 percent, which is a big percentage increase on what looks like to be a relatively small share of the total, or not. And here, the take-home point is under all the alternatives here, employer-sponsored insurance and Medicaid would remain the predominant sources of coverage for children.

Similarly, on this next slide, if separate CHIP coverage had ended but Medicaid expanded even to 200 percent of poverty, employer-sponsored coverage would still be the predominant source of coverage for all children.

I hope you found these examples illuminating. Again --

[Laughter.]

MR. PETERSON: -- they are one-dimensional, showing only the impacts on coverage, not the many other criteria that are also worth considering.

For next steps, the Urban Institute is working to update the projections, first to 2018, when separate CHIP -- when CHIP funding ends under current law, then to 2020, looking not only at separate CHIP coverage ending, but also to the maintenance of effort ending, when states can roll back their Medicaid eligibility levels for children to the minimums required under federal law, generally 138 percent of poverty.

And again, Chuck, to your point, what that's going to model is assuming all states roll back to the minimum. Are they all going to do that? Doubtful. Nevertheless, that will give kind of an upper bound on that.

So, we look forward to your comments on these estimates and any more thoughts on the policy approaches, their implications, and the parameters you think are important as we move forward with our analysis in future meetings. Thank you.

CHAIR ROWLAND: And as we did in the earlier sessions and as Chris has done at the end of this discussion, I think it is important to -- we have this concern about what happens to the kids currently on CHIP, but it's more important to try and figure out, going forward, how children at various income levels are provided for, whether through Medicaid, through a bridge program, or through better coverage in the exchange, because the last thing we want to do is to say, if you were previously entitled to CHIP, you are grandfathered in forever somewhere. What we're really looking at is how do we make coverage affordable for families for their children.

Patty, then Peter, then Chuck, then Trish, then Sara.

COMMISSIONER GABOW: Well, thank you. I have to commend you on your slides for both presentations and they're really very helpful.

So, I have sort of two questions. If you do fix the family glitch, no premiums, and expand Medicaid, if you do all three of those, Medicaid up to 200 percent, do you still end up with this same number? So, that's one part of the question.

The other is, I'm sure you've thought about --

MR. PETERSON: The answer is no. I mean, the answer is we don't know yet, so that's not an option that we looked at.

COMMISSIONER GABOW: But, it seems like if we think that the -- and maybe we don't think this, but if we do think that simplifying is important and that if we go from four programs for children to three, we probably need to do something in all three arms that exist.

So, I think it would be worth looking at that. From what you said about who's in this 445, it may not -- doing all three may not still fix it. But the question, and I'm sure you've thought about it, is what would get rid of that four -- I mean, so if we don't want to step backwards and now all these kids are covered, even though I'm not in favor of keeping a separate CHIP program for life as we know it, we don't want to go backwards.

So, I guess, can we ask the question, the flip side, what changes would be needed to get rid of CHIP and still cover every kid? I mean, that's asking the question from the other direction, and it seems like if we don't want to go backwards, that's the question. But maybe

that's not a question you can model. I don't know. But it seems like that's the question.

MR. PETERSON: I guess if your standard is zero former CHIP children uninsured, then that's why extending CHIP forever is one of the broad approaches that is on the table. Doing --

EXECUTIVE DIRECTOR SCHWARTZ: Or other very low cost to the family coverage of some form.

MR. PETERSON: Right. So, it's trying to figure out what combination of those would work. But I think what you need to consider is that an increase in premiums and cost sharing above what children are currently paying could result in some children becoming uninsured, and then it's a question of, but, are the other outcomes that happen, do they make up for that in terms of where those children end up, in terms of not being four programs, there being three, you know, increasing the number of children who are in the exchange pools. So, there are multiple priorities that are sometimes at odds with each other. That's the point.

COMMISSIONER GABOW: I mean, I think the thing that Diane keeps bringing up is that -- which I think is really important -- is this just isn't about CHIP children.

So, really, the question is what is the model that needs to exist in which there are no uninsured children.

[Off microphone conversation.]

COMMISSIONER GABOW: And, I mean, maybe it is that there is no-cost coverage for children. But, I mean, the rest of the world has -- developed world has solved this problem and they're not as rich as we are. They may not be as dysfunctional as we are, but maybe they are. I don't know.

But, I mean, really, there are two questions. We certainly don't want to go backwards from where we are with children. So that's the first hurdle, is what would we need to at least achieve that hurdle. But the goal should be for this country, what would the model need to look like to have no uninsured children.

CHAIR ROWLAND: Peter.

COMMISSIONER SZILAGYI: Patty and I are sharing too many taxi rides, because I had precisely the same questions, about doing both, you know, simultaneously.

A second one, which is a little bit of a variation, which is to model what the income is for the children who are uninsured. It kind of gives us a better

window for who they are.

The third was the last point Patty made about if there was -- it's not a policy, but what would the implications on cost be if there were no uninsured children. How costly, you know, you would say, a cost to whom, but to society or to, you know, the federal -- it's not the family cost, obviously, but the societal cost. What would the cost be, because uninsured children cost something, too. And I think it would be, at least, helpful for me to know how costly that would be to the country, or perhaps cost savings, if we could figure out a policy that there were zero uninsured children.

And the third maybe more complicated question, or fourth, is can you, without getting into the weeds, can you -- there are so many assumptions in these models, like people will go on the exchange, you know, that they can maneuver it. The same thing with Medicaid. Can you give us a bit of a sense, without getting into the weeds, for how robust some of these assumptions are, because, you know, we're jumping on numbers which could vary greatly depending on the assumptions when you get under the hood of the models.

MR. PETERSON: So, to be honest, generally, I share your concern, very much so. And as we looked at some of the output on their testing, I feel comfortable that some changes in the assumptions, underlying assumptions about take-up, for example --

COMMISSIONER SZILAGYI: Right.

MR. PETERSON: -- don't change the outcomes all that much. So, that makes me feel good, where it's, like, it's not some, you know, in the black box, if you flip this tiny little switch, everything changes dramatically.

So, I think, you know, you can't put confidence intervals on model estimates like this, but nevertheless, I feel like they are, in the scheme of things, relatively narrow, if one could convey it in that way.

But, then, to the technical question, they are modeling people making choices based on what maximizes their utility given the cost that they face, and based on their current enrollment. So, in other words, if folks are, for example, enrolled in public coverage and now CHIP is available to them, they assume, well, you're going to enroll. On the other hand, as we look at all kids, if there's a family, for example, and this family is

uninsured, even though they are eligible for CHIP, then, you know, fixing the family glitch or expanding Medicaid doesn't mean they're just going to automatically enroll, even if it is better for them. It's based on the revealed preferences. They've already made decisions. I don't like public coverage, or I like employer-sponsored coverage. So, all of that is taken into account and I think it makes it a pretty robust model.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: I share the, you know, turn this upside down and try to figure out how we solve the problem. But, it strikes me that there's an interesting policy convergence here. On the one hand, the enhanced match that came out that sustained itself with CHIP means this is largely a federal program. So, unlike Medicaid, which is so highly dependent upon state expenditures, we have more flexibility here federally, it seems to me, about what we pay for. And in 2017, the Secretary has to revisit the essential health benefit.

So, it strikes me what we need to do here is to think about a couple of different options. One is to look at ESI and could we structure a child-only benefit that

looked different and that addressed the issues of affordability and no high deductibility. I think about the California exchange, which has standardized benefits around out-of-pocket exposure. So, could we think differently about what a child-only benefit would look like that wouldn't be high deductible, it would be appropriate for kids, and it would cover not just -- because a family glitch clearly doesn't get us there, which I think is great information and surprising.

So, how would we restructure a benefit that was not a high deductible, that a child-only benefit, and that covered cost sharing. And I think those kinds of issues become pretty intriguing as at least a policy option that we might want to explore, given the heavy reliance on ESI for these families. Could we restructure the way we think about what that benefit is and how we pay for it.

COMMISSIONER MILLIGAN: Chris, you always do a really nice job presenting data and answering our questions.

I want to actually come at it from a different tack, which is if the purpose of this is to help build a body of evidence for the Commission to consider a

recommendation down the road about what happens after 2017, I think we're going to absolutely need to contextualize it in terms of federal spending, and I don't think we're going to have credibility making recommendations about family glitch or Medicaid expansion without having the context of what the impact on the federal budget would be.

And, so, my question is -- I have in mind four budget estimates that kind of come out of some of the modeling that we're talking about, and the question is going to be whether that's in scope for the simulation, the effect on the federal budget, because I don't think we're going to be able to make a recommendation about Medicaid expansion or family glitch without having a sense of spending, the spending implications on the federal government.

So, the four that I -- the four scenarios that I see is one is kind of rolling forward the current state, you know, CHIP extending, extending, with enhanced match that's largely federal, as Trish mentioned.

The second is sunset happens and CHIP goes away. Separate CHIP goes away.

The third is the variations on fixing the family

glitch, where there's a lot of federal budget implications on APTCs and cost sharing reductions, I would think, and so how much is that cost relative to the CHIP cost, for example, and the Medicaid expansion, and what does that cost at 175 or 200 relative to APTC costs, relative to CHIP match cost.

So, I think -- I mean, I think these goals about covering all kids and all of that are laudable, but I think our recommendations are not going to be meaningful if we don't have the federal budget context in mind.

CHAIR ROWLAND: To that point, Chuck, I think it's important that this is about separate CHIP, but there is federal enhanced financing in the Medicaid component of CHIP, and so in looking at the costs of a recommendation, we need to take both of those into account.

I also think that, while I love to always look at national numbers, we all know that Medicaid and CHIP vary a lot across the states, and so in the context of the 3.7 million kids that we talk about here, it would always be helpful for you to just give us the distribution of those children by state so that we know a little bit more about, you know, if there's a big impact in three states and what

share of the population covered by Medicaid is it in any of the other states.

MR. PETERSON: I think we could do that by region, but getting at the state-specific level then opens up a lot of quibbling. And, so, we'd just have to think about that, and I'm not -- Urban has previously intimated that they are not comfortable doing --

CHAIR ROWLAND: I don't mean doing these tables. I just mean a straight, here's 3.7 million kids that are in separate CHIP programs and here's how they distribute.

MR. PETERSON: Got you. And then --

CHAIR ROWLAND: Not running this analysis state by state, no.

MR. PETERSON: And then back to Chuck's point, all of the recommendations that we do have to have a CBO cost estimate associated with them, and I totally hear your point. That's certainly one of the key criteria that we want to think about. The challenge that we face is we theoretically could use Urban to produce some cost estimates, but at the end of the day, what CBO produces is what's going to rule. And they do make estimates, they do make assumptions that we would not be able to match. And,

so, I think it's just worth noting that we just have to be careful.

The other thing to note, and it's part of the assumptions, is what do you assume about CHIP? So, for example, you know, as of today, CHIP is paying 70 percent -- the federal government is paying 70 percent on the dollar for CHIP expenditures, but then next month, it's going to be 93 percent. So, as we compare what are the CHIP options going forward, is it 93 percent? Is it 70 percent? And, lo and behold, those kinds of assumptions make big differences in what the costs could be.

COMMISSIONER MILLIGAN: Chris, I think all your points are valid, and I know that, you know, the final arbiter is going to be CBO if, you know, legislation. I just think, though, that as Diane mentioned earlier, in recognizing that these are simulations and it's really directional, I think that -- and I wouldn't presuppose how to do the methodology about it and whether, you know, to use the enhanced match that's about to start and all of that. I just think for the Commission as a whole and my counsel to my fellow Commissioners is we have got to contextualize the decision making and mindful of the budget

implications if we are to be taken seriously and credibly. So I just -- whatever rough order of magnitude can kind of frame it I think we're going to need.

EXECUTIVE DIRECTOR SCHWARTZ: And also, Chuck, just so you know, we do talk with folks at CBO sort of on an ongoing basis so that they are aware of what we're up to and the contractors we work with. That doesn't necessarily mean they build it into their models. So it's not like that they would just be hit with this out of the blue and not know. So, you know, we talk to CBO, we talk to GAO, we talk to the folks at ASPE, so that we are aware of other things going on and they are aware of us, that the context that these conversations are going on kind of crosses the different analytic agencies.

COMMISSIONER ROSENBAUM: Actually, one of my points was going to be Chuck's point that the budgetary implications of any of these approaches obviously are huge. I actually identified three: one is the practical for the families, one is the budgetary, and one is the operational for whoever has got to put it into place. I think for any direction we flag, you've got to answer those questions.

But it seems to me, going back to the first

presentation this morning, we're sort of -- we've come full circle. So, again, we have this incredible decision to make about what we are either -- what we're telegraphing, either explicitly or implicitly, about the employer-sponsored system. That is to say, we could go into this in one of two ways. One is that we are coming up with remedies that couple continued access to public insurance with making the employer-sponsored system work better for people where it's not working now because they're offered something that on paper is legally affordable and it's not, okay? And CHIP lets them sort of maneuver around this in ways that the Affordable Care Act does not. And so we're going to -- our recommendations might include changing the definition of affordability or allowing people to take their subsidy toward employer-sponsored coverage, whatever, okay?

The other assumption we could make is we are just going to let the employer system run its course. Whatever's going to happen to the employer system over the next ten years is such a vast issue, I think -- I mean, we are the transitional generation, I think, for employer-sponsored coverage, and we could decide that rather than

counsel a remedy that attempts to make it function better for dependent coverage, both in terms of what it costs to get the coverage and then the value of the coverage once you have it, that we're just going to sort of leave things be with parents using the employer system as best they can today. It'll become a system mostly for parents who are, you know, making more money. And we're going to build -- our attention is on building the thing, just like CHIP was in the beginning, that's going to catch people.

But I think in some ways you could sort of imagine that we come up with two fundamentally different sets of working assumptions about the employer system, and then take those paths down a road and answer the questions of cost, practicality, you know, operational feasibility, and down those two different roads one may be fix up the exchange, one may be the Medicaid expansion on the public side; but the crucial issue is do we or don't we model an employer fix.

I think we're absolutely correct; the problem is a lot more than just the family glitch. The problem is that you're checkmated. Even if you fix the family glitch, you still have this insane affordability test, you know,

which was -- it's ruinous for families looking at dependent coverage. It's so expensive they can't afford it. So that to me is its own discussion for us all, and then sort of these questions flow from it.

COMMISSIONER HOYT: I just had a small point of clarification. In the two slides regarding coverage among all children, are the remaining CHIP kids in the Medicaid bar then? So the kids who are in CHIP but aren't in separate CHIP programs?

MR. PETERSON: So they will go based on where the two prior slides say that they ended up, whether that was uninsurance or Medicaid or employer-sponsored coverage or exchange coverage, or --

EXECUTIVE DIRECTOR SCHWARTZ: But the Medicaid expansion kids are counted as Medicaid in the slides.

MR. PETERSON: Yes. Yes, they are counted as Medicaid.

COMMISSIONER GABOW: This is a question for Mark. I think it's an actuarial question. Given that children are not expensive as a whole group but that you have 5 percent of children accounting for 50 percent of the cost, if you made a decision that all high-need, high-use

children went into Medicaid -- pardon me? Well, I mean, you have to be able to identify them. And we just said working at it, that's not easy. But I'm just asking the question. Removing that 50 percent of the cost, what would that do to premiums both in employer-sponsored and in the subsidized -- and in the exchange to affordability? I mean, I'm trying to understand if you really thought about -- there are a group of high-need, high-use children that you can't identify. It's not going to be, you know, someone who is a kid who gets in a terrible accident and is in an ICU from trauma for four months. That isn't going to be the kid you can identify, but there are a subgroup that you would be able to know in advance.

So does that have enough of an impact on premium to change the affordability equation?

COMMISSIONER HOYT: That's a really good question. I don't know the answer off the top of my head. It would be a matter of trying to figure out where all those kids are in the different groupings that we've looked at. So, sorry, I don't have any answer right here. I'd have to think some more about it.

CHAIR ROWLAND: A lot of those kids are now [off

microphone] already in the Medicaid program for the most -- many of them, and you have the Katie Beckett waivers and everything to bring high-need children even in families with incomes above the normal Medicaid eligibility into the program. And the 5 percent accounting for 50 percent is kind of true in our entire health care system, every time we look at Medicare, every time we look at general spending. And so some of the problem is how many of them are recurring and how many are just there and then they pass through, the next year it's a different set of people.

COMMISSIONER GABOW: Well, we just did that study, published it in Health Affairs, for adults, and they're not the same people, even at six months. But I don't know, of the predictable ones in children, would that make a difference in the premium. Even if you changed how they get in, for example, a kid in a neonatal ICU, if you could get in right at that point, that's -- it depends on what the trigger is, even if you're only temporary high-need, high-use, could you somehow move in -- I don't know, but it seems like if you take 50 percent of the cost out for a group that's not really expensive overall, now you really would have an impact on premium. But I don't know

all the little fun things about being an actuary, which I'm sure, Mark, you know.

COMMISSIONER HOYT: Yeah, there's countless fun things.

[Laughter.]

COMMISSIONER HOYT: One other comment I would just make real quick about ESI in general is that the data on kids is almost non-existent.

COMMISSIONER GABOW: Yeah, right.

COMMISSIONER HOYT: Terrible. They don't know how many kids are in there; they don't know how old they are. They don't know anything that actuaries would want to know to evaluate risk and pricing. It's usually just extremely imprecise as to who the dependents are, all of that. So that's going to complicate it.

MR. PETERSON: Patty, I would just go back to the slide in my prior presentation on the data, that among the children between 139 and 200 percent of poverty, almost half of their spending was on acute conditions; chronic conditions were -- I forget what the number was, but I feel like it was a quarter or so. And so that just assumes like, so back to Andy's question, the answer is yes, if a

child with asthma went in the hospital, that would have counted as chronic. But then, okay, so now your approach is let's flag the kids who have these certain problems, so you're taking that 23 percent -- which is a lot smaller than I anticipated, quite honestly. I thought the percentage that would be chronic would be higher. But given it was whatever that percentage is, and then you have to come up with a bar, so maybe the asthmatics are not counted as children with special health care needs, and that pie begins to shrink. I think the take-home point is to not have -- it may not have as big of an impact as you might think.

On the other hand, when you think about what Arkansas did with respect to adults where they have a private option, and then the policy is, yes, you go into the private option, but if you are an adult with a special health care need, then you go into regular Medicaid. So, you know, this could be addressed.

VICE CHAIR GOLD: I had a suggestion for something that would help us, I think, that should come pretty easily out of the model. What you have here assumes an uninsured -- a change in an uninsured kid is a change in

an uninsured kid and they're sort of equal, each kid is equal. What I'd like -- and I know they are equal, but what I'd like to see, because I think it'll differ for this CHIP versus Medicaid option, is what the average -- you know, which people we're targeting. So I think the Medicaid option probably helps the lower-income kids and the CHIP option may help more the upper-income, and I think that's important information that we have.

The other thing I don't know -- and it gets to the cost issue -- I'm not sure what the relative cost is of solving something within the Medicaid program versus solving it within the exchange. And it would be useful to understand that so we know what some of the tradeoffs are when we're looking at this.

COMMISSIONER CARTE: What I hear a lot of folks saying seems to point to the need to look at high-cost, high-need children within CHIP and to zero in on that. And then we also have other issues that are cropping up, more in some states than others, but drug-related issues for babies with neonatal abstinence syndrome and other cost drivers like the drugs. I think we'd be well advised to look at that data in more detail.

COMMISSIONER RETCHIN: Just to piggyback on Marsha's point, and maybe it's asking again Peter's perspective on this, the two models are really addressing coverage, but they're not addressing access. And I wondered in terms of -- I assume in the exchanges the reimbursement for providers is higher than it is for Medicaid -- I don't know that -- and whether the participatory rates are different, Peter. Do you have any background on that?

COMMISSIONER SZILAGYI: It's just too new. I haven't seen data on that.

COMMISSIONER RETCHIN: I know if you looked at the adult side, the differences would be stark. I think the exchanges reimburse in some areas of the country almost just a small discount off of commercial.

COMMISSIONER SZILAGYI: Yeah, I think it's similar in children, but I haven't seen how that affects utilization or quality or anything.

COMMISSIONER RETCHIN: One would suspect, although maybe it's different pediatricians, but we'll get into this later in a different presentation. Certainly on the adult side, it's really changing access when you move

to those two different models.

EXECUTIVE DIRECTOR SCHWARTZ: It also matters about the network, because I think, you know, there has been a lot about narrow networks in the exchange plans, but you also have an implicitly narrow network in Medicaid.

PARTICIPANT: Narrow [off microphone].

EXECUTIVE DIRECTOR SCHWARTZ: Narrow in different dimensions.

COMMISSIONER COHEN: So I just -- sort of following up on this part of the conversation, I just wanted to ask if you could review -- I'm sorry, I don't remember -- a little bit. When you were looking at the issues -- so, again, this is really focused on coverage, but not our other dimensions which are cost, benefits, networks, and sort of the analysis that you had done on CHIP versus Medicaid and another thing. Did you do -- you did CHIP versus ESI on benefits and networks. Can you just remind us what's in our record or what the literature sort of says about those? Because I think that goes to the question of are the needs of categories of CHIP children, you know, adequately addressed in ESI or other -- and is there a meaningful difference there that we should sort of

be aware of as we sort of orient towards one solution or a hybrid solution?

EXECUTIVE DIRECTOR SCHWARTZ: I think these are sort of stay tuned because, again --

COMMISSIONER COHEN: But was that part of the earlier analysis? I just couldn't remember.

EXECUTIVE DIRECTOR SCHWARTZ: We had an analysis on benefits in the March report last year, and it's sort of a murky picture because of the variability across states. There's certainly concern about dental to some extent, some concerns about some of the therapy services, audiology, but there's quite a lot of variability at the state level.

On the networks level, we don't have good measures, and that is sort of true in general. I think there was sort of an implicit assumption that the CHIP networks were better than the Medicaid networks, but there are not any hard data to bear that out. And I think everyone, I mean, I think across the spectrum of issuers are sort of struggling with what's the right measure of what, because you also have these, you know, one-off agreements within different issuers for certain types of specialists.

So we don't have a definitive answer.

COMMISSIONER COHEN: Okay. I can totally understand. And can I just say the area I think that's sort of maybe of interest or concerns me the most actually would be mental health. I mean, you know, obviously clearly identified issue with the oral and other things, but the sort of issue of mental health and how sort of benefits and networks in CHIP might compare to ESI. It's obviously a big -- it's a very substantial issue for children. In some cases, it's very preventive, and that would seem to be a relevant thing, if we could get any insight into it.

CHAIR ROWLAND: Okay. Well, thank you, Chris. As always, we want more than you've delivered, but what you've delivered has been very helpful.

Now we're going to turn to our audience. If anyone has public comment, we ask them to please come to the mic and identify themselves. And we thank you for being with us all morning long and look forward to your comments.

Public Comment

* MR. HALL: Hi, I'm Bob Hall with the American

Academy of Pediatrics. I want to thank you all so much for the continued focus on CHIP. It's amazing the amount of time that you all are spending on this incredibly important but relatively small program for the population of children that we have in front of us.

For context on that, our data seems to show that the average pediatric practice has about 20 to 30 percent Medicaid, but only really about 2 to 3 percent CHIP. So perhaps that can help frame your thinking about how this works on the ground.

The other thing that I'd like to focus on is Dr. Szilagyi's comment to sort of think about this more broadly. At least at the Academy, our Access Subcommittee on the Committee on Federal Government Affairs really perceives insurance generally as a tool to get children what they need. And thinking about that more broadly perhaps would be beneficial.

One of the standards we try to look at is: Do families have affordable access to a medical home so that their children have the best chance to get what they need to reach their full potential? That seems to be a little broader than obviously the importantly limited discussion

on coverage, and there was some discussion of that, and coverage is obviously an incredibly important first step to get that. But the assumption is it is important in the mental health context and the dental health context, et cetera. And so it has been very insurance oriented, and perhaps a broader aperture on what kids need or are getting would be beneficial.

The other thing I'd note is that the Academy for a long time, for a number of Congresses, pushed a specific proposal called MediKids, and this is something that had been around for a long time, had a broad degree of support within the child health community. It was sort of a Medicare for children, but essentially it would provide EPSDT for all children -- you're born, you're in -- Medicare payment rates so that access would assumably improve. And so that's something that we're still toying with whether or not that would be beneficial to bring back up. We are clearly seeing a lot of churn issues, et cetera, in the kids community, but it's very beneficial that we're at such a low rate of uninsurance.

Finally, I think we've sort of not really talked about this too much, but the needs of kids who don't have

documentation I think are really important to flag. That's something that I think we're often afraid of politically to discuss, but it's critical that that population also receive care. And to the point, again, that Dr. Szilagyi brought, there is a cost to not have those kids insured. There is a cost to not having those kids getting what they need within our society.

So thank you so much for what you're doing.

CHAIR ROWLAND: Thank you.

MS. WHITENER: Hi. I am shorter than Bob. I am Kelly Whitener with Georgetown Center for Children and Families, and I had two comments -- one on the earlier presentation around the approaches and considerations for the future of children's coverage. I'd like to offer an additional consideration, which is that if you think about insurance coverage and one of the things that it provides is a risk mitigation for families, and then couple that with the chart that Chris showed around acute versus chronic care spending, it looks like a big chunk of what's happening is something happens that no one expected that results in an acute need that is expensive. And we know that something that Medicaid and CHIP really offer is

protection against that risk.

Something that modeling doesn't show is, you know, with perfect knowledge we can see the impact of everybody and where they all fall in all of their buckets. But we know that in real life no parent has perfect knowledge, and no parent knows when that acute thing is going to hit. One of the real values of these public programs is that it protects against that unknown.

So one consideration might be, as you consider those approaches, thinking about risk mitigation and how we can sort of incorporate that in the future of children's coverage as it is incorporated in Medicaid and CHIP today.

My other comment is on the second discussion around the transition of the stairstep children, and I think we had a lot of rich discussion from you all about what it meant and additional questions that it evoked. For me, the main take-home that I saw in looking at the outcome of that research was that it takes a long time to transition a group of kids. So, you know, there's a lot of unknown, but certainly one known is that these states took six months to a year to make that transition happen for a relatively smooth transition compared to what it might look

like if kids were going into the marketplace or other all sorts of different coverage sources rather than just from CHIP to Medicaid, which is more one directional and theoretically easier. And it still took six months to a year, and for some states longer than that.

So as you think about timing for your recommendations for Congress and the timing of CHIP funding, in some ways we're already too late to be thinking about CHIP ending in 2017. So just fold that into your thoughts as well.

Thank you.

CHAIR ROWLAND: Any others?

[No response.]

CHAIR ROWLAND: Okay. We will stand adjourned until 1 o'clock.

* [Whereupon, at 12:06 p.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION

[1:04 p.m.]

CHAIR ROWLAND: If we could please reconvene.

As most of you know, the Commission is statutorily required to submit a report to Congress on Medicaid disproportionate share hospital payments, and our first report is due on February 1st, 2016. In subsequent years, we will do additional analysis that will be provided in our March reports to Congress, but right now, we have an imperative to produce a report by the 1st of February, and so this session continues our examination of the issues in the DSH payment area and our focus for trying to get the materials and the issues together for our report. And I am going to have both Jim Teisl and Rob Nelb walk us through the current status of our thinking.

Session 5: Medicaid Disproportionate Share Hospital Payment: Major Policy Questions

* MR. TEISL: That's right. Thank you.

So today, we'd like to remind and update you about this required report on Medicaid DSH as well as talk about several policy issues that have arisen based on our analyses conducted so far.

We'll also present a number of potential approaches for the Commission to consider, which we could then further develop into recommendations or further discussion at your direction.

I do want to cover a couple key points of background without spending a ton of time on it. As a reminder, Medicaid DSH payments are supplemental payments that states are required to make to hospitals that serve high numbers of low-income patients. You will recall that states have a lot of flexibility in determining which hospitals receive DSH payments and in what amounts.

The total amount of federal funds available to each state for making Medicaid DSH payments is fixed, and they're known as allotments. The ACA included reductions to these allotments, which were originally going to begin in FY14 and were intended to coincide with increases in health coverage. The reductions have been delayed several times now and are currently scheduled to begin in fiscal year 2018.

And if Commissioners are looking for more background on DSH and some of the work that we presented last May, Appendices A and B in your materials are a good

place to start.

So, as Diane just mentioned, MACPAC is required to submit an annual report to Congress on Medicaid DSH and specifically on the relationship of states' DSH allotments to several things listed here that could indicate a state's need for DSH. Our first report is, again, due February 1st, 2016. We are currently working on a draft for Commissioner review and comment, and we hope to get that to you in the next several weeks.

As you will recall, in May, we talked about the fact that state DSH allotments are based on the amounts that each state was spending when Congress put limits into place in 1993; thus, states' allotments bear really little meaningful relationship to the factors listed on this slide. Our first report will illustrate this as required, but the report also presents an opportunity for the Commission to comment or make recommendations regarding other issues related to Medicaid DSH policy.

The Commission could consider various policy approaches related to Medicaid DSH, and those could include focusing payment on particular hospitals or reconsidering the types of things that DSH is intended to cover,

including how state allotments are determined. This slide summarizes several of these issues, and we will come back to these at the end, but wanted to sort of put them up, up front, so that you could be thinking about them as we walk through some of what we've learned.

I do want to spend a minute on data issues. So while the questions that our report is required to address are of considerable interest both to the Congress and the policy community, existing data sources don't fully support our ability to answer them. Thus, the Commission could consider whether data improvements are warranted and what you might want to say about that.

Our primary data sources again, is the Medicaid DSH audit data that each state submits to CMS each year to demonstrate that DSH payments to individual hospitals didn't exceed those hospitals' amount of uncompensated care. However, these data only include hospitals that actually receive DSH payments, and that's about half of hospitals nationally.

They're subject to a lag of nearly five years, which especially at the current point in time is quite an important five years. They don't indicate how much of the

non-federal share of Medicaid payments is provided by the hospitals themselves, which affects the net payment amount that hospitals received. We've talked about that in the past, and Rob will provide an example of that issue in a little bit. And again, these are all issues that the Commission could consider making recommendations to address.

Another significant source of information that we're relying upon is Medicare cost reports, which nearly all hospitals submit to CMS. However, because they are primarily for the Medicare program, they don't break out Medicaid payments in sufficient detail for our purposes, and the uncompensated care data that they include don't align with Medicaid DSH requirements and definitions of uncompensated care.

I would mention while we can sort of point out the limitations associated with the Medicare cost report, it's sort of beyond our charge to actually change it.

At this point, I am going to hand it over to Rob, who is going to provide some information related to two broad questions for you to think about. Those are, what types of hospitals should DSH payments support, and what

types of uncompensated care should DSH payments be based on?

* MR. NELB: Thanks, Jim.

So despite our data limitations, there is a lot that we have learned so far from our analysis that can help inform some of these policy questions and possible approaches. I'll begin by summarizing some of our findings about which hospitals currently receive DSH payments, some of the landscape of other federal support to hospitals, and some data that we have about the effects of the ACA on hospital finances. To help inform this first question, what types of hospitals should DSH payments support?

So, first, based on our review of Medicare cost report data, it appears that virtually all U.S. hospitals meet the minimum statutory requirements to be eligible for DSH payments, a Medicaid utilization rate of 1 percent. And although most hospitals are eligible for DSH payments, only about half of hospitals actually received DSH payments in 2010. Some states provided DSH to virtually all of the hospitals in their state, while other states made DSH payments to just one or two hospitals. This is driven in part by variation in state allotments. States with larger

DSH allotments can more easily make DSH payments to more hospitals.

Now, while states have considerable flexibility to determine which hospitals receive DSH payments, about one-quarter of DSH hospitals are statutorily required to receive DSH payments based on their high Medicaid or low-income utilization rates. These so-called deemed DSH hospitals are particularly reliant on DSH payments. We have begun an analysis of hospital margins using cost report data and found that these deemed DSH hospitals reported negative total margins in the aggregate before DSH payments and relied on DSH payments to help offset those losses, to have positive margins after DSH payments.

COMMISSIONER COHEN: Actual question. Can you remind us within your paper what is high Medicaid for us?

MR. NELB: Yes. So there are two ways to qualify as a deemed DSH hospital. One is having a Medicaid utilization rate that's above -- one standard deviation above the average in the state, and the other is a low-income utilization rate (that's Medicaid and uninsured) that exceeds 25 percent. So those are the two thresholds we're working with.

Now, Medicaid DSH is not the only source of federal support for hospitals, and so we want to acknowledge a few other sources on this slide that DSH hospitals may receive for Medicaid, Medicare, and other programs. I won't review each of these in detail, but you have more information about each of these in your materials on table 1, page 7.

I do, however, want to highlight some data challenges that we have across the board in linking DSH data with data on these other federal sources. We've begun to estimate the proportion of U.S. hospitals that receive some of these other types of payments, but we do not yet know the extent to which Medicaid DSH hospitals receive these payments.

Yeah.

VICE CHAIR GOLD: Just a question. You have nonprofit tax exemption here and in the text, and I read it. I understood why you're referencing it, but it seemed a really different kind of thing and particularly when the funds are there on the table in the text we got. I just wondered if you wanted it because unlike the others, which actually are money flowing in, this is money that doesn't

flow out, and it's also -- it would be one thing if it was targeted, but it's almost all hospitals and nonprofit. And it's not particularly targeted to hospitals that are DSH hospitals or anything else.

So it's worth mentioning whether the charity care or whatever obligation they have should offset this, but that money looked -- it was odd. It was apples and oranges.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: To respond to that, I don't think it's apples and oranges because, as we've discussed here, the biggest deduction on the 990 is the Medicaid shortfall. So it's being counted in two ways. It's in the calculation that makes them eligible for DSH, and it's being counted again in the 990. So, in that sense, it is apples to apples.

I will say this now, but one of my recommendations was going to be that the hospitals have to pick what they're going to use their shortfall for Medicaid for. They can have either/or, but you can't have both, and presumably, they'll pick what's beneficial to them. But that would be better than using it twice for the -- using

the same money twice. So I do think it's relevant to be in here for that reason.

MR. NELB: Next, we want to look at the effects of the ACA on hospital finances, and we what we know so far.

As you know, pending DSH allotment reductions are premised in part on this assumption that ACA coverage expansions may reduce the need for DSH payments by reducing hospital uncompensated care and increasing hospital revenue from newly insured patients.

Some early reports that we have found, primarily from private hospitals, suggest that this is, indeed, the case and helping for them -- is helping to improve hospital finances in general. For example, this past summer, Moody's Investors Service, a credit rating agency, recently upgraded its financial outlook for nonprofit hospitals from negative to stable for the first time since 2008, due in part to this declining uncompensated care and increased revenues.

However, it's important to caution that we don't yet know the full effects of the ACA on Medicaid DSH hospitals in particular. So, for example, even if many

hospitals are doing better financially under the ACA, it's possible that some safety net hospitals may be serving a larger portion of the remaining uninsured. They may not be benefitting equally.

Next, I will walk through what we know about various types of hospital uncompensated care at DSH hospitals and some preliminary data about the effects of the ACA on these types of uncompensated care in order to help inform the policy question: What types of uncompensated care should DSH payments be based on?

Now, first, as a refresher, Medicaid DSH payments cannot exceed a hospital's uncompensated care, which is defined for Medicaid DSH purposes, as two components: Medicaid shortfall and unpaid cost of care for the uninsured. Other definitions of uncompensated care also include bad debt, and so I'll briefly talk about what we know about bad debt as well.

Let's begin with Medicaid shortfall, which is the difference between a hospital's total Medicaid payments for services and a hospital's total Medicaid costs. In 2010, DSH hospitals reported $6.4 billion in Medicaid shortfall, which is about 20 percent of their DSH hospital

uncompensated care.

Now, the ACA is actually expected to increase Medicaid shortfall because of increased Medicaid enrollment, which increases Medicaid costs. However, it's important to note that this shortfall may not be a net loss to providers, particularly if they are getting paid for services that they weren't getting paid for before.

In addition, it's important to note that states can address Medicaid shortfall through regular payment rates as well as DSH, and so to the extent that states choose to increase their regular payment rates, this would lower the increases of Medicaid shortfall expected by the ACA.

We'll take a little deeper dive into this and provide a breakdown of Medicaid shortfall before and after DSH. This figure illustrates total Medicaid payments to cost for DSH hospitals in 2010. We look at the state with the lowest payment-to-cost ratio on the left and the state with the highest payment-to-cost ratio on the right as well as the national average for all DSH hospitals in the center. The dotted line represents 100 percent of hospital Medicaid costs, which as the Commission has previously

noted, is an imperfect measure of payment adequacy but one of the few we have to work with.

You can see that across the board, standard Medicaid payments to DSH hospitals are below costs, but that after UPL supplemental payments, the average Medicaid payment-to-cost ratio is 94 percent, which for comparison is slightly higher than what Medicare paid in 2010.

After DSH payments, most DSH hospitals received more in total Medicaid payment than their costs. This surplus can be used to help offset other types of uncompensated care, such as unpaid cost of are for the uninsured.

Now, I do want to point out a data limitation that we have with this analysis, which is that we're only looking at gross payments to hospitals and cannot net out provider contributions towards the non-federal share. So, for example, in the highest-paying state in this example, the state primarily makes DSH payments to public hospitals, which make large intergovernmental transfer payments to the state and, thus, reduced that hospital's net payments. We don't know how much to back that out of the analysis.

Next, let's look at unpaid cost of care for the

uninsured. In 2010, DSH hospitals reported $23.2 billion in unpaid cost of care for the uninsured, which was the majority, about 80 percent of their DSH hospital uncompensated care.

Early reports on the ACA suggest that health reform is reducing unpaid costs to the uninsured, particularly in states that have expanded Medicaid. However, it's important to note that there will, of course, still be uncompensated care after the full implementation of the ACA. For example, the Congressional Budget Office currently estimates there will be about 30 million uninsured in 2018, the first year for which Medicaid DSH allotment reductions are scheduled to take effect.

And finally, let's look at bad debt for individuals with insurance. Those are things, like copays and deductibles, that insured individuals failed to pay. Based on Medicare cost report data in 2011, DSH hospitals reported $11.8 billion in non-Medicare bad debt, but I want to caution that there's a lot of caveats that go along with this number. Most notably, the data we have on Medicare cost reports includes bad debt for the uninsured as well as individuals with insurance, and so we can't really compare

this with the data we have from DSH audits because there's likely an overlap with that care for the uninsured.

Nevertheless, based on the data that we do have, it does appear that early reports suggest that bad debt is decreasing in states that have expanded Medicaid coverage. However, we have heard concerns from hospitals that bad debt may be increasing, and so we will continue to monitor this as more data become available.

Now I will turn it back to Jim to set up the discussion.

MR. TEISL: Thanks, Rob.

So, at this point, we'd like to hear from you regarding these issues that we have presented and what, if anything, you would like us to further develop into potential recommendations. Keep in mind, of course, we are required to do this report annually through 2024. So if there are issues that you think require some additional analysis prior to getting to that next step, there are future opportunities as well.

If you are thinking about potential recommendations, we can come back in October with some draft language to think about, so today, we were hoping to

focus more sort of on the concepts, rather than precise terminology, that we might end up using.

The specific issues we raised today and in your materials that you might wish to discuss are again listed here, though, of course, we hope to hear from you whether you think these are the right issues and whether there are others that you wish to raise for us to look into further.

Thanks. And I think we can probably leave this up.

CHAIR ROWLAND: Okay. Everybody.

[Laughter.]

CHAIR ROWLAND: We'll just go right -- we'll go back and forth. We'll do Patty, and then we'll do Sheldon, and then -- we missed Andy. And then we'll do Chuck, and then we'll do Andy, and we'll just keep going. But we'll start with you four, and everyone else, keep your hand up, so I can let you in.

COMMISSIONER GABOW: Well, first of all, thank you, and I will say I love DSH as a starting statement. But I think there are four things that I would like to see us pursue, not necessarily four recommendations in October, but to think about what is -- I do agree with you about the

data improvements, and I think that those that you've listed are the appropriate ones.

The second is I do think we have to tighten who gets paid, and I personally like the Medicaid plus uninsured greater than 25 percent because we know that people are churning. So thinking about that as one bin, I think is an important point, and I think it fits with what the purpose of the original intent of the disproportionate share payment. It was for those hospitals that do a disproportionate care for people who are uninsured or can't pay.

The second, I mentioned when I responded to Marsha. I really think that we should recommend that a hospital cannot use Medicaid shortfall for both the calculation of credit, under 990, and for their Medicaid DSH, that you have to -- I mean, either the government has to pick and say it's going to only be X, or a hospital has to pick. And you can't double-dip. I mean, that seems like such a basic concept of life.

And the third thing is that I think we should think about how we pay hospitals directly based on whether they meet that definition because I think the way the cuts

are going to happen, as I understand it, is what happened to the state uninsured rate. And I could imagine state uninsured rate dropping and a safety net hospital's uninsured rate not dropping proportionately or maybe not even dropping at all. So I think thinking about this as a hospital-specific issue rather than what's happening at the aggregate state, particularly as the states get -- in big states, this would probably be a bigger issue, perhaps.

So those are the things that I think we should pursue, and thank you for your work on one of my favorite things.

COMMISSIONER RETCHIN: Yeah, this is a very important area, and I appreciate the presentation, and I think this is an extraordinary time for looking at DSH and what has been a very necessary supplemental income.

Let me just understand what Patty said, though. So when you said, Patty, that double dipping is listing on the 990 the writeoff from a shortfall in Medicaid and then getting DSH, would you have -- so a hospital, for example, that has -- let's say a hospital that has 15 percent Medicaid, 35 percent Medicare, and the rest commercial would make that choice, and might well say we're just going

to declare the writeoff because it's important for us to meet the expectations of the community benefit, right?

Then a hospital, though, that has, let's say, 35 percent Medicaid, 45 percent Medicare, and only 20 percent commercial, would they also have to make that choice?

COMMISSIONER GABOW: What --

COMMISSIONER RETCHIN: Okay. Well, let me just answer then --

COMMISSIONER GABOW: I mean, somebody who's smarter than me would have to go through looking at what this would mean, but --

COMMISSIONER RETCHIN: Let me follow that --

COMMISSIONER GABOW: But I think that the principle I'm trying to follow is that you can't count the same thing twice.

COMMISSIONER RETCHIN: Let me keep going then. So by that calculation, obviously the hospital that has only 20 percent commercial and has 80 percent government-sponsored care -- let's just put that in there. I know you can't declare a community benefit for a Medicare shortfall, but you've got to realize this is a safety net hospital because their Medicare is probably not going to be the

suburban hospital Medicare. It's going to be very low income. They're not going to be able to meet their deductibles or co-pays, the Medicare population. So by that calculation, they'd have to take the DSH just to be able to even come close to meeting the needs for their Capex.

So then you'd have the safety net hospital that would then lose its nonprofit status or not be able to declare --

COMMISSIONER ROSENBAUM: No, no. No, no, because the community benefit definition includes a lot besides the Medicaid shortfall. I think the point that Patty is making -- and I'm sitting here sort of trying to move it through my head -- is that hospitals declare, and they declare a dollar value, to their Medicaid shortfall for community benefit purposes.

COMMISSIONER RETCHIN: Right.

COMMISSIONER ROSENBAUM: It's a knowable number. We could do a match between the DSH hospitals and their nonprofit status and see if they declared a Medicaid shortfall, and if so, how much.

The Medicaid shortfall they're declaring may be

far greater, that's my question --

COMMISSIONER RETCHIN: Could be.

COMMISSIONER ROSENBAUM: -- than the Medicaid they're getting back from DSH.

COMMISSIONER RETCHIN: Could be. My point on this was there are DSH hospitals, and then there are DSH hospitals. And if you put them all into the same category -- so that's why it's so important to look at the high-need hospitals, because this issue of double dipping, when you have a hospital that, say, has 18 percent commercial, they're making all their Capex on just that sliver, and to penalize them -- they're not making a margin on Medicaid or Medicare. There's still a shortfall there. Size matters. I understand that. But these are two very different groups of facilities.

And one more point is I really think the ACA in terms of what it really did, enabling many hospitals to move off their bad debt, those hospitals made out very well. The safety net hospitals, many of them, didn't -- they didn't budge. They just supplanted DSH with actual Medicaid. So I think you have to be very careful to not punish the group of hospitals that are safety net.

COMMISSIONER GABOW: Well, to respond to that, I clearly never want to -- as someone who spent 40 years --

COMMISSIONER RETCHIN: I know. I know.

COMMISSIONER GABOW: -- at one of these --

COMMISSIONER RETCHIN: Well, I know. That's why-

COMMISSIONER GABOW: It's not my goal to punish anybody who's taking care of the poor. And if you wanted to say what's the biggest thing to help the safety net hospitals in this country, it's for the states that did not expand Medicaid to expand Medicaid. And that would be the single biggest thing to help the safety net in America.

COMMISSIONER MILLIGAN: So I'm getting in the debate crossfire.

[Laughter.]

COMMISSIONER GABOW: We're going to be on television next week.

COMMISSIONER MILLIGAN: Well done, Jim. So I wanted to talk about tax exemption, too, but I think the main -- I want to follow Sheldon's -- I think there's DSH hospitals then there are DSH hospitals, and I think that that's an important -- that targeting the funding to the neediest hospitals I think is where that conversation goes.

And just on the tax exemption thing briefly, we did a study in Maryland when I was at the Hilltop Institute quantifying or estimating the value of tax exemption compared to the value of reported community benefit, and it was -- this was five, six years ago -- slightly north of $500 million a year of tax-exempt -- the tax subsidies against about $700 million, roughly, of reported community benefit. And there's mandatory reporting. And I would say the 990 is part of it, but -- so I'm going to do my little tax exemption thing for a second.

Tax exemption means exemption from federal income taxes and some other federal taxes having to do with unemployment insurance and things. It also typically in states means exemption from state income taxes, state and local property taxes, state sales taxes, among other things. And then it also means subsidized borrowing through being able to issue tax-exempt bonds and being able to acquire capital cheaper. And it also means receiving donations that are given, arguably, many times because the donor gets some tax value on the individual's tax return to make the donation, which they may have made anyways because oftentimes they are grateful to the hospital.

But all of that is important and valuable, and I think why we have to keep it in the picture here. But I do think that targeting DSH kind of addresses some of this discussion.

COMMISSIONER RETCHIN: The only point I would add there that I mentioned with Sara was if we're going to analyze that, we ought to look at operating margins. That will definitely -- that will be a separate --

COMMISSIONER MILLIGAN: Yeah, and I just think that -- I agree with the point Patty's making that the tax exemption is a form of subsidy. It is a form of lost federal revenue and state revenue, to me isn't so different from receipt of funding. But I want to make a couple of other quick points because I know a lot of other people are waiting to speak.

I think that the bad debt component of this -- I'm personally not very supportive of that, and I think that this is going to be an area where it's going to be quite a bit of a moving target over time, going back to the discussion before lunch about the increase in high-deductible plans. And what I would hate to see is DSH going to subsidize hospitals that can't collect against

wealthier individuals who bought a high-deductible plan and aren't paying their deductibles, and the shift over time toward high-deductible plans, having DSH as the safety net for that, I think the data -- this is where the data lag I think is really way behind where insurance products are going commercially.

Two more comments, and then I'll stop.

The next comment is we talk about Medicaid being a poor payer, and the data shows it when you look at it from a payment to cost ratio basis. But Medicaid is a good payer in other ways, and I don't want to lose sight of the fact that Medicaid is a pretty prompt payer. It has lighter utilization management, kind of, sort of, controls than most other payers. The cash flow is quicker, and there's much -- typically much less scrutiny about claims. So I think if we look at it just from a payment to cost ratio basis, we're not taking into account where Medicaid is a preferred payer.

And my last comment is I think when we talk about DSH and the remaining indigent care, and there's DSH hospitals and there's DSH hospitals, I think we're not going to -- we're going to be confronted with the issue of

undocumented individuals seeking care. We're going to be confronted with the fact that some hospitals will continue to have quite a bit of indigent care because the patients they serve have no pathway to insurance.

So I'll stop there.

COMMISSIONER COHEN: Okay. A couple of things.

First of all, I agree with the suggestions and the comments on data improvements. I mean, even for Medicaid, a five-year lag is pretty outrageous, and I think it's worthy of us saying something about this. It's a hot issue, and it's an issue on which we can have data, unlike some others, and it's just, I think, appropriate for us to say something about that.

About targeting DSH payments, which I think is absolutely the right approach, but I'm going to disagree with Patty on how, I think disproportionate implies relativity, and relativity to me means within the state, because there is so much variation within the states. For example, in some states Medicaid is a much bigger payer, and the average Medicaid discharge might be 25 percent or 35 percent. So it's not -- so to pick a national level I think doesn't quite sort of get to what we're trying to get

to, which is this -- you know, a state can fix that through rates if sort of the average is high. What you're really looking at is hospitals that have compared to their peers on a much higher rate of Medicaid than uninsured use. So I think the relativity within the state is quite important for targeting. And I also think picking a fixed level is not fair to states that have a very small Medicaid program as well. So not just one that has large.

I do think that Slide 13 is remarkable, the one that indicates that Medicaid pays more than 100 percent of hospital Medicaid costs. I would love to spend two hours grilling you on what really is a Medicaid cost and is this really right, you know, on average and, you know, what is it capturing and is it marginal or not. But I won't. But, you know, on its face this is remarkable. Chuck's points are well taken. Medicaid is a good payer in a lot of states and on average, and that is not sort of well known or accepted or the talking point that's really ever -- for hospitals, let me be clear, you know, that's really known in the general discourse.

But one thing that does show up is that that's not true if you look at rates. It's only true if you look

at total -- at sort of total spending or total payments, and it does mean that every marginal Medicaid patient that walks in the door doesn't necessarily bring much to the hospital. So that's just an important thing to think about. I mean, rates that equal these costs or even discounted by the amount that are CPEs or IGTs it seems to me would have better sort of incentives overall.

And then my last question is I still don't completely understand -- and I think in part it's naiveté, and certainly politics is a factor here -- why states rely so heavily on DSH, especially states that spread DSH very, very broadly across a lot of hospitals. And this is a question: Is it because they can't use those same IGTs and CPEs for rates and they can only use them for DSH? Is that one reason?

MR. TEISL: Part of the issue is the ability of states to target DSH payments differently than they might be able to rates generally, right? So if a particular hospital is contributing a non-federal share but it's used to support rates, it's more likely that those rates will apply more broadly than to the hospitals that contributed the non-federal share.

COMMISSIONER COHEN: Okay. So in other words, a state, for example, that gave DSH to a whole lot of their hospitals doesn't give the same amount to all of their hospitals, and you can target the amount in a much more targeted way using --

MR. NELB: Yes, although states can target their regular payment rates to specific classes of hospitals --

COMMISSIONER COHEN: If they categorize them.

MR. NELB: Yeah, there's certain ways to do it, but it's that -- and then another piece about DSH is that it does have some budget certainty to the state. There's a set allotment. So if utilization goes up or down, the amount from the state budget is the same because it's fixed. So just another unique piece about DSH.

COMMISSIONER COHEN: Okay. Thank you.

COMMISSIONER RILEY: This is great and important work and good work through a maze of complexity, and I would echo much of what's already been said. It seems to me there's two buckets of issues where we need to think about policy recommendations. One is clearly around data, because we don't know what we don't know, and don't know it, particularly around the netting out, Andy's point. I

mean, where -- these are legal, appropriate uses of dollars, but if we don't net it out, we don't really know what that Chart 13 tells us. And I would just echo the notion, I would love to see a policy discussion -- I would like to see the elimination of the term "Medicaid shortfall" in the discussion for three reasons. One is that, quote-unquote, shortfall is, we have often heard, shifted to private payers. So how do you shift it to private payers, increase private payers' costs, count it as community benefit, and get DSH? So I'd say it's a triple dip, not a double dip. And I think we really have to look at that, and I would just say, "Hear, hear," to the notion of community benefit, although Sheldon's points are very well taken about how we define that.

And, finally, there's something fundamentally inflationary in it because we assume that hospitals are always efficient and good and Medicaid is paying too little, and I think there has to be a policy discussion about, you know, how much is too much cost from hospitals and how much is too little payment from Medicaid. And without those discussions -- so I'd like to eliminate the whole Medicaid shortfall definition or rephrase it. But it

seems to me those are policy discussions we have to play out.

COMMISSIONER HOYT: A couple of questions. Is MedPAC required to do a report as well on DSH?

MR. NELB: Not that [off microphone]

COMMISSIONER HOYT: Huh, okay.

[Laughter.]

EXECUTIVE DIRECTOR SCHWARTZ: They frequently do, so it's not --

COMMISSIONER HOYT: It seems like you'd want both.

EXECUTIVE DIRECTOR SCHWARTZ: But the Medicare cuts have already -- Medicare DSH cuts have already been made.

COMMISSIONER HOYT: It seems to me we've had a mantra kind of simplify to the third power, you know, repeat. And this issue just seems to beg for simplification, but we're not talking about it. We may not want to for different reasons, but there's certainly quite a bit of info in here that to me, if I'm on the Senate Finance Committee especially, seems to say -- so you're just admitting that Medicaid's base rates are way too low.

You know, we may not want to recommend they be raised to a floor level or something else, but it seems to me like we should be ready to address that.

Even in the state with the highest DSH, it's still only at 86 percent reimbursement. If I'm a finance guy, I'm just going to sit there and wonder, "Well, why don't we require that they pay base rates at a higher amount?" It seems like that even if you can justify at least having DSH, if not the supplemental payments, because there's still some remaining bad debt or charity care, it's like it needs to be rejiggered.

The other thought I had on the graph, to me, maybe I don't know how to read fiscal conservatives, but I would think some people would just go ballistic, if they saw this chart, with the federal government. Medicaid is a federal program reimbursing hospitals at 110 percent of cost. I don't know that this would fix it either, but could we also do some kind of projection to 2018 or '20? I would want to know. I'm asking myself, "Well, what does this look like? Did we fix this when we reduced the DSH payments?" Now what would it look like? I know we've got some reductions in place. Show me what that looks like.

COMMISSIONER CRUZ: I think I read someplace -- and I may be wrong -- that there are some DSH money allotments from the federal government that goes unused every year. Can you expand on that, and shouldn't that also be part of the discussion?

MR. NELB: Sure. Yes. So when we were here with you in May, I think we shared the general finding about $2 billion in DSH funding was unspent in the most recent year. So a state gets a federal DSH allotment, but in order to draw that down, just like any other Medicaid dollar, they have to put up state funding to match it. So for a variety of reasons, states do not draw down their full DSH dollars. They may use that state dollar in other ways to make other Medicaid payments, but there is a portion that is unused.

These figures show what was actually spent --

CHAIR ROWLAND: It's a portion of the allotment --

MR. NELB: Allotment.

CHAIR ROWLAND: -- that's unused.

MR. NELB: Yes.

CHAIR ROWLAND: It's not like there's a pile of money sitting there waiting.

MR. NELB: Yes. That's a very good clarification.

So figure 13 was reflecting what was actually spent in 2010 to those actual hospitals.

COMMISSIONER CHECKETT: Well, first of all, I have to comment back to the tax conversation. A very dear friend of mine once pointed out that the only real difference between for-profit and not-for-profit entities is that the for-profit entities pay taxes on their profits, and if you think about that, there's actually a lot to be said in terms of the fact that lots of people are making profit, and it's just really kind of how it's taxed and how that benefit is used. And I think that goes to the earlier discussion about the importance of looking at that to I think we don't want to make broad assumptions about for-profit hospitals and not-for-profit hospitals, et cetera.

In terms of DSH -- and the paper is great, as usual, and a topic that has a lot of interest from the Commissioners. The one thing that -- and, Jim, I think you may need to even have a moment with me here because, in my six years on the Commission, I'm now changing my position, and I am going to personally advocate for a deep dive into

the state match. So write that down. It will be my swan song.

But seriously, I think a couple things have happened in the course of the time for the Commission. One is the move to value-based purchasing, and to look at these enormous amounts of money going into hospitals, it's really for what? And it's not that it's just Medicaid or uncompensated care or whatever, but it's like, in addition, what are we getting for that? Is there community value? Are those funds going to population health management? Are people getting better? And I think, philosophically, we have just come so far in that discussion that at some point, as much as I understand DSH and tremendously support it, I really do think as policymakers, we need to start to be looking at what is really happening at those hospitals. The ACA and states that have passed expansion will start to take pressure off DSH hospitals and safety net hospitals.

So I think we should start to ask the tough questions: Is it UPL? How much? Is it taxes? Is it CPEs? And really, what is the total amount of cash versus claimed funds going to hospitals? And I think it's an important question.

I think the data search for that is going to be pretty extraordinary, and I can't wait to see what we can come up with that. But I would really say to look at that and to really, down the line, start to say, and as long as DSH continues, then at what level can we also have an expectation about how people's population health and the communities improve by those funds?

Thank you.

COMMISSIONER SZILAGYI: Yeah. I'm trying to catch up to you all on DSH, not being a DSH expert. I'm trying to sort out in my mind -- and I have kind of a data request that might be helpful, this issue that there are DSH hospitals and there really are hospitals that serve the poor. And I'm trying to sort out in my mind the background of DSH and what the purpose is and how the money is really flowing, and what would help me, because I didn't see it here, is what percentage of DSH allotments go to hospitals that are -- let's say take care of 1 to 10 -- whose Medicaid populations is only 1 to 10 percent? And what percent goes to hospitals where it's 20 to 30 percent, and what percent goes to hospitals where they are really DSH hospitals? And that would help me in terms of -- and then

what is the trend? What has been the trend? Are we veering away from more and more of the payments going to the truly DSH hospitals or veering toward them?

Maybe these are completely naïve question, but I don't have a good sense in my mind for where the money is heading and to what extent is the money heading in the direction that the original principles of DSH, which actually sound like pretty good principles to me, what they intended.

COMMISSIONER COHEN: But only up until 2010.

COMMISSIONER SZILAGYI: Right.

CHAIR ROWLAND: But that also depends on which state you're in because a lot of these rules are much more governed by the state than they are -- this is where we have to be, both national policy and also look underneath that state variation.

VICE CHAIR GOLD: You probably want the state distribution of DSH money as well to help you understand that. Right.

CHAIR ROWLAND: Just need to be in California to know.

COMMISSIONER RETCHIN: Okay. So the horse isn't

dead, but he's a little moribund. But I am going to go back to this division.

So, first, in terms of Donna's comment, it's true there are a lot of -- I'll call them not-for-profit hospitals who clearly are making margins 15 percent, and you've got to question what they're doing with their margins.

But then there are what I now will call nonprofit because they're not making a profit. The safety net hospitals -- I'll go back to my example, and Trish was mentioning this. It's very difficult for a hospital that has an 18 percent commercial population to really cost-shift, and it's getting worse because post ACA, the marketplace is not actually paradoxically able to more go after these vulnerable safety net hospitals, because if you only have 18 percent commercial payers, they can actually exclude you from the network, require even steeper discounts. So there is no ability to cost-shift, and so the ability to fund capital is even going to go down.

So I really want to emphasize this very high-need hospital that I think that safety net is even more vulnerable now.

VICE CHAIR GOLD: Yeah. If we are talking about policy and if we do talk about that in the report, it seems to me -- and maybe this is sort of a step that we would have mentioned, but it seems called for from the questions here.

If you look on page 2, it says what types of hospitals should get DSH, what should uncompensated care -- it seems to me, there's a first-order question: Is there still or is there a rationale for DSH? Should it continue? If it should, what is it based on? And so one needs to sort of answer that first-order question to answer the other two.

I gather from people's comments here that people probably do think there is a rationale, but I think laying out that rationale in relation to the history is probably important if we're going to get into the policy issues.

COMMISSIONER HOYT: I had two things I forgot the first time.

I do think we should take this opportunity to strongly request the major data components that we have talked about countless times that we don't have that block us from getting more specific about exactly what's going

on.

A second question is procedural. Where do we make the recommendations? Is the channel distribution for this report the same as the March or June report, or should we make recommendations in the March report about our DSH report?

EXECUTIVE DIRECTOR SCHWARTZ: So what we were working on, an assumption, is staff -- because of the short time period between February 1st and March 15th, is that we would issue this report as an electronic report, February 1. We can print out copies, to hand-deliver them so that we meet the requirements for having transmitted the report, and that we then include it as a published printed thing as a section of the March report. So we would meet the requirements, but then we don't have to put out a separate volume right on top of the March report. We'd probably get more bang for the buck putting the two pieces together.

So that's the assumption that we are working on from sort of the workflow and production perspective, but obviously, if you have other thoughts on that, now would be a good time to hear about that.

CHAIR ROWLAND: Obviously, we do need to meet the

February 1st deadline, and it would be useful to have in that report any recommendations that we can come to conclusion about. In the future, it will always be in the March report. So I think we should include, as Anne mentioned, whatever our February report is as a chapter in the March report.

We obviously don't have a lot of time between February 1st and March 15th to add or change any recommendations. So I think the goal would be to incorporate whatever recommendations we want to make in the February report.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. Actually, let me just add to that, which is it's not so much the issue of February to March because, basically, there's almost no way to get anything accomplished in that time frame.

The game plan that the staff is operating under is that we would like to get this basically taken care of no later than the December meeting so that this existing group of Commissioners bring it to a close and then can move on. We'll have more new Commissioners in January and probably not a great place to start. Obviously, anybody

comes on in January is going to have to catch up and learn because it will be a topic of subsequent reports.

So that what we're anticipating here is have the discussion today about sort of help us understand which direction you're going in, and you have given us some of that, although a little bit more specificity would also be helpful, come back in October with something that looks like draft recommendations that get a little bit more specific on it, and then bring you a final report that you could kind of say, "Yes, this is the thing," in December.

CHAIR ROWLAND: Or at least bring the final recommendations, and then you can put the text to bed in January. I mean, I'm sure that we'll always be asking for more data and more information, so we would never want to have it get totally done by the end of --

EXECUTIVE DIRECTOR SCHWARTZ: And we would never be bored, and we would always have the opportunity for the next March.

CHAIR ROWLAND: But I think one can also think about not only coming to some final recommendations in this report, but since we have to do one every year after that, kind of also keying up in this report what other issues we

would want to be taking on and looking at what other information and data we would like.

But I'm back to -- Sara was next up on the last, then Chuck. I haven't forgotten.

COMMISSIONER ROSENBAUM: A couple of things. One is, I think in addition to Marsha's point about some context, some background for the chapter, and the earlier point that Sheldon made about there's hospitals and then there's hospitals, I think that we not only have to say that there's hospitals and there's hospitals -- and we've developed over many decades now sort of a strategy for keeping certain hospitals going. There are certain hospitals that really aren't going to keep going without a more purposeful strategy like this.

I mean, I think the other missing piece here is how states have used intergovernmental transfers quite apart from DSH, okay? So there may be some states that target their DSH funds to certain types of hospitals because certain of their hospitals that actually are their biggest safety net hospitals are pretty much supported through intergovernmental transfers, depending on the corporate structure of the hospital.

I also think it's important -- so in addition to sort of explaining some context here, it would be worth asking both the IRS and CMS why the distinction was drawn. Obviously, it must have come after a fair amount of consultation back and forth between Medicaid shortfall as a community benefit for purposes of nonprofit status and the fact that Medicare shortfall cannot be treated that way. Medicare shortfall is treated as simply a shortfall. It's not a community benefit, and that was a very deliberate decision, and sort of figuring out how a decision to treat -- I assume some of it may got to the fact that even though we see DSH being used to cover the Medicaid shortfall, it falls short of the gap.

I mean, it may well be that the reason that they're allowing it is because it's a means tested and public program and classic concepts of aid to the poor argued for treating Medicaid differently from Medicare for charitable purposes, but it may also be that in fact, although the Medicaid shortfall does get offset with DSH financing, the offset may be relatively modest for some hospitals compared to the true size of their shortfall, especially if they're big Medicaid hospitals.

So I think sort of trying to fill in, coming at this for Congress by giving some context for what hospitals are we talking about here, how do we stratify our hospitals, how do we express to you this jury-rigged system of financing that's been developed and where are we today because of insurance reforms, and is this jury-rigging system still working, and what part does Medicaid reform play in that. I mean, you know, we were whispering here that, of course, there is Medicare DSH, but we are pretending that that doesn't exist.

So I think trying to pull a full portrait together will be a good thing here, and then our recommendations will start to make some sense even to us, maybe. I don't know.

[Laughter.]

CHAIR ROWLAND: Chuck.

COMMISSIONER MILLIGAN: Thank God, you've got till October.

So I want to just -- and maybe this is context sharing. So lots of states that I'm aware of on the Medicaid side, the match for DSH comes from local government. So I'm going to oversimplify a little bit, but

the match for DSH comes from local government often. And so you see a community where the safety net hospital is the public hospital, that their local county taxpayers are expected to come up with the funding to pay for the state match to get the DSH drawdown, which is why you see 2 billion left on the table, is because the local governments aren't coming up with the match to funnel it through, often. I'm oversimplifying.

And I am going to conclude this little thing with coming back to Donna's comment about value proposition. What has happened in states that I'm aware of is that DSH then is treated almost like pork at the state level, and so if the allotment is a million dollars, it's kind of divvying it up through sort of state politics and hospital association politics and who is eligible for what, and that kind of plays out and that kind of distributes down to the local governments, their share of the max, to support their local community hospital, roughly speaking.

And so what you end up happening then is that DSH is distributed broadly to a lot of the low Medicaid -- arguably low-Medicaid utilization hospitals because of state politics and hospital association politics, and then

that community has to come up with a match, and they may or may not, based on their own view of taxation and their tax burden, whether they can do it or not.

And so one of the other things that's coming out of all of this is you are seeing DSH used to prop up hospitals that arguably should be closing, and a lot of communities are becoming more of an urgent care, outpatient, or ambulatory kind of place. And as utilization is going down generally, you are seeing that a lot of hospitals are getting propped up that have low census. And it changes the payment-to-cost ratio because you've got the same fixed costs distributed over fewer payers and patients and bed days, and so that distorts a lot of stuff too.

So just to kind of conclude my little thing here, I think that a recommendation I would be comfortable down the road is something that tries to kind of normalize the purpose, which is safety net focused, maybe less discretion at the state level, narrow the definition of who is eligible at the hospital level, so that it's not like a hospital that accidentally does some Medicaid, and that it become much more policy and rational focus around really

supporting safety net providers, and that there's a value proposition in that.

So I just thank you for indulging that little speech.

CHAIR ROWLAND: I think that that is a great place to end. I think that is the goal of what we want this report to do. Clearly, I think some of the information on which are DSH hospitals and other DSH hospitals, who's getting these dollars today, how are they distributed by state, what are some of the differences by state is useful information to include in this report. But I think in terms of developing recommendations, we want to both look at the data issues. I think that's a key area where we can and should be making recommendations. We've made them before. We need to make them again because much of the analysis that we need to do in the future we can't do unless there's better data to do it to begin with. And I think really to look at the intent of DSH and the focus on where it should be going and really some of the issues and how it's being used and potentially misused now need to be laid out as part of that.

So I thank you both. You've got a lot of work.

You will need 18-hour days between now and the October meeting, but we look forward to having a really robust report that we can give to Congress. I think they wrote this into our statute because they really wanted someone to think hard and long on it, and I think we will show them that we're capable of doing that with your good work. Thank you.

And we know that there may be some public commentary on this portion of the Commission's work, and so if anyone in our audience group wants to come up to deliver remarks, we will now entertain them. If you do, please identify who you are, and also, if you have written remarks, submit them for the record.

Public Comment

* [No response.]

CHAIR ROWLAND: No public comment? Did we just totally mystify you with our discussion? Okay. However, I would say for the public record that we know this is an issue near and dear to many facilities and many groups, and so if there are external groups that have comments they wish the Commission to consider, please submit those to MACPAC and we will make sure that all the Commission

members also are appraised of whatever those comments are.

Okay. We will now then move on to ask April Grady to join us to talk about the Medicaid spending trends. As you know, there is a lot of interest in the Congress and in the nation in what is driving Medicaid spending growth and in how to contain overall health care costs, and so April is going to start us off with a review of kind of the history of Medicaid spending and where we're going.

Session 6: Medicaid Spending Trends

* MS. GRADY: Thank you, Diane. I'll review the history of the spending, but not how to contain it. That's for next --

CHAIR ROWLAND: You really -- just offer up a few ideas.

MS. GRADY: Right. Just a quick overview of the presentation I'm going to give, with some key points here.

The first is that the majority of historical growth in real or inflation-adjusted Medicaid spending has been attributable to enrollment. And in terms of eligibility policy, that's been a big driver of changes over time.

In terms of cost containment, reducing spending relative to current projections requires that we cover fewer people or lower spending per enrollee, and that seems very simplistic, but I'll get into the details later and try and frame the way that we might think about some of the policy discussions you'll have in future Commission meetings.

Another key point is that the new adult group and people age 65 and older are the groups that are going to have the fastest enrollment growth over the next decade.

In terms of prices, there are a number of options for holding down provider payments, but access to care, as you know --

CHAIR ROWLAND: April, could you pull the microphone a little closer?

MS. GRADY: Sure. Prices can be held down primarily by reducing provider payments, but access to care, as you know, is a big concern with that policy intervention.

And then, lastly, efforts to address volume and intensity of services may include a wide range of strategies.

Okay. So starting with some facts on Medicaid spending growth, here is just a slide summarizing the points that I'll make as I walk through some of the figures that follow.

Of course, as we know, total Medicaid spending is equal to the number of people times spending per person. The program can grow because we have more people or because we're spending more per person, and this might seem like a very obvious concept, but one major purpose of this presentation is to focus very clearly on the components of spending growth so that we can be clear about the mechanisms by which we're expecting the policy interventions that you consider to have an effect on overall Medicaid spending growth in the future.

In terms of the components of growth over the past few decades, starting with 1975 and going through 2010, the majority of this historical growth in real Medicaid spending has been attributable to enrollment. And one thing to point out here is that we chose 1975 in part because it was about ten years after program startup. We wanted to look at growth after the program had matured a bit to see what the long-term trends looked like.

Another point here is that we adjusted for medical price inflation here, so the components you're seeing in terms of the spending per beneficiary growth, what that represents is an increase in use and intensity of services. We've sort of taken the price component out, assuming that Medicaid would grow with medical price inflation like any other payer. There's any number of ways that you can do these calculations, and I'm making a big deal about this because you will get different answers if you use different inflation factors, and you may do that for different purposes. But that's why I want to point out here that what we're showing is net of medical price inflation, what has driven Medicaid growth is primarily the number of beneficiaries, not an increasing use of services by those beneficiaries over the years.

This is the same pie chart from the previous slide, but what we're doing here is showing the components of growth by eligibility group, and what you'll see here is the two biggest slices are attributable to people with disabilities. So down on the bottom here you see that 38 percent of the real Medicaid benefit spending growth since 1975 is attributable to an increase in enrollment of people

with disabilities. The other slice I'll point out there is the disabled 12.7 percent, and that is showing the contribution of the increase in spending per enrollee for disabled people to overall growth.

So what we see is that this disability population accounts for about half of the real spending growth over the past few decades. And what I'll say is that even though the disabled population is accounting for a large share in terms of enrollment, it's not that there was explosive growth in the number of disabled beneficiaries in any given period. Even very slow growth in the population of people who are eligible based on a disability can lead to substantial increases in program spending because each new person that you add is very expensive. So that's how we end up with the numbers that you see here.

I can see that the gray bars aren't showing very well on the screen here, but what this slide is showing here is -- previously I was focusing on the long-term growth over the period of 1975 to 2010. What this graph is showing is that if you look at any given period of time within that long span, the year-to-year change fluctuates a lot. And spending is the top line on the graph, and

enrollment is the bottom line that you see there. And what we have here highlighted are some examples where either enrollment or spending or both had a significant change due to a policy change or economic conditions. So I'll sort of walk across here and explain some of the examples that we put on the graph.

The Omnibus Budget Reconciliation Act of 1981 is shown there, the effect of that. There were a couple of things. One is that the law reduced the number of cash assistance recipients at that time, and because cash assistance was directly tied to Medicaid in those days, that led to what you can see as a negative growth -- a decline in enrollment in the period following the passage of that legislation. At the same time, there were actual reductions in the federal matching for three years, and that's why you see the reduction in spending growth there on the graph.

If we move across to the period of the late 1980s through the early 1990s there were a variety of things happening here. It was a very active time with Medicaid legislation, expanding eligibility for pregnant women, infants, and children. There were also expansions of

Medicaid payment of Medicare cost sharing, which is something we talked a lot about last year, in 1988 and 1990. So you can see that enrollment line on the bottom there sort of shoots upward, and that's a combination of things happening. In addition to those eligibility policy changes, there was also a recession in 1990-91, and that had an effect on enrollment.

The line above it is spending, and you can see spending went up with enrollment. But at the same time, one of the things that was happening in the early 1990s as well was the increase in the use of DSH that we just heard about in the previous session, so that was also a contributing factor.

I won't go through all of the bars here, but the point is to show that over time there have been different contributing factors to the growth in Medicaid enrollment and spending that we see.

This is just summarizing some of the points I want to make about federal spending growth on the next few slides. I won't read these. I'll walk through here.

One thing to note is that CBO and CMS Medicaid enrollment and spending projections do differ from each

other, so there's not one number that we go to when we look at projected growth. Here on this slide, there's about a 3 to 5 percent difference, depending on which estimates you look to, and this can create some confusion just based on which source you go to. So we always want to be careful to cite who we're looking at.

COMMISSIONER ROSENBAUM: Is the difference the takeup rate estimates?

MS. GRADY: That is part of the difference between the two. There might be differing assumptions about CHIP as well. That's frequently been something that we see. As you know, CHIP -- CBO is required to make certain assumptions about the continuation of CHIP, and those are not always consistent with what CMS assumes because they're not bound by the same federal budget act requirements. So that does explain some of the difference.

This slide here is just showing the difference between the spending projections that CBO and CMS put out. And here what we're showing are major components of total federal outlays since 1965 when Medicaid was enacted. What you can see here -- and I wish it was showing up better on the slide -- is that there's been a real shift since 1965

in the federal budget from discretionary to mandatory program spending. In 1965, mandatory programs were about 30 percent of the federal budget. Today they're more than 50 percent. So we've seen a decrease there in the discretionary spending share.

The other thing I'll point out here is that Medicaid, despite the recent growth in the program due to the eligibility expansion and other factors, is still projected to remain a smaller share of the federal budget than Medicare. And if you squint really hard, there's a red line showing CHIP, just for context. You'll see how small that spending is relative to the Medicaid program as a whole.

This slide should look familiar. We showed this in May. Sort of nothing new here to report. What this is showing is different measures of Medicaid as a share of state budgets, depending on whether you include federal funds and what type of state funds you include in the total. And the reason I put this up here is, one, to say the state share depends on how you measure it. And the other is to say we don't have good projections of state spending into the future for a number of reasons. One is

that although we might know or project what Medicaid spending will be, what total state spending will be is sort of a separate question, and each state is going to independently figure that out over the years.

The other thing is that there will be a big difference in terms of expansion versus non-expansion states in these different Medicaid shares of the budget, and that's because the expansion states are going to be receiving 100 percent, eventually 90 percent, match for their new adult populations, and that's going to have a big impact on Medicaid as a share of the total budget, including federal funds. But it might actually not have a big impact on Medicaid if you're just looking at state funds. So it's just a long way of saying state projections are harder to do, and that's why we don't have them readily available.

Turning back to Medicaid growth overall, I've talked about projected federal growth, and now I want to talk about projected Medicaid growth overall. What we're showing here on this slide is average annual growth and in projected Medicaid enrollment and spending per enrollee over the next decade.

On the left side here with enrollment, what you'll see is that the two groups with the projected fastest enrollment are, not surprisingly, the new adult group, at 12.5 or 12 percent a year. A lot of that is front-loaded at the beginning of the period. Obviously, this is 2014 to 2023, but most of that jump is attributable to the increase in the early years.

The other group, as I pointed out, is those age 65 and up. They're expected to grow about 3 percent on average in terms of enrollment over the next decade. And that's mostly a function of the aging population. It's not a change in eligibility policy. It's simply more people turning 65 and becoming eligible for Medicaid.

The second set of bars here is showing annual growth in spending per enrollee, and the first thing I'll point out here is that for each of these groups, with the exception of the new adults, the spending per enrollee is expected to be slightly higher than medical price inflation, which is projected at 4.1 percent for the medical CPI. So children, for example, spending per enrollee is expected to grow by 4.8 percent a year; whereas, medical price inflation is 4.1. So that

difference between the two is some increase in the service use or intensity, not attributable to prices.

The other thing I'll point out here is that you'll see a decrease in spending per enrollee among the new adult group, and that deserves some explanation. CMS projects that people who have enrolled in the new adult group first are people with higher needs, who are sicker and higher cost. So what they project is going to happen over the next decade is that as more people enroll, they will be the healthier folks, and they will actually bring average spending for that group down over time. There's sort of nothing magic happening in terms of savings. It's really just the changing composition of that population group that's expected to bring spending per enrollee down, and I'll talk a little bit more about that in a moment.

What we're showing here on this slide is the distribution of Medicaid spending by type of service and the annual growth in those types of service. I'll start with the left-hand column here. What we're showing is the share of Medicaid benefit spending that went to each of these types of services in 2013, so before many of the Affordable Care Act changes are made.

As you can see, hospital spending accounts for about 40 percent of the total, and I'll say here this is both fee-for-service and managed care spending, so this is the distribution overall within the Medicaid program. Hospital was followed by a category that is categorized as the other health and residential and personal care in the national health expenditures. That's where a lot of the home and community-based waivers and other Medicaid home care services are located, and then on down the line here you can see the distribution of spending.

Another line I'll call your attention to -- two other lines I'll call your attention to -- is the physician and clinical line, which was 12 percent in 2013, and prescription drugs, which was 5 percent in 2013.

The column to the right there is showing historically on average how these expenditures have grown between 2006 and 2013, and, you know, there's some variation there. But, in particular, I'd highlight prescription drugs. That's a place where the growth -- and this is net of prescription drug rebates -- growth in prescription drug spending was on average 1 percent each year.

The last three columns of the table are showing what is projected, and, yes, 2014 is still a projection. It's just the way the data work. The final numbers aren't in. But you'll see there that prescription drugs have jumped up to 23 percent, and that's a function of two things: one, we have the expansion to new adults coming, so there are more people using prescription drugs in Medicaid; and there's been an introduction of new high-cost drugs to treat hepatitis C that have particularly contributed to this growth in 2014 that's projected.

CMS expects that the growth for prescription drugs is going to go down in 2015 in part because of increased negotiation by payers with drug manufacturers. And then in 2016, again, there's an even further drop expected. So that's one line that I would highlight with prescription drugs.

The other here is physician and clinical. You'll see that there was a 27 percent increase in 2014, and that's attributable, again, in part to the coverage expansion. There are more people using physician and clinical services because of the new adult group coming on board.

The other thing here is the primary care physician payment increase, and although that was in effect in 2013 and 2014, what happened in practice is implementation was slow, and a lot of the money was actually paid out in 2014, so you see this big, big jump there in 2014. In 2015 and 2016, things go back down for a lot of these services, in part because of the moderating of the coverage expansion. There's this initial surge and then sort of a steady increase or stabilization, and then also these other factors that I talked about that are specific to the primary care payment bump expiration and the prescription drug negotiation with manufacturers.

VICE CHAIR GOLD: April, since this comes after some of your per enrollee figures, do you need to more specifically show that this is the aggregate change?

MS. GRADY: It could be better labeled, and I wish I could break this out in terms of what is per enrollee and what is people. But, yes, that's why I've spent a lot of time talking about this one, because, you're right, it's a mix of spending increases due to both people and spending per enrollee.

What I wanted to point out here is -- I've

focused a lot on or mostly on Medicaid benefit spending in the slides up to here, and what this slide is showing is the distribution of total Medicaid spending, including benefits and program administration. And the thing I want to focus on is the slice at the top there, state program administration is about 5 percent of total Medicaid spending. That has been fairly constant for a number of years in terms of the state program admin aspect of the Medicaid program. I just wanted to point that out because we're omitting it in part because we don't -- we have a different story to tell about benefits, but also because it hasn't changed significantly. There's not a lot to report there.

CHAIR ROWLAND: April, where is DSH in this distribution?

MS. GRADY: DSH is going to be in the fee-for-service slice because those payments are not flowing through managed care plans. They're specifically paid by the states.

CHAIR ROWLAND: But it might be useful to actually have it separated out.

MS. GRADY: That's actually -- that would be

possible. We could do that.

CHAIR ROWLAND: Patty?

COMMISSIONER GABOW: I know this is in other places, but what percent of the population is in managed care and in fee-for-service? And it may be that even though 70 percent is in managed care, that the reason for the flip in the dollars may be the DSH piece, which would be good to know, because this would imply, of course, that --

CHAIR ROWLAND: Within the fee-for-service is the disabled and the elderly.

COMMISSIONER GABOW: Right. That's what I was going to say.

But it would be good to think about that, and I do agree separating out the DSH separate would help clarify that too.

MS. GRADY: We can certainly do that.

COMMISSIONER ROSENBAUM: That part of the managed care premium per capita payment that represents administrative activities, does that show up in the 5 percent or in the managed care payment?

MS. GRADY: Very good question, and it does show

up in the managed care portion.

We don't have a great way of breaking that out with precision at the state level. CMS does estimate for the national health expenditures the portion of Medicaid spending that's due to government administration versus the cost of administering managed care plans, so that's something --

COMMISSIONER ROSENBAUM: With BMLR looming on the horizon now, I mean, these issues are sort of getting a grip on -- and still, whatever it is, I'm sure it's relatively modest, but I think understanding that states increasingly will have -- for years now had Medicaid -- had managed care entities administering big chunks of their programs for them and that these entities now may be subject to new limits would be good.

MS. GRADY: And though it's not shown here, my recollection from looking at the National Health Expenditures projections, the government administration portion is about 4 percent. Numbers will differ from this chart here. And the piece that's attributable to the -- it's referred to as the net cost of private health insurance in the National Health Expenditures – I believe

that's about 5 percent currently. That’s 5 percent of total Medicaid spending, not of the managed care portion.

CHAIR ROWLAND: Chuck?

COMMISSIONER MILLIGAN: Sure. Yeah. Just a data point on this too. I think if it was labeled the fee-for-service, it is really volume based, service based. So if we're going to set aside DSH, we might want to also set aside Medicare Part B premiums. We might want to also set aside GME, other things that are not quite -- so I wanted to just -- DSH isn't the only one in that bucket to me.

MS. GRADY: Okay. So those were a lot of facts on spending. So now I want to talk a little bit more about the factors that are driving some of these things that we're looking at.

As I mentioned, Medicaid enrollment can grow without a Medicaid eligibility expansion. Population aging, what we've seen again in the projections is that the age-65-and-up group is expected to grow about 3 percent a year, and that's absent any real change in eligibility projected over the next decade.

People become eligible when they turn 65 sometimes, but there are other people who don't immediately

come on to the program. It's not until they need long-term services and support, so it's not an immediate sort of flip-the-switch situation. There's sort of two types of people that might come on to the program.

The other situation where there may be increases in enrollment not due to policy change -- during an economic recession, income goes down, unemployment goes up. More people come on to the program, particularly nondisabled children and adults.

The next factor, of course, even though we've just said that Medicaid can grow without an eligibility expansion, eligibility does play an important role. If you look at CMS projections for the next decade, the newly eligible adults account for about 17 percent of the fiscal year 2013 to 2023 increase in Medicaid benefits spending that's projected. Of course, this is very uncertain. This is CMS's best guess at how many people will be residing in states that choose to expand the Medicaid program, and I believe when I looked at the number, they assume that about 60 percent of the potentially eligible new adults will reside in states that choose to expand, so that's what this increase reflects.

We've also seen that some states have reduced eligibility levels for adults when the maintenance of effort expired in 2014. These have been pretty small reductions in a handful of states, but still in play. And as you talked about this morning, states are subject to a maintenance of effort on eligibility for children through fiscal 2019, so there won't be any contractions until then in terms of child eligibility.

Moving on to the factors that drive spending per person, prices is first on the list here, and states generally have discretion in setting provider payments from year to year. Those may or may not track with underlying growth in health care prices, and they may be influenced in some cases by mechanisms for financing the state share. This is something that you talked about with DSH in the previous session.

And of course, regardless, states have to weigh the effects of their payment policies on provider participation and beneficiary access, so this is something that might limit their discretion somewhat.

States do have a little bit less control over drug prices, which depend in part on the size of

manufacturer rebates. States generally have to pay pharmacists what it costs to get the drug, and there are differing estimates of what that cost might be. But in turn, the rebates are where the sort of variation may occur, and generally speaking, the rebates are federally specified. But states may go out and negotiate supplemental rebates on their own, which some of them do.

In terms of service volume and intensity, and the effects on spending per person, there's a wide range of strategies here that states might take. Of course, limiting or eliminating covered benefits is an obvious one and a very blunt instrument. Adult dental is one that you've talked about before in terms of states needing budget savings. It's one of their go-to places over the years.

Another option that you've discussed is reengineering delivery systems in any number of ways, which may involve changes to provider payment methods that are aimed at increasing value.

Changes in beneficiary incentives through cost sharing and other means is also another way in which you might affect service use and intensity. And of course, we

have efforts to identify and prevent fraud, waste, and abuse -- reducing payments that are improper or unnecessary is also another way to affect spending per person.

VICE CHAIR GOLD: April, can I just make a suggestion? Maybe the prices, when you have so many people in capitation, I think your prices have to also include capitation rates, and the issues are similar. Some of them are based on fee-for-service, and some of them, yes, you can change them, but you may not get any bidders in your -- have an actuarial test on them and things like that. That's different than shifting the populations that were in fee-for-service to managed care. It is a very fee-for-service model and a program that isn't a fee-for-service --

MS. GRADY: Right. So there's no between --

VICE CHAIR GOLD: Trying to explain it clearly, we probably need to talk about it being a hybrid program that varies state by state with what the mix is, but the prices and the effect on the intensity of care is addressed in different ways.

MS. GRADY: Yes, that's a good point.

Okay. The last factor I'm going to talk about is case mix, and this is the enrollment mix. And this is

something that's sometimes hard to separate from service use, but it is a distinct factor. And the relevant point is that it does have implications for setting payment rates based on risk, and that may be in the context of managed care and understanding the profile of the population. When spending per enrollee or costs per enrollee vary substantially, you need a good way to account for that when you're setting your payments. So managed care is the obvious example, but this may also be in the context of proposals for per capita caps or other limits on federal Medicaid spending in terms of how to appropriately set payments that take account of the population characteristics.

So that concludes the presentation, and I think we'll be coming back to you next month in October to talk about some specific strategies that take this sort of background information as context and advance the discussion in terms of a broad range of options that you might consider.

CHAIR ROWLAND: And the plan is to take these charts and put them into a presentation on the Web with a little more context so that the wonderful explanations

you've given us as you walked through are a little more self-evident to those who just go onto the Web to look at the presentation.

MS. GRADY: And I think after the meeting materials, which did not have those context slides, we added some that I didn't read through here, but we can beef those up as well.

CHAIR ROWLAND: I think you might need to at least beef a little bit that up --

EXECUTIVE DIRECTOR SCHWARTZ: Yeah.

COMMISSIONER RETCHIN: -- because some of these are a little more difficult to understand if you're only reading the title.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I think the idea was it seems like a useful educational tool for a broader audience than gets to sit here at these meetings or bothers to read the transcript, so we like to take this slide presentation as sort of the outline for something that would be more of a stand-alone product.

CHAIR ROWLAND: Chuck?

COMMISSIONER MILLIGAN: With that in mind, I'm just going to make a couple of comments that I think would

enhance the deck when it goes online. I think there's a lot of discussion to be had, but for purposes of just maybe the deck, April, on slide 21 -- I think it was slide 21 where you talked about some discretion about provider payment levels, and you noted that with drugs, some of it is outside of state control. I would add FQHCs.

The PPS payment rates are a source of a lot of discussion right now among Medicaid directors, and there isn't state discretion really. So I think that that's an important addition to that particular slide.

I didn't make the notes on the slides themselves, but when you talk about benefits, there is a distinction that I've often made about optional benefits when states can -- you gave the example of adult dental where states can say, "We're not going to cover this anymore because it's an optional benefit for adults," versus something that's a mandatory benefit for adults where states have some discretion about setting the amount, duration, and scope. And I think that distinction matters because -- I will give an example, and it's probably not a good real-life example, but you can have a mandatory benefit, like inpatient hospital, but a state could entertain whether it

only wants to cover 20 inpatient days a year as part of its benefit design. So there's an amount duration and scope piece for mandatory benefits, that I think it's worth distinguishing those and maybe calling those out separately. And EPSDT kind of negates all of that for kids.

And then the one other -- my last comment about this is when you talk about payments sometimes being driven by mix, the last slide, I think the other example that comes to mind for me is in the nursing home setting with RUGs, and more states are moving to RUGs.

Here's the issue to me about risk-adjusted rates in general, which include RUGs. What we're seeing in nursing homes now is that because more states are expanding home and community-based services, the people are often in nursing homes. The acuity level is increasing a lot. There's a lot more than dependence and behavioral challenges and all kinds of complexity and addiction and other things. But what that means is that there's a change in mix within nursing homes, and RUGs is another risk-adjustment system that I think is maybe worth just noting as a bullet.

I think those will help with the deck. Thanks.

CHAIR ROWLAND: Okay. Trish and then Sara.

COMMISSIONER RILEY: Just another quick sort of clarification. I think given the controversy around Medicaid expansion and the cost of new adults, to be really clear that that chart on 15 is 2014 to 2023, and then on slide 20 when we talk about newly eligible adults that account for 17 percent, how much of that is enrollment growth, and do we know anything about their current PMPM costs? I'm just afraid that's a statistic that could get misused in that first slide.

CHAIR ROWLAND: Sara?

COMMISSIONER ROSENBAUM: A number of comments. I think this will be incredibly useful as a way to sort of explain the program for people.

I don't think the title -- I'm looking at slide -- I was looking at slide 21 as well. I don't think the title is really prices. I think states have some control over what gets covered, and there are many places where they have control and many places where they don't. As Chuck pointed out, for example, for under 21, there are much stricter coverage standards than there are for adults.

Generally, they have control over what they pay for certain goods and services, but not completely. So both rural health clinic services and federally qualified health center services are on a formula.

The Vaccines for Children program is actually something that is not a matter of great state discretion because the vaccines are covered according to a federal standards, and prices are negotiated. And that's how that works, so I think maybe a little bit more amplification on what's called the price slide, which I would break up a little bit.

And then the other thing is -- you know, it goes to your -- the picture at the beginning. It's also heavily driven by what the federal government recognizes as a valid state expenditure, right? Where states were raising provider donations and reporting them as an expenditure, that's no longer recognized as an expenditure. Where states were reporting intergovernmental transfers as an expenditure, that is recognized but only under certain limits.

So, in other words, if we're going to be thorough about this, I think -- or not thorough because this is

really a brief thing. But I think we want to draw people's attention to -- enrollment drives this, what you have to cover drives this, what you must or may pay providers drives this, how you organize your delivery system drives this, and ultimately what the federal government will recognize as a legitimate state expenditure drives this. All of these factors drive federal Medicaid spending.

So, in fact, the options, if you want to get bloody about it, are way bigger than what we're suggesting here, and I must say I would probably dump the last slide because we don't know what our strategies are yet. We don't know as a Commission what we're doing. I think what we want to use this to do now is to say, "Here's what's driving spending -- here's what spending looks like, and here's what's driving spending." There are a lot of things in Medicaid that drive spending. External activities drive spending. A recessionary economy drives spending, and so I'd rather that we spend our time on here's what we're spending, and here's what driving it, and not put up for general consumption yet what the strategies are because that suggests that we've deliberated on what the strategies are. And we haven't.

MS. GRADY: Yes. Just to be clear, the examples that were given were just sort of out loud, not part of the actual slide deck.

CHAIR ROWLAND: Mark?

COMMISSIONER HOYT: I thought it was interesting that if you look at the 40-year period, the average rate of spending growth seems to be so much higher the first 20 years --

COMMISSIONER ROSENBAUM: Yeah.

COMMISSIONER HOYT: -- and then much lower the next 20. It might be worthy of a comment.

The other thought I had was it sounds like the CHIP program is included in this.

MS. GRADY: Almost all the figures exclude CHIP, except for that federal outlays slide.

COMMISSIONER HOYT: Good. It does. Okay. Because I was wondering about -- we mentioned age or kind of hinted demographics. It would probably be impossible to calculate, but if CHIP was in there, I would think that would hold down the rate of spending per person if you have a huge influx of kids.

MS. GRADY: Yeah, it might, but they are out from

these projections.

COMMISSIONER HOYT: Okay. Well, I saw CHIP on that other page, so I wasn't sure.

COMMISSIONER RETCHIN: I just had a formatting issue. When I look at slide 6 and then go to slide 15, on slide 6 it's pretty small print that those are inflation adjusted, but is there an average price deflator there that can be included so I could get some sort of a comparison?

MS. GRADY: There is, and the other option is at the very beginning where I showed the growth decomposed after adjusting for medical price inflation. One other way to show that is after adjusting for general price inflation so that you can see the medical -- what in addition to general inflation is driving the spending -- plus the utilization, so both of those things could be done.

CHAIR ROWLAND: Thank you, April, and we'll look forward to seeing this reformatted, and thank you for this volume of information that I think gives us a better insight here into the spending and the distribution by population. Thank you.

So we'll take a brief break, and then we will be back to talk about behavioral health.

* [Recess.]

CHAIR ROWLAND: Okay. If we can please reconvene? It's time for us to turn our attention to one of the key issues that we continue to discuss in the Medicaid program, and that's the integration of behavioral and physical health into Medicaid, and we're pleased to have today with us Allison Hamblin, the Vice President for Strategic Planning for the Center for Health Care Strategies, and Shannon McMahon, the Deputy Secretary for Health Care Financing from the Maryland Department of Health and Mental Hygiene. And we're going to ask Katie to set us in motion for this discussion.

Session 7: Behavioral and Physical Health Integration in Medicaid

* MS. WEIDER: Great, thanks. As you know, in our June 2015 report, we had a chapter dedicated to behavioral health. In that chapter, we had descriptive analyses of the prevalence of behavioral health conditions among Medicaid beneficiaries, Medicaid enrollee use of those services, and also Medicaid expenditures of behavioral health services. Today we will build off that work and begin our examination of behavioral health integration,

which has been a topic of interest to the Commission, and we're excited to have a panel of experts here today to provide our first introduction to this topic.

First, I'll briefly kick off our panel by discussing how behavioral health integration is defined conceptually and at the practice level, discuss research related to behavioral health integration, and also highlight MACPAC's review of some state-initiated behavioral health integration efforts.

Next to me are our two panel presenters today. We have Allison Hamblin and Shannon McMahon, and I'm going to formally introduce them and also go over what they'll be presenting in just a few moments.

So when talking about behavioral health integration, we first need to know how it's defined. In general, integration has been described as the systematic coordination between general and behavioral health care. However, the term integration has been used to define a wide variety of activities. It's everything from patient referrals, to collocation of providers, to mission change within a provider network. As a result, the term was often used frequently but inconsistently.

Nevertheless, a few recent efforts have worked to conceptually define integration, Including the Agency for Healthcare Research and Quality's Lexicon for Behavioral Health and Primary Care Integration, which Commissioner Waldren helped develop. This work specifies what behavioral health integration can look like at the practice level. Other efforts include the SAMHSA-HRSA Center for Integrated Health Solutions, which describes an overarching framework and standard levels for classifying integration across a continuum. And there's also the National Council for Behavioral Health's Four Quadrant model, which discusses the directionality of integration.

Each conceptual model has a different approach in defining integration, and these differences reflect the varying integration mechanisms that will implement it at the practice level, which can include collocation, data sharing, communication, just as some examples. That said, there is no unified definition of integration and no model of integration will align perfectly with the conceptual or practice-level definition.

Despite these varying definitions and mechanisms for implementing an integration effort, there is a large

body of research examining the effects of behavioral and physical health integration. Research has documented the effectiveness of integrating behavioral health into primary care settings for adults with depression and anxiety disorders. However, the evidence base supporting integration models for other populations, such as children and adolescents, individuals with substance use disorders, and individuals with serious mental illness, is often limited or suggests mixed result in improving health outcomes and reducing costs.

These research gaps make it difficult to generalize the benefits of integration and determine the specific integration elements that can lead to improved healthier outcomes or cost savings.

Of note, there is a growing research around behavioral and physical health integration's effects on Medicaid and on Medicaid beneficiaries. This work usually consists of case studies of integration efforts occurring at the plan, program, or provider level. Available work suggests that behavioral health integration can improve care and reduce costs in the Medicaid program. But more research is needed to understand why some models are

successful, how these programs can be financially sustained and maintained, and also if successful models can be adopted elsewhere.

As a foundational step towards better understanding the effects of behavioral health integration, MACPAC contracted with the State Health Access Data Assistance Center, SHADAC, at the University of Minnesota School of Public Health. We had them conduct a scan of state-level Medicaid programs focusing specifically on the integration of behavioral and physical health. In your binders is a review of the programs we examined.

Since the definition of behavioral health integration is in flux and there is a continually expanding number of initiatives undertaking integration in some fashion, we limited our search to only include certain programs. As a result, this is not a comprehensive list of all the behavioral health integration efforts under way in Medicaid, but it should provide the Commission with a flavor of the varying models of behavioral and physical health integration.

As you will see, our review was focused on efforts that could be classified into one of the following

models: accountable care organizations, health homes, managed care, and primary care case management.

Additionally, it was focused to only include state-initiated behavioral health integration efforts. This limited the review to only include efforts that were implemented through state Medicaid programs or policies and not those driven at the plan or provider level.

Additionally, the review only included efforts that primarily focused on integrating behavioral and physical health. Many managed care models integrate behavioral health in conjunction with broader efforts to coordinate care for beneficiary across the health care system. This includes integrating the full array of physical, behavioral, long-term care, and supportive services for its members. We excluded these broader efforts because in these instances it's often difficult to isolate the effects of a specific integration intervention in these larger models.

For purposes of this project, behavioral health disorders encompass all mental health conditions, and programs in the planning and development stages or those that had expired as of March 1, 2015, were not included in

the review.

To identify these programs, SHADAC consulted publicly available information as well as conducted some state follow-up. From this research, SHADAC documented the payment models, structures, target populations, and provider types that are involved in behavioral health integration in Medicaid.

So from this scope, we reviewed 19 programs across 17 states. Most of the programs that we have catalogued are relatively new, with 16 being developed since 2011. Half of the programs were classified as health homes, and also half had focused on serious mental illness.

Of the programs reviewed, there was substantial variation in how and to what extent physical and behavioral health care is integrating. For example, integration programs may require physical and behavioral health providers to use unified health records, to share care plans, data, and reports, while others used dedicated care managers to oversee and coordinate access to services for their beneficiaries.

However, it was often unclear how these integration elements were implemented at the practice

level. For example, only a few programs clearly identified collocation of physical and behavioral health care providers. However, since we collected programmatic-level information, more individual practices may have undertaken their own efforts to collocate providers than we could detect.

Additionally, we found that many programs described data-sharing and care management activities, but each used different methods to implement these activities. In addition, programs often do not describe the degree to which integration elements are implemented or monitored at the practice level.

This review should serve to highlight the varying models of integration and the varying definitions of integration that I had highlighted earlier.

Now, we can spend the rest of the day discussing and debating all the integration efforts under way in Medicaid, but we didn't ask the next two presenters to define our expanding universe of behavioral health integration. Instead, they'll move our conversation past what is integration, and they'll provide context on how these models of integration differ, what their goals are,

and also identify barriers to integration.

So to introduce our first speaker, we have Allison Hamblin. She is the Vice President for Strategic Planning at the Center for Health Care Strategies. In this role, she leads CHCS' program activities relating to integrating care for Medicaid beneficiaries and has specific expertise in the areas of physical and behavioral health integration. During her presentation today, she will go into more detail regarding the varying roles of integration and also barriers to integration.

And then we'll also hear from Shannon McMahon, who is the Deputy Secretary of Health Care Financing at the Maryland Department of Health and Mental Hygiene. In this role, she is responsible for the state's Medicaid program. Prior to becoming Maryland's Medicaid director, she too worked at CHCS and was the director of coverage and access. During her presentation today, she will discuss the goals of integration and barriers to implementing an integration effort on the ground level.

I'll stay up here during the panel's presentation, as it will be helpful for staff to benefit from the expertise on the Commission on where to go next on

this important topic. With that, I'll pass it over to Allison.

CHAIR ROWLAND: Thank you, Allison.

* MS. HAMBLIN: Thank you so much for the opportunity to be with you today and for sponsoring this reunion with my former colleague Shannon. I appreciate that.

I am going to speak briefly about current trends and opportunities that we're seeing across the states at two levels with respect to integration. First, at the system level and principally through managed care reforms, and we'll describe what we're seeing in terms of some trends as well as key considerations for Medicaid programs that are embarking on these reforms. And then I'll turn to efforts that we're seeing at the provider level where states are looking to create new incentives and better incentives to promote integration of care in the clinical environment. And then, finally, I'll talk about some high-level policy considerations relevant to both areas of activity.

So at the system level, and what I say here may be familiar to many of you, just to ground the conversation

in the status quo, and that is, in terms of the existing environment in Medicaid, by and large, when we think of specialty behavioral health Social Security -- and I will say that my bias and the focus of a lot of my work is on the specialty behavioral health side, and so please, when we move to discussion, I'm happy to clarify where I'm coming from. But a lot of my sort of default conversations and comments about behavioral health will refer to populations with serious behavioral health needs and services delivered in specialty mental health settings. And when I speak about primary care, I'll probably be more explicit about that.

So in terms of that specialty behavioral health landscape, again, generally the status quo where states are coming from is typically a carveout environment where specialty behavioral health services have been carved out and financed and organized separately from the delivery and financing of physical health services. And within the behavioral health realm, most states historically have had unmanaged systems for delivery of behavioral health services. So whereas states have increasingly moved to managed care or some system of management and coordination

over time on the physical health side, behavioral health has typically lagged on that curve and has been more unmanaged than its physical health counterpart.

That said, in terms of trends and where a lot of state activity currently is, on the behavioral health landscape we are seeing a shift away from fee-for-service towards increasing use of some system of management, whether it's through an administrative services organization and a non-risk framework or in terms of a risk-based managed care contract with a managed behavioral health entity of some kind. And so generally we see the world moving from unmanaged to managed in some sort on the behavioral health side. And in terms of integration, we've generally seen -- and I will have to say where the bulk of the activity in this realm has been over the last three or four years has been towards increasing use of integrated, comprehensive managed care arrangements to manage both physical and behavioral health services for the entire Medicaid population, at least on the adult side. So an increased use of integrated managed care contracts carving in behavioral health services.

And just to give you a data point there, about

four or five years ago there were only two or three states that had these types of integrated, comprehensive managed care arrangements that included specialty behavioral health services for their entire Medicaid population. There are now at least 13 states; again, about 10 of those are pretty new in terms of announcement of implementation that are now carving in those specialty behavioral health services into an integrated managed care program.

So this is a pretty dramatic change for Medicaid across the states, and this seems to be the way that the world is moving. And so I'm now going to talk a bit about key considerations that we're seeing to guide states as they move in this direction towards a more integrated managed care environment.

First let me say in that regard that from what we are seeing and observing from the states that have been earlier out of the gates, what we have learned from folks like the TennCare program who went this way earlier and now have almost ten years of experience in--maybe more like eight in operating an integrated managed care program, we are strongly encouraging states to consider a gradual evolution in this direction given all of the changes that

are required to do this work well. And the pace of the move towards integration should vary based on the existing infrastructure and the existing capacities of the system in a given state.

There's a high degree of variability across the states in terms of their readiness to move in this direction, and so we're seeing states be thoughtful about their moves in this direction. We are not seeing a lot of argument at an intellectual or policy level about whether or not this is a good thing to do. There is a growing amount of consensus in the field and within states and among stakeholders who traditionally may have been resistant to moving towards integrated managed care arrangements, that there's a recognition that integration is a good thing, that finance -- the way we finance the system and the way we integrate the benefit has direct implications for clinical integration on the ground and provider incentives and the ability to share information and all sorts of things that can impact how well integrated the care is that a given individual receives.

But that said, again, not all states are at the same level of readiness to move in this direction, and

we're seeing a lot of step-wise evolution based on some considerations that I will now lay out for you.

One is the existing behavioral health provider capacity in a given state to contract with managed care. As I mentioned, many states are coming at this conversation from a history of no managed care on the behavioral health side, and there have been more grant-funded mechanisms for paying for behavioral health. In some cases, fee-for-service is even sort of an evolution for how behavioral health providers are reimbursed. And so it's very important for states to think about and be cognizant of what the capacity of their behavioral health provider networks are to effectively contract and be paid in a managed care environment.

Secondly, a key consideration is the capacity of the existing managed care partners or the available managed care partners to manage a specialty behavioral health benefit. Again, in some states there is a high prevalence of national managed care plans who may have affiliates or subsidiaries that operate as managed behavioral health organizations who may have experience working in other states in an integrated managed care environment. In some

states specialty behavioral health is entirely new to the managed care organizations, and, thus, there needs to be time for plans to build the internal capacity to understand the clinical needs of the population, to understand the service array, to understand the language of behavioral health, to get to know the provider network, levels of care, all of the things you need to know to do effective utilization management, medical management, care management, and the like. Again, this is not an even playing field or a level playing field across the states, and it's very important that states, again, consider their evolution toward integrated managed care, that they think about who their managed care partners are, and what their readiness is to move in this direction, as well as what their ability is or their inclination is in terms of reprocurement. Many states are not in a position to wholesale reprocure their managed care contracts, and so they need to think about what this evolution might look like in terms of their procurement cycles and their procurement ability.

The last key consideration I want to mention here is the extent of competition in the managed care

environment in a given state. In some states there is a large number of plans in a given region, and this is new for managed behavioral health. Typically, managed behavioral health organizations have either been statewide, or there's a single managed behavioral health organization in a given region. And so the notion of having competing managed care organizations or multiple managed care organizations managing the behavioral health system in a given region is new to Medicaid. And I don't think we as a field yet know what the implications are, particularly in terms of managing a crisis system. And so that is part of this evolution that I think is very much worth watching and worth being mindful of.

Now, I'm going to turn to -- well, actually, before I turn to the provider level, I just want to say that I have obviously focused a lot here on the managed care environment, and I obviously recognize that many states do not operate in a managed care environment, or there are certainly a good number that don't, and so one other platform that I wanted to mention that we're also seeing some interesting movement in terms of support for behavioral health integration is through Accountable Care

Organizations. And just a brief mention that one mechanism we're seeing through ACOs to promote integration of behavioral health is through inclusion of behavioral health costs in total costs of care calculations as being a key incentive for Accountable Care Organizations to bring in behavioral health and to encourage ACOs to include behavioral health providers in their networks.

And, so, for states that aren't operating in managed care frameworks, who are considering or who are implementing Accountable Care Organizations, or even within managed care environments, the notion of how to incorporate behavioral health into the financial arrangements that support ACOs is another opportunity that we're seeing states taking advantage of.

So, now I'm going to move briefly to talk about how Medicaid is looking to integrate physical and behavioral health at a provider level, and specifically at the question of what should Medicaid pay for, and to some extent, how should Medicaid pay for services to promote integration at the provider level.

So, in some ways piggybacking off of the excellent report that Katie summarized briefly to start

this presentation, one area of activity that we're seeing a significant amount of take-up around in support of this general concept of integration is Section 2703, health homes in Medicaid. A few health home programs are highlighted in the report, and just to put those in context, currently 19 states plus the District of Columbia have approved Medicaid health homes in place.

And health homes, as you may know, and I know the Commission has covered health homes in previous sessions, but the key connection for health homes in this context is the ability for states to pay for care coordination and care management services. Recognizing that language is important and care coordination and integration are not exactly the same thing, care coordination and care management are critical components to effective integration and the health homes provision has enabled states to have a scalable mechanism for paying for these incredibly important services, the glue to the system through the health homes provision.

Of the states, the 20 states plus the -- including D.C. who have implemented health homes, all but two include individuals with SMI, with serious mental

illness, among their target population. So, this has been a really critical platform for states specifically to focus on more integrated care for individuals with serious behavioral health needs.

Importantly, an additional ten to 12 states are currently in development of health homes programs. So, clearly, this is an opportunity that many, many states are finding attractive.

Health home programs look very different state to state, but I would say where there is a high degree of consistency is in specialty behavioral health settings and what the health home model looks like across states, specifically placing care coordination, care management resources in community mental health settings to improve coordination for individuals with serious mental illness.

Outside of health homes, in paying for care coordination, we're seeing a lot of interest in how to promote team-based care in clinical settings. A number of states, like Massachusetts and California, have been looking at, and some more than others already implementing financial incentives to encourage primary care settings to bring in behavioral health services and vice-versa,

encourage community mental health settings to bring in primary care services.

Another piece of glue here in terms of what Medicaid can pay for that can be invaluable to integration and care coordination is paying for peer support, paying for community health workers in general medical settings, in behavioral health settings, typically paying for people with lived experience with either mental illness or addiction who are in recovery being an extension of the clinical team as a really, really critical component of what makes for integrated and coordinated care.

And, lastly, what I want to say here just in terms of what Medicaid should pay for, we are hearing and seeing across the states a real interest in expanding their treatment capacity, whether by bringing behavioral health into primary care and other medical settings or by expanding the array of available treatment options for mental health and addiction disorders in the community. As we raise awareness through screening and paying for things like effort, providers are going to be more intent upon making sure there is actually a place to refer people to and a place for folks to get services once their needs are

identified. And, so, paying attention to the capacity issues is really important.

So, I'll wrap up with a few considerations here. One is I underscored the value of care coordination and care management. States have struggled to some degree with multi-payer alignment of the health homes model. One example of that is the health homes model is targeted by clinical conditions, and so you can only as a provider offer that service to folks who have conditions that the state has included in its state plan amendment, and that's different than how other payers support care management activities. And, so, reconciling those differences across payers is a -- can be a challenge with implementing these models and it's an opportunity to think about how we can create better alignment going forward.

There are also key questions in the field, I think really important policy questions, around how much to pay for these services. This is very new. There is a huge variation across the states in terms of the rates that are paid for care management, care coordination services through health homes and other vehicles, and it's going to take some careful evaluation work to understand who are the

best targets in terms of the population to benefit from these services and what is the right amount to pay for them that can ensure the sustainability of the service.

And, lastly, I promise, a couple last points. Quality measurement in the behavioral health field is an area where we could stand to make a big investment and to get some real consensus around how do we move behavioral health towards outcomes-based treatment and outcomes-based payments. Just like we're trying to do on the physical health side? As managed care becomes more and more integrated, managed care organizations are going to be looking to construct the same type of value-based payment arrangements in behavioral health settings as is happening in physical health settings and the field really needs to mature in terms of how we should be measuring those outcomes, let alone paying for them.

And, finally, I would be remiss without calling attention to privacy rules. The MACPAC paper does a very nice job of calling those out. Data sharing and information exchange is a key element of care coordination and integrated care, and the more we can enable systematic information exchange without a lot of extra hoops and

hurdles, so long as we appropriately protect sensitive information, but also look to effectively manage population health, some of these particular protections around behavioral health information can be challenging, both for states and providers as they look to implement these models.

So, with that, I will turn to Shannon.

CHAIR ROWLAND: Okay, thank you.

Shannon.

* MS. McMAHON: Good afternoon, everyone. Thank you very much for having me. Again, I'm Shannon McMahon. I'm the Deputy Secretary for Health Care Financing in the State of Maryland, and in that role, I'm responsible for overseeing the state Medicaid program. And I'm lucky enough to have my predecessor sitting on the other side of the table, so he can definitely add some color commentary after my initial remarks --

[Laughter.]

MS. McMAHON: -- and you all can engage on that further after the meeting, as well, I'm sure.

So, I'm really thrilled at the opportunity to give you kind of the lay of the land, and some of it

predates me, sort of the challenges of getting to some of these integration efforts that Allison and Katie so nicely outlined, and talk about them really at the ground level. Some of them are things that happen in an agency. Some of them are at the provider level. Some of them are at the payer level. And to really try to talk it through so you can sort of appreciate sort of where we were and where we are and where we would like to be.

And Maryland is really in the very early stages of integrating behavioral health and substance use services, and we're using an administrative carve-out that just started this year for the 1.2 million Medicaid members. The ASO operates on a fee-for-service basis and it's really part and parcel of broader payment and delivery system reform that's happening on the ground in Maryland.

So, 18 months ago, Maryland really embarked on what I would describe as the first phase of payment reform that's multi-payer payment reform through modernizing its all-payer hospital waiver. And the new model really shifts away from traditional fee-for-service payments to global budgets and total per capita hospital caps.

Since hospitals are about 40 percent of total

costs of care in Maryland, as well as in Medicaid, the realignment of financial incentives with those global caps is really shifting their lens toward a more prevention-oriented health care system that has the opportunity to really bend the cost curve through improved population health.

So, in advance of the ACA childless adult expansion and in the face of this big payment reform effort that was happening on the hospital side, DHMH really started looking at models to better integrate mental health and substance use services for both the uninsured and the soon-to-be insured through the Medicaid expansion.

So, prior to this effort, behavioral health services for both Medicaid and the uninsured were carved out of Medicaid managed care and were administered by an administrative services organization. Separately, substance use services were managed by the eight Medicaid managed care organizations in Medicaid. So, over here, behavioral health through an ASO. Over here, eight managed care organizations managing substance use. And, again, I'm using the same terminology that Allison was using in terms of that specialty mental health and through the carve-out.

In addition, management responsibilities for mental health and substance use disorder services were managed by three organizations within the larger umbrella of DHMH. There was an Alcohol and Drug Abuse Administration, there was a Behavioral Health Administration, and then there was Medicaid. And as Commissioner Milligan knows well, DHMH considered a number of models over a two-and-a-half-year period in terms of what the best way to approach integration would be for Medicaid members. And, actually, Allison and my colleagues and I at CHCS were lucky enough to provide some technical support to Chuck and now my team as they puzzled through what those options would be.

And in the end, the decision was to carve both of them out of Medicaid, carve both behavioral health and substance use services out of Medicaid, deliver them through one ASO arrangement. Medicaid oversees that ASO arrangement and oversees the financial side of that ASO arrangement on the Medicaid side. The SAMHSA dollars do still flow through a newly merged Behavioral Health Administration so that those silos of the Alcohol and Drug Abuse Administration and Behavioral Health are now merged

together into one administration.

So, while this decision has not yet allowed for what I would describe as substantial coordination or somatic care with our eight MCOs, it does represent what I would describe as a significant incremental step toward broader administrative integration.

So, first -- the first step, I think, is having Medicaid oversee these dollars. I mean, the vast majority of the folks who are served are Medicaid recipients and so we oversee the financing of that. We are the ones who certify and submit the CMS-64 asking for federal dollars for that. It makes sense for us to lead that work and to have a seat at the table.

The funding streams were aligned so that Medicaid-eligible specialty mental health and SUD services are in the Medicaid budget now, so they're no longer in those multiple silos, and that has allowed for better coordination, better accountability, both at the payer and provider level.

And then I mentioned, of course, the administration merger of the Alcohol and Drug Abuse and the newly created Behavioral Health Administration, which now

oversees the state general fund dollars and the uninsured and SAMHSA grant funding for the broader state system.

So, in addition to bringing these services together administratively, we have been working to do a lot of work to give support to providers, and Allison referenced that, that sort of provider-level support. Maryland is really a leader in adopting HIT, placing a considerable emphasis on advancing HIT with our stakeholders, both through the all-payer model and, as well, through our support of having more providers achieve stage one meaningful use.

And also sustaining our national leading health information exchange, CRISP, the Chesapeake Regional Information System, for all patients. CRISP really is the regional extension center for us and the providers are actively engaged in expanding HIT through Maryland, not limited to the HIT, but care coordination, using it for predictive modeling, clinical administrative data integration. So, as you start to try and integrate on the provider level, at the provider level, those tools, making sure they have those tools in the toolbox and are trained to use those tools in the toolbox has been really, really

important at the ground level.

And while this significant delivery system reform is happening, we got a new governor. And the new governor is very, very interested in, as many new governors are, in the heroin and opioid abuse epidemic that is emerging, and has established a Heroin and Opioid Emergency Task Force. Also there is an Interagency Coordinating Council where all the agencies involved in providing substance use treatment, public safety, corrections, are sitting at the table talking about these issues and are doing so in a very technical and meaningful way. And I think it's really a credit to his leadership and to his staff to kind of getting everybody in the room and starting to have these conversations. Whether it's about making the right connection as people are leaving jail, if it's making sure that people have access to managed care and they know where to go for primary care, et cetera. So, we're really having those conversations at the interagency level, as well.

And, so, while the integration of mental health and substance use for services under the ASO certainly presents an opportunity to better coordinate care for folks with co-occurring disorders, I would be remiss if I didn't

say that there are significant challenges remaining, and I know when I was preparing with your staff in advance of this, I felt like, wow, there's so many more things that we should be doing. There are so many more things that we can be doing.

But, practically speaking, we made a lot of progress. But I think it is important -- first, Allison highlighted the data sharing requirements, a very, very big issue for us as we move from that partial managed care, partial fee-for-service model to this administrative carve-out. It's been very difficult for us to get aligned on patient consent, make sure that we had the appropriate data use agreements in place with the various provider groups, and to make sure that providers were trained to put these consents in front of folks and to really explain to them what they are and for individuals to really understand what they're consenting to.

And, so, I think that the part two barriers are real and are things that we are working through. I'm pleased to say that we've had a very high degree of consent over the last couple of months, and it seems like it's growing, but it's definitely been a heavy lift on the part

of the department.

So, Allison also alluded to -- Allison and Katie both alluded to health homes. We are one of the states that they cited that have a health home program, and in Maryland, we have a chronic health home program that was authorized under 2703. It includes our psychiatric rehab programs, mobile treatment providers, opioid treatment programs, and it targets individuals who have behavioral health needs who are also at high risk for other chronic conditions, offering them enhanced care coordination, non-clinical support services from community-based providers for whom they readily receive care. And, the state identifies high utilizers within this program for additional targeted outreach from five participating providers.

We have about 6,000 individuals enrolled in the chronic health program. And I'd like to say I could tell you exactly what we think about it and what the path forward is. We're really in the middle of the evaluation of the program and our 90/10 funding will end at the end of this year, so we're even more incented to figure out what the path forward would be.

But, a couple of things that we'll be considering as we are looking -- as we are working on this evaluation, and actually just talked about it just the other day. First, trying to think about that data sharing and that data access, so both that provider training on engaging with patients about data sharing, but then, also, what sort of data do the providers need to really move the needle in that integration. So, getting folks over to physical health, getting the physical health information over to the behavioral health providers.

Creating tools, like performance dashboards, so that we can understand what provider performance really looks like. So, these guys are doing a good job. These guys are not doing a good job. Their outcomes are good or not. And that powerful information, I think, will help us establish better accountability, and start to think about some different shared savings models with some of these larger practices who are part of that model.

And then, again, I think, dovetailing on my comments about the opioid treatment issues and access, we're very interested in recruiting additional opioid treatment providers to build capacity that would be

interested in participating in the program.

And then, finally, I think the last challenge that I want to dig in on, and it's one that's, I think, familiar to this group, is our ability to pay for services that are subject to the IMD exclusion. And, I think you all know that the IMD exclusion is one of the few instances where Medicaid is not permitted to provide payment for medically necessary services and effectively prohibits states from using Medicaid dollars for services provided by IMDs, which are facilities with 16 or more beds that are primarily engaged in diagnosis, treatment, and care of persons with mental diseases and chemical dependency.

And, the practical impact for us in Maryland is that we have a number of large IMD providers. One, Sheppard Pratt, one of the largest and probably premiere psychiatric hospitals in the world, and definitely in the country, that has over 400 licensed inpatient psychiatric beds, has, frankly, been forced to reduce its capacity because of the IMD exclusion and because of, as a byproduct of our carve-out, we are unable to have -- we don't have any services at risk, so CMS has not allowed us to include IMD services in our payment.

So, consequently, we have submitted a waiver to CMS, an amendment to our existing health choice waiver that would allow us to pay for services in the IMDs. Our exclusion would target those private IMDs, either -- for both psychiatric and substance use services. I think we have really started to make the case. The public comment period just ended at the end of last week, and are hopeful that we can continue that conversation with CMS in light of recent guidance that they put out about wanting to try to build a more robust and better integration in states, asking states to think about things like the ASAM criteria as sort of the bar for treatment, which we actually have implemented as part of the carve-out.

We are also really giving a lot of thought to what our options are in terms of moving forward with both the private psychiatric hospitals and our inpatient hospitals and are able to make a fairly credible and financial argument about the cost of care on an inpatient basis versus the cost of care in an IMD, and the impact of that on that broader health system transformation that's happening with the all-payer waiver.

CMS has certainly approved these waivers in the

past, and we had one up until 2008. So we're hopeful that they're interested in starting again and we'd love to be the leader of that.

I'd be remiss, though, if I didn't point out that Congress is also very interested in this issue. There are a couple of bills related to the IMD issue that I think we have certainly been supportive of, either through the National Association of Medicaid Directors or directly with members of Congress.

First, there is a bill that is cosponsored by members of the Maryland delegation that would extend the Medicaid emergency psychiatric demonstration, of which we were a part, that ended -- was to end at the end of this year, but actually ended early. It ended this past July, and so that's also sort of feeding our challenges on the IMD side. We had previously had the ability through that demonstration to pay for IMD services and now at the end of that demonstration are unable to do so.

There is also another bill in Congress -- it's on the House side -- the Breaking Addiction Act of 2015, would also allow -- would actually require the Secretary of HHS to accept applications to waive IMD exclusion from states

that seek to provide comprehensive addiction treatment. So, I know that bill is also pending.

So, bottom line, I'll just summarize and happy to answer any other questions. The IMD exclusion has serious ramifications on our broader payment reforms, and many beneficiaries are going to be forced into EDs and acute general hospitals where we will definitely have capacity issues. It's just now emerging and are definitely monitoring it very closely.

And, our waiver is budget neutral. It's going to save money for the state and federal government. It's going to serve individuals in a clinically appropriate environment, lower-cost settings, and will also have that clinical benchmark of the ACM criteria, so we are looking forward to those conversations that will hopefully start in the next few weeks.

So, in closing, I just want to echo Allison's comments and Katie's comments about incremental purchase. I know states are in a variety of different places, and as we evaluate our health home model, prepare for these waiver negotiations, our thinking about our quality metrics too, and trying to think about how we can better integrate some

of the quality metrics, we have -- having daily conversations about financial data and how we can make sure that we're all speaking the same language on financial data and evaluate the first year of the integration, we're actively discussing strategies to better integrate somatic care delivered by the MCOs with behavioral health services. So what the sort of 2.0 looks like is moving more toward that integration with our MCO model.

So I appreciate your attention to this really important issue. I'm happy to answer any questions that you have. And I'm happy to continue to engage with your staff as you're thinking about next steps in terms of any writings or future hearings.

CHAIR ROWLAND: Well, thank you all very much. This is obviously an area of great importance to the work of the Commission with the start that Amy Bernstein gave us of really outlining the population in the Medicaid program and the prevalence of some of these mental health challenges. We know that we really need to also focus on then how the services are best delivered to them. I found it very interesting.

We've also talked about the barriers just in

state administration of who does what, and I think that's equally important to some of the provider-level challenges.

So I'll now take questions from the Commission members, and I thought maybe we'd ask Chuck to start with the first point.

[Laughter.]

MS. McMAHON: He is going to stump the chump.

COMMISSIONER MILLIGAN: You didn't ask Chuck.

Well, a couple of thoughts, just general thoughts. I thought the presentations were great and channeled all the best, great group of people.

So I want to maybe comment really from a MACPAC perspective kind of thinking through for me what -- you know, where we can go as a Commission and sort of the landscape and some of that.

One of the issues that I think I want to mention is about dual eligibles. It wasn't particularly mentioned in the presentation, but one of the drivers of integration and whether it's managed care or not is the fact that a lot of service utilization for adults with SMI, those individuals are dual eligibles.

And I think when I was in Maryland, we looked at

the data, and it was about 40 percent, roughly speaking, of the utilization was from dual eligibles. And what that means is primary care is not inside of Medicaid, and pharmacy, a lot of pharmacy is not inside of Medicaid. And so I think that there is a behavior health integration piece that bears on the dual eligible demos that we've talked about in other settings. So I want to keep I mind that integration of somatic care and behavioral health care has a dual eligible piece to it.

The second thing is I do want to sort of emphasize the point that Shannon made at the end about the IMD exclusion, and it's not simply -- and we've talked about this on the Commission before. It's not simply the prohibition on paying for inpatient services in an IMD, but the fact that IMD is not covered means you can't pay for a lot of outpatient services in kind of a home and community-based waiver sense because there's on institutional equivalent.

So unlike -- for example, with nursing homes, there's a facility. With ICFMRs, there's a facility, and that covered facility means that you can do home and community-based services because it's in lieu of being in

the facility. Without the IMD coverage on an inpatient basis, you can't build out a really robust home and community-based service array, Medicaid covered on the HCBS side because there isn't a facility comparison or alternative.

So I think the IMD exclusion is broader than just covering the inpatient side, and I think that that from a federal policy point of view is an important thing for MACPAC to take note of.

The third thing, I guess, I'll comment on is, as we talked about just a few months ago, all of this really comes back to parity in a lot of ways and the importance of just kind of keeping parity in our line of sight about integration.

And I guess I want to maybe conclude by saying that the couple of different states where I've been the Medicaid director, I've gone in very different directions about integration. I'm now in New Mexico. I'm at a health plan. Behavioral health is integrated. Everything is carved in in New Mexico.

And in Maryland, as Shannon noted, mental health and substance use disorder services are carved out in an

ASO model, and I think there are important reasons for those distinctions. One is, in New Mexico, unlike Maryland, the large MCOs, large carriers, the largest on the Medicaid side don't participate in the exchange, and so the churn issue in Maryland, it's more profound going from one carrier to another. And so with adults who are churning, an ASO, as part of our thought process, anyway, when I was there was that an ASO was an easier transitional vehicle as opposed to going from a bunch of MCOs to some different QHPs, that they're not the same entities.

Another distinction was the fact that in New Mexico, dual eligibles and others are part of the managed care programs, unlike HealthChoice in Maryland. So that was an important driver of the decision.

And the other is the complexity of managing eight MCOs and more in a lot of other states, but from a provider point of view -- from a provider point of view, getting credentialed with eight MCOs, dealing with MCOs, prior authorization, utilization management rules, eight MCOs claims payment platforms, eight MCOs -- all of that stuff, it's a pretty big lift from the provider to have to deal with such a variety. And in New Mexico, it's a smaller

universe.

So I hadn't intended to go first. In fact, I wasn't sure if I was going to talk at all, but thank you for the invitation, Diane.

CHAIR ROWLAND: Marsha, then Donna, then Patty. Okay.

VICE CHAIR GOLD: Yeah. It is good to see you, Allison. You're doing good work.

I was hoping I could get you to elaborate more on what the prevalent models are. Not with respect to names, but with enough detail so I can understand them. I mean, a while back when we studied this in 2000, I think, it was sort of slice and dice, and one of the issues, you crave out benefits, you crave out people, is at a risk model. And what I couldn't tell when you were -- I couldn't tell which people were in and out, and when you were talking about doing it through managed care, whether you were talking about a model that applies to all Medicaid beneficiaries and it includes the SPMI people and its regular Medicaid managed care plans, or is it a specialized model that focuses on the chronically mentally ill and does it through that route? I know there's different ways it

can be done.

And I didn't know if the home health, either -- maybe it's not exactly the federal home health, but whether that component is part of an integration when it's capitated at least as a way of managing.

So when you said the prevailing model is capitated -- or is managed care plan, is that model for who, and how structured? Or maybe it differs.

MS. HAMBLIN: Great questions, Marsha, as I would expect. If I don't cover everything, please let me know. Thank you for the opportunity to clarify.

Within the managed care trend -- and let me just make sure. So integrated managed care, including specialty, mental health benefits for persons with serious mental illness, is not yet a prevailing model. But I would say given how many states have announced that they're going in this direction in the last two years. This seems to be a train that is leaving the station in many places in a way that -- without naming names, states that were very much not going in this direction two years ago are now going in this direction, and so it seems that what were largely concerns around inappropriate redirection of Medicaid funds

for behavioral health that are protected in a carve-out arrangement, concerns about those dollars in an integrated arrangement being taken away from the behavioral health system, that was generally the loudest argument against carving in in the past. Those concerns seem to be quieting.

I don't know that we know that we shouldn't be concerned, but we aren't hearing those concerns quite as much, and I think states are getting more comfortable that there are mechanisms through contracting to protect against that redirection.

So in terms of this movement, while still slow, but growing in inertia, there are a few different approaches that states are taking in terms of what entity to use to be the integrated managed care entity for persons with serious behavioral health needs in an integrated managed care arrangement.

So I'll mention three, three types. One is a specialized managed care organization that is specifically designed for an integrated benefit for persons with serious behavioral health needs. The Mercy Maricopa model is highlighted in the report that Katie shared earlier, and

that is a great example. I think it's fair to say in the modern era, the first of its kind in that realm, very much a special needs plan-type framework designed for persons with serious behavioral health needs.

Interestingly, in Arizona, it actually went through the managed behavioral health organization procurement process. So it went through what in Arizona is called the regional behavioral health authority, which historically has been the capitated managed behavior health carve-out, newly carving in physical health services for individuals with serious behavioral health needs, as well as continuing to be the behavioral health carve-out for everybody else.

That program, to Chuck's point -- and I appreciate your bringing up the dual eligible issue, Chuck, because I had actually had it in my talking points and skipped over it, and it is critical in states. Anywhere from 25 to 50 percent of the population with SMI is dually eligible, and if we're doing this in order to better integrate care, we're effectively leaving out that opportunity if you're not trying to integrate the Medicare benefits for this population as well, and so Arizona is a

great example where this new integrated plan is also a Medicare Advantage plan to address fully integration for both Medicaid-only as well as dually eligible individuals with serious mental illness. So that's an example of sort of a specialized managed care arrangement.

Florida is another state that has used that approach, and it may also be mentioned in the report.

A second approach is to actually just do this through mainstream managed care for everybody, so all managed care plans, Medicaid managed care plans in the state are now responsible for managing all state plan behavioral health services in addition to all of the other Medicaid benefits that they previously have managed.

Kansas is a great example of this approach. So Kansas, a couple of years ago now -- and my timeline off a little bit -- two or three years ago at this point re-procured their managed care contracts. Now all the three managed care contractors, their mainstream plans, they are responsible for all of the specialty behavioral health benefits for everybody.

And then the third approach I'll mention is kind of a hybrid, and New York is an example of this hybrid

approach where the state is implementing a carve-in of all behavior health services in the state plan across all managed care organizations, but then within that -- or among the managed care organizations, the state is also qualifying a subset of them as specialty plans, referred to in the State of New York as health and recovery plans, or HARPs, who in addition to managing the state plan services also will have access to an enhanced array of waiver-like services that are newly available to individuals with serious behavioral health needs who qualify for accessing these new services. And these are sort of typical home and community-based services that are part of this newly enhanced benefit package.

So those are three examples. I think they probably cover the universe of what we're seeing out there, and I think it remains to be seen which models will take off more than others.

VICE CHAIR GOLD: Thank you.

CHAIR ROWLAND: Donna.

COMMISSIONER CHECKETT: Well, thank you to all the presenters. It's a fascinating topic, and I think, personally, just the evolution, which you did a really

great job, each of you, hitting on in different ways. But from even five years ago when it was like unthinkable to the fact, I think when we were in our planning session at one point with the Commission, and somebody says, "Should we even talk about it? Is integration in behavioral and physical health even an issue anymore in the senses that" -- it's kind of like not really being talked about, like should we or shouldn't we. It's more like just how do we do that, how do we integrated, how do we ensure that people are receiving care in the most effective manner?

Personally, I think one of the things that's driven that discussion has been the information we've received using data about the high cost of physical care and physical health for people who have both behavioral and physical health diagnosis. The report, the information the Commission had in its report, people with both diagnoses died 25 years younger. It's pretty compelling for Medicaid agencies and frankly even for people who have been holding out for the carve-out for a long time. At some point, you just have to go, "Okay. How can we work together on that?"

So, first, I have to take a moment to say that Aetna operates Mercy Maricopa, and we're terribly proud of

that program and continue to learn every day about what it means to -- right now, we're up to 24,000 people with serious and persistent mental illness in Phoenix, which is Maricopa County, so it's actually up to 24,000.

And one of the most striking changes that I see -- and I actually talked a lot with the staff there because so many states are frankly interested in the model -- we have a whole new set of partners, and our best friends are the sheriffs, the fire department. We used to go meet with, you know, the other community health plans or our providers. We'd meet with all those guys, but now we actually have standing meetings with law enforcement and work very closely with the judicial system. We love taxicab drivers. It's been really interesting about what it really takes to reach and work with that population.

And so I think when I look back, so what does this mean for the Commission, I think because of how fast this trend is moving -- and I totally agree, Allison and Katie. It is just moving, moving, moving. I think we need to really stay on top of it. I would really ask the Commission to think of a way to be getting fairly frequent updates on just what states are looking -- I mean, I could

tell you right now, three or four more states, just as we're meeting, are having discussions about integration, and so I think our role being tracking and our role also being what are we learning, what isn't working -- I think it sounds like, Shannon, you guys in your first year have really identified things for states to do. So how can we really -- I know, typically, we're very methodical, and that's an important role. But I also don't want us to really miss an opportunity to help shape this very important discussion.

So thank you, and a great report.

CHAIR ROWLAND: Shannon, picking up on Donna's point about law enforcement, as the ACA has been implemented, there's been a lot of attention to how to link people going in and out of the jail system with mental health benefits. Is that an area that Maryland is really pursuing?

MS. McMAHON: So it is on a couple of levels. First, I think some work that predates me where we have administratively dealt with the in-and-out-of-jail issue from a payment perspective, so that we are able to pay for stays that happen when individuals are released from jail

for 24 hours, that Medicaid can match those stays, and then also so that we're not paying for services when folks are in jail. So that predates me.

But what we have been spending a lot of time on over the last couple of months is trying to kind of iron out some of those eligibility processes as people are entering or leaving jail, trying to make sure we have connectivity in the jail so folks can help, get help having an application filled out, and in some cases have paper applications, help with verifications and things like that so that folks are able to leave jail.

Actually, I was just in a conversation where we're starting to talk with our partners at the Department of Public Safety about ways that we can potentially have a cost allocation plan with them, so that they're able to do some care coordination. Helping to match people up with an MCO of choice, Making sure they're working with value options our ASO, to get their next Vivitrol shot, to make sure they're going to their AA meetings, things like that. So trying to get some more of that care coordination going as people are leaving correctional facilities is something we've been working a lot on.

CHAIR ROWLAND: I have Patty, Sara, Andy, Mark, and Sharon.

COMMISSIONER GABOW: Thank you very much. I think that [off microphone] behavioral and physical health is really a terrific direction because the patients have both issues, and heretofore we've been asking the most vulnerable population to navigate two complex systems, and it really was not in anybody's best interest, so that's good.

I have four comments. One is about this relationship with the criminal justice system, and at least our experience was that even if you could work with them in the jail system -- and the biggest mental health institution in Colorado was the city-county jail without a doubt. And our biggest expense, after personnel, was psychotropic drugs. But when they would get out, no matter what we did, the wait list to get into treatment, so this issue of access was such that the appointments were so far out that you couldn't give them enough meds to get them to that point, so they'd re-engage with the criminal justice system for offenses that were usually not major. And I think this issue with the criminal justice system is even

magnified when you talk about adolescents and the juvenile justice system. So as we think about this, looking at both adult and juveniles are really important.

The second comment relates to juveniles again, and that is, what we found was the bed situation for children and adolescents, particularly children with developmental disabilities who were now reaching adolescence and were becoming much more difficult to manage, there seemed to be no place to manage them. And this was really a big issue. You can integrate the payment model. I think that's good. But if you have no place to do this -- the other group -- so it was criminal justice, children and adolescents, particularly those with developmental disability.

And the third group that we found really frustrating with trying to place were adults who need nursing home care who had serious mental illness because no nursing home wanted to take those patients, and so some of them just basically lived with us for all practical purposes.

I think there are some unique populations, as we've learned in Medicaid overall, there are some unique

populations that, as we think about what integration means, we have to think about, well, where is the delivery model for this. And related to the device model gets us back to the DHS issue. One of the characteristics we didn't get into, which was in your paper, is are there some unique community benefits that might be a criteria for being a DSH hospital, and certainly having inpatient psychiatric beds or a psychiatric ED are things to think about in that mix.

And the final comment I would make is that as we've looked at our high-need, high-use population, of course, everybody knows they have high mental health needs, but what we found -- and I'm sure this has been found by others -- is that the kind of home health entity varies with whether you have both diagnoses but your major issue is chronic mental illness versus if you have both but the thing that's really significant is your physical health need. And the delivery model isn't the same for both of those to be effective, and so it creates this -- in an integrated model, which I am all in favor of, there still has to be some separation of the delivery of care because not everybody fits nicely into a bed. So thanks.

COMMISSIONER ROSENBAUM: Actually, several

questions for either one of you. I assume you probably both know -- have had experience with this.

The first is for children, of course, the IMD issue is not present. You've got inpatient psych coverage, so I wonder if you might talk a little bit about the experience of trying to build continuity arrangements around children and adolescents. I assume there are 12 other problems that come up, but -- and whether that sheds any light if you were going to change the IMD exclusion on some flexibility that you'd want parallel to adults.

The second is if you guys could comment at all on the 2010 amendments to the home and community-based services provisions of the statute that actually eliminate the need to show an institutional level of need in order to get some home and community-based care. Is that at all useful in this context? Or is it, you know, sort of not particularly because you still have a room-and-board problem?

The third is your thoughts or observations on the proposed change under the Medicaid managed care rule for allowing short stays as a managed care benefit and whether you see that as helping at all with the problems you're

running into or not.

MS. HAMBLIN: We are collegially working out our allocation here. I'm going to take a quick first stab at the first question, acknowledging that I spend much more of my day on adult system issues than children issues.

It's a great question in terms of if there's -- you know, are there opportunities to -- you know, sort of what's different given that we can pay for stays in IMDs for kids and sort of what are the implications for, you know, making the case for adults.

So one is I think there's more to be learned from the whole system of care approach for children with serious behavioral health needs, with serious emotional disturbance, than we've taken advantage of in terms of how we think about structuring integrated models for adults with both physical and behavioral health needs. My sense of the opportunities to learn from those children's models are very much about kind of the cross-system collaboration, particularly with juvenile justice and mental health and child welfare and so forth, and how we can translate that to what those partnerships should look like in terms of their equivalence for adult populations.

My sense is we may not have as much to learn in terms of the medical integration in those models. Again, not an expert, so with some caveats there. But I think the medical integration in some of those integrated models for children has not been as much of a focus as some of those other cross-system linkages, which are incredibly important, and I think, again, there are untapped opportunities to learn there.

I would also venture to say that, as Chuck alluded to earlier, having access to that IMD benefit for kids is really helpful in terms of making the in-lieu-of case and being able to include in rate development, you know, cost-effective alternatives to those institutional costs. And that is such a powerful tool. On the adult side, it's this fleeting opportunity where you can use it for a brief moment in time, and then it goes away once the savings are realized. And so I think that, I would guess, would be a strong advantage that we have on the children's side that we don't have on the adult side.

MS. McMAHON: And so on your HCBS question, I think you actually -- as you teed up, I think our problem is exactly what you said. It's the room-and-board side of

the issue. And so I think the complexity of working through that, absent the room and board, is difficult.

On the short-stay proposal that's in the proposed managed care regs, for Maryland there's two challenges. One, the in-lieu-of, since we don't have anything at risk, right? So because we have an ASO model --

COMMISSIONER ROSENBAUM: To sort of amplify, I mean, I'm not sure that everybody here knows what the in-lieu-of --

MS. McMAHON: Oh, okay. Right. So states are able to have waivers from the IMD. There are a few that still have it, and they are able to do it through a cost neutrality mechanism through their 1115 waiver, demonstrating that they are providing those services in lieu of others at a cheaper rate. And that's actually part of the argument that we're making in our 1115 proposal to CMS. The difference there is that that requirement right now -- and CMS has allowed it to happen -- has to be in an at-risk environment. So the services -- you have to have managed care, the services have to be financially at risk, which is not the case through our ASO model.

So what we have said in our waiver application is

that the in-lieu-of service should be payer agnostic, right? So it shouldn't matter whether somebody's using an ASO model with fee-for-service, whether they're doing it through a managed care arrangement, whether they're doing it through an ACO.

In terms of the stay limit, there was a fair amount of deliberation about that issue among the Medicaid directors, the National Association of Medicaid Directors, and I think that we in Maryland felt like, you know, placing that day limit in reg was challenging. It's challenging when you're trying to operate with -- you have ASAM criteria, and you want your providers to all be certified and operate in that environment, and then you're saying but federal law won't allow us to pay more than that.

So we've tried to say give states flexibility. If we're going to do it through a waiver, you know, let us negotiate that with you all. And so that's been our position about the short stay.

We certainly appreciate that they acknowledge this issue in the regs and hope that something stays in whatever the final product is, but definitely those two

issues were sticking points for us in Maryland.

CHAIR ROWLAND: Okay.

COMMISSIONER COHEN: Thanks for great presentations on a really important topic that I have come to realize what an important part -- how important it is in general and what an important part of Medicaid it is.

I had one question and then a comment about the IMD. The question is -- so we've talked -- and, Allison, you and I have worked together on this stuff -- you know, about the really amazing pace of change in terms of structure on integration. And I guess we don't know very much about how that is impacting the actual provider, practice, and patient experience in terms of integration. But I'm a believer in, you know, sort of eventually that should at least be a facilitator of that on the ground. Practice change, which is really where patients are impacted.

But you mentioned it, Allison, in your presentation, that sort of capacity of providers is a huge issue. You mentioned issues about privacy -- I'm going to actually park that a little bit because I'm not sure what -- data privacy, what Medicaid can really do about that.

And then I think there's also issues, I think, about licensing in different states that can be a barrier. But I wanted to really focus on the capacity part.

So in other sort of practice transformation kind of work there, there's been a lot of money that has gone to providers to sort of teach them to transform and to do capacity building and other sorts of things. And I guess I'm wondering whether -- first of all, can states do that with Medicaid funding? What's the ability of states to sort of do that work with Medicaid funding? And if not, what are alternatives for states? How much of a barrier is it not to have that? Is that even a service, you know, that is perceived as really useful? Like what is it that Medicaid can do to help sort of jump-start this capacity-building effort, which seems to be really needed?

MS. HAMBLIN: Yes. So I would say, you know, from the very interested watching and consultation that we have been doing with states for moving in this direction, I would say this is a huge issue everywhere. You know, I'd say, you know, with the possible exception of states that have really mature managed behavioral health programs. Where providers have been working in a managed care

environment and are used to what a managed care contract looks like, you know. States like that, you know, I don't know if it was a huge change. In Arizona, for example, for the behavioral health providers to start contracting with Mercy Maricopa instead of with Magellan, who was the regional behavioral health authority. It was a mature managed care marketplace. I think the risk there is much lower or the need for capacity building and sort of extensive provider technical assistance is much lower than in states that are moving from generally unmanaged or from very lightly managed behavioral health systems to not only manage but generally led by traditionally physical health managed care organizations who may not be fully aware up front of the extent of the technical assistance needs of the providers. And I think states are generally cognizant of this issue. Probably I would venture to say would underestimate the magnitude of the challenge and the magnitude of the technical assistance need, just like anything, right? It's always going to take longer and be a little harder and take more money and time than we think it will.

My understanding is that you can't use Medicaid

funds -- you certainly can't use 2703 funds for this type of capacity building, technical assistance. But I would definitely concur that it's an area that will require a lot of investment, if not in dollars, in time and other resources, just to make sure that we minimize the risk of service disruption, you minimize the risk that you lose providers in the network because they are not able to successfully transition to a new operating environment. And for most of these providers, it's a pretty substantial business change for them to move from one environment to another, and it needs to be handled very carefully.

And the good news is we're seeing states move very deliberately and slowly and mindful of this need as they get into it. They may go in a little aggressively, but they're quickly realizing that they need to take more time and extend implementation timelines to make sure that these pieces come together.

MS. McMAHON: I can add just -- and building a little bit on what Chuck said about the eight MCOs. One of the advantages of the ASO model in Maryland is that the ASO -- speaking about value options, you know, they're making some investments in what we're doing, right? So they have

-- they've had the contract for a long time. They did the behavioral health carve-out. So they're making investments in some of those data analytic tools, both by contract requirement because they have both Medicaid and our general fund program dollars, but also because they know at the practice level it's going to make a difference for them and their ability to engage with the providers. And it's also an opportunity because they're not -- you know, it's not MCOs. It's an opportunity for the providers, because it's not eight different MCOs. It's one payer that they can engage directly with. And so they've been a good partner to that end in terms of helping us play through that.

And then at the provider level, I think like in our health home, I mean, we have done -- you know, we scraped internal dollars together to be able to give, you know, regular reports to those provider groups so that they have kind of a regular dashboard and things like that. But it's been kind of a consolidated effort that's been pieced together that we are going to have to in a comprehensive way, after those 9010 dollars dry up, figure out how we're going to be able to fund both the service side of it as well as that administrative side.

CHAIR ROWLAND: Okay.

COMMISSIONER HOYT: I had three questions. Two of them kind of fall together, I think. I'm wondering about --

CHAIR ROWLAND: This is a new trend in my Commission, from one question to two to three to four.

[Laughter.]

COMMISSIONER HOYT: It's Patty's fault.

CHAIR ROWLAND: Simplicity, Patty.

COMMISSIONER HOYT: Do you have an opinion about integration and whether it saves money or not? Does it save money? And if it costs more, is that okay? Are you getting higher quality, more access to care, something else?

MS. McMAHON: I can say for certain that we don't know the answer to that. I think we feel like we've seen some administrative synergies already, just from a staffing perspective, getting people into the same building, getting them to talk to each other, getting them engaged in thinking about sort of whole-person care. I mean, I think that alone is -- you know, if it's not saving money, it's certainly driving quality and driving, you know, different

lines of thinking.

And then, you know, I think, as I mentioned, we're definitely, you know, early-stage evaluation of our first year, just trying to get all the data streams aligned and trying to figure out sort of what the spends and trends have been and what the implications are on the somatic side, too, and I think that's a tougher nut to crack for us and probably a little bit easier in some of the other models that Allison cited where there's full integration.

MS. HAMBLIN: Yeah, I would echo that. I don't think we know, at least for populations with serious behavioral health needs, yet, just given how new -- whether it's the health home models or the integrated managed care strategies, given how new most of them are.

However, I would say that, and I think someone brought this up earlier, I think part of the momentum behind this sort of rapid movement in this area right now is all of the data coming out showing that among high-cost populations, there is a very, very high prevalence of serious behavioral health conditions, and so I think the supposition, subject to what needs to be careful evaluation and monitoring as these programs continue to roll out, is

that given that our highest cost, highest need populations really need integrated care, that integrated models are the key to delivering some promise of cost savings if we are going to save money by providing better care for this sort of deep end of the pool, so to speak. But, we don't have the data yet.

COMMISSIONER HOYT: Well, I think that is something we would be interested in, as the study progresses.

The other question I had relates to states and their staff. I think it would be -- at least, I would be interested, but I would think the states would be interested, too, how behind the scenes they are integrating their staff. I worked for a consulting firm -- this was a few years ago -- and we were working with states on what we're talking about here and it was almost humorous, in a way. They practically assumed there would be magic would happen if these networks and delivery systems would come together and integrate. But then when we turned and asked them, and what plans do you guys have, and it's, like, huh? It was just as fragmented and siloed as it could be and a bunch of these people never talked to each other, and so

here could be a vendor or somebody else coming back to the state. It was just almost bizarre. You guys have to change, too. How are they changing?

MS. McMAHON: So, first, I'll say, you're right. I think especially folks who are on the behavioral health and addiction side, sort of the more traditional -- what I would say more traditional Medicaid finance people do not speak the same language, and that's, frankly, become very evident to me in my six-and-a-half months in this job.

And, it's been very interesting and it's definitely been an evolution, just in this short amount of time, where we're all sitting in the room together talking about shared priorities. We're talking about shared finances and we're talking about shared contracts. And, so, that in and of itself, I think, helps drive that shift.

I think one of the really important things that I'm personally seeing is the need for staff capacity, different kinds of staff capacity. So, having individuals who have both that clinical background but also some financial acumen to understand -- and service-level acumen tied together to help us in Medicaid make good sort of population health decisions, coverage policy decisions, et

cetera. And, so, it's getting those two kind of worlds together and get them together and married, I think is definitely a challenge that we're facing, and I think at the state level, it's always hard to get that balance.

MS. HAMBLIN: The only thing I would add is that it's interesting, I think. We're seeing movement in this direction, and I think we'll see more in terms of agency-level integration. And it's interesting that in some cases, that's preceding delivery system integration. So, California is an example, where DHCS has integrated the mental health and substance abuse agencies within the same department as Medicaid, and they are now developing and moving forward with a number of delivery system integration strategies, whereas Arizona is actually a good example of the state proceeded first with the integrated managed care reforms and subsequently has been integrating at an agency level. And, so, it may happen in different orders in different states, but it seems to be happening more and more.

CHAIR ROWLAND: Sharon.

COMMISSIONER CARTE: Katie, in your slides, you had a bullet that said that there is kind of a dearth of

any evidence-based data for integration for adolescents and children, and we've got this appendix summarizing all this great activity. So, my question is, are there any states that you'd point to that might have lessons sooner than later as far as children and adolescents, or even successful -- you know, you mentioned the juvenile justice-mental health-child welfare collaboration, or are we just really all at the beginning of that? I think I was one of the Commissioners that wanted to talk about this when we were in the planning session, but it's sounding more and more challenging than I thought.

CHAIR ROWLAND: Careful what you wish for.

COMMISSIONER CARTE: Right.

MS. HAMBLIN: So, I am not an expert on the system of care models, but there are people who are very much experts and some of them work at CHCS and we'd be happy to point the Commission to some folks who may be able -- who could weigh in on that. Some of those models have been in operation for quite some time, and I've seen some of the data for programs like Wraparound Milwaukee and some of the kind of premiere names in the field in terms of what they've been able to achieve. New Jersey has had a system

of care for its child and adolescent population with behavioral health needs for many years, and I believe they have recorded some real program successes and impacts on costs and utilization. So, I think some of the data are out there --

COMMISSIONER CARTE: Well, as a quick follow-up, would you know if they tended more toward where you all talked about the ACO care coordination model or more integrated MCO, which is both --

MS. HAMBLIN: Uh --

COMMISSIONER CARTE: You don't know?

MS. HAMBLIN: I think it's a variety. Yeah. I mean, not fully -- they tend not to include at-risk physical health dollars. They tend to solely deal with the behavioral health dollars and other system partnerships, as far as I understand. But, there may be, and there likely are, fully integrated models that I'm just not aware of.

CHAIR ROWLAND: It would be great if you could have the staff there just let the staff here know of any of those models.

MS. HAMBLIN: Absolutely.

MS. WEIDER: Yeah. Just getting back to what the

slide had said, when we were going through the literature, there are so many literature reviews out there looking at the integration of behavioral health into primary care settings for adults with depression and anxiety disorders. When we started looking beyond that population, I really only found one literature review -- it came out very recently, too, I think it was just in May, or June, even -- that looked specifically at the children's population, and I think it only had about 12 just case studies, which is why we wanted to highlight that issue. But, we can keep digging into that for you.

MS. HAMBLIN: And the only other thing I'd add is that on the health home side, there are recent approved health homes focused specifically on children with serious emotional disturbance, one in Oklahoma and one in New Jersey, and there may be others, as well. They are rather new in terms of implementation, but in terms of keeping your eye on them, tracking for the future, I think they will provide a lot of lessons. New York is coming down the pike with a children's focused health home model, as well, in its case focused on children with a history of complex trauma, which will be interesting to watch.

MS. WEIDER: And when you look on the SHADAC report, you'll see a summary document of all the programs we reviewed and it does have the health homes that looked at children with serious emotionally disturbances, so you can look at it that way, too.

CHAIR ROWLAND: Okay. Trish.

COMMISSIONER RILEY: I very much apologize I had to step out, so if you've answered this, you can say it's because you're rude and I'm not answering it again.

[Laughter.]

COMMISSIONER RILEY: But, I honestly had forgotten about the ACA IMD demo until you mentioned it, and it was an intriguing thing. Can you say more about who did what and where we are with that and what do we know.

MS. McMAHON: Sure. So, there were 11 states that participated in the emergency psychiatric demo. It allowed for Medicaid payment of IMD services, both emergency psychiatric services and then, also, IMD services. And, so, we -- when we looked at the data, and actually when we were putting together the 1115 waiver application, and I have the numbers in here that I can certainly share with the staff, but we definitely saw cost

savings, probably in the $10 to $15 million range on an annual basis, in terms of being able to give, you know, provide those services to individuals in an IMD versus through an acute care general hospital.

So, we feel like it's very promising. Senator Cardin has been gracious enough to put a bill in to extend the demonstration, and it's pending in Congress. It sounds like, now that they're back, it sounds like it may have some momentum. I'm not completely sure, but I understand that it might move.

COMMISSIONER RILEY: And, do you know, will there be a federal report and evaluation of it?

MS. McMAHON: There will be an evaluation of it. It was actually supposed to end at the end of December and it ended in June, actually at the end of June. And, so, it's administered by CMMI, so there will be an evaluation.

CHAIR ROWLAND: Okay. Steve.

COMMISSIONER WALDREN: Just a quick, getting back to when Andy was talking about capacity and practices. So, I've been a member of an advisory council for the National Academy for Integration, which has been around for about five years, and it was working on kind of creating a

groundswell of integration of behavioral health and primary care. About three years ago, we switched, because we started to see the uptick of that, and now it's more of the how.

So, they've actually been creating resources on that to help practices. So, this is a group of primary care providers that are working in integration and the subspecialists in behavioral, mental, and substance abuse. And they have a playbook that describes how you can do that.

And the other thing I wanted to mention is, again, when I think we used -- I don't think we can use the word "integration" and ask the question. I don't think we can say, well, does behavioral integration do this, because it's like saying, well, does transportation -- is transportation an effective way to get from here to the Capitol building. Well, if you're thinking that that is a bicycle or walking, yes. If you think that's a 747, that's not the same.

So, I think the same thing with integration. If we're talking about the clinical integration, or are we talking about the finance integration, are we talking about

all the different public services integration, all those are really, really valuable, but I think they have different values. You get different things out of them. So, that's why we created that lexicon to say we really need a language to talk about integration, because it's not a single thing. So, I just want to make that point as we think about integration moving forward.

CHAIR ROWLAND: Okay, and Sheldon.

COMMISSIONER RETCHIN: Can I ask about whether -- do you have any knowledge about the IMD excluded facilities, what percent are for profit? And in the demo, did -- I would assume that for-profits were probably part of those who participated, or do you know?

MS. McMAHON: So, in Maryland, all of our acute care general hospitals are not for profit. So, we're probably not the best metric for you.

COMMISSIONER RETCHIN: No, no. I meant those that, with the waiver, you were able --

MS. McMAHON: Oh, you're talking about the --

COMMISSIONER RETCHIN: IMD.

MS. McMAHON: -- the IMDs.

COMMISSIONER RETCHIN: Yes. Yes.

MS. McMAHON: You know, I don't know the answer to that, but it's something we could certainly find out.

COMMISSIONER RETCHIN: Because, and I don't know enough about it. In fact, I had never run across a for-profit psychiatric hospital until I moved. But, since the 1970s, the growth in the IMDs has, I think, largely been, or at least maybe not largely, but fueled by the for-profits who could get and skim -- I don't want to use that word -- but certainly took a large number of the commercial patients, which now became better insured, and so the IMD exclusion has been used, in a sense, to not -- I mean, we can't take those patients. We can't take Medicaid. It's too bad. We really wish we could.

Now, I think, the next iteration of that could be, gee, we really would do it, but, you know, we're exclusively behavioral health and we really think integration is a better move for Medicaid. Just a -- just sort of thinking ahead.

CHAIR ROWLAND: That's a good though.

You know, I think what you have offered us today is really very rich and a very good discussion that really amplifies the pulling together in the inventory that Katie

has been working on, and certainly from here, I think, this is material we want to pull together as part of our March report to at least do the lay of the land, look at some of the issues and challenges.

I think it's particularly of interest to this Commission about the issues of how do you integrate at the state level, at the administrative level, and what capacity do you need to really do these more complex ways of managing care for such a vulnerable population.

You mentioned one other thing that I think we'd like to also pursue a little bit, is that the lack of quality metrics. And, so, we keep talking about evidence-based recommendations and measuring the impact, but if you don't have any quality metrics, it's really hard. And, so, I think those are areas where the Commission may want to weigh in on sort of necessary next steps to continue this flow.

But, you've given us a really great overview of what's going on. We'd love to stay in touch and continue to learn about what the models out there are and what the experience is, and, I think, have had -- for late in the day -- an extremely rich discussion. This has been quite a

long day of sitting here in this dark room that goes from being freezing cold to sometimes a little warmer and then back to cold, but maybe the cold has kept us awake. But, I thank you for joining us and for your insights, and Katie, for the work you've been doing, as well.

And, we also always note at the end of our session, if there is anyone who wants to add a comment to the Commission's consideration from the audience, please come forward to the mic at this point. Or have you had such a long day, too?

Public Comment

* [No response.]

CHAIR ROWLAND: Okay. Well, I will, then, adjourn the Commission meeting and thank you all for your participation, and to the Commissioners and the staff for their quality work. Thank you.

[Whereupon, at 4:44 p.m., the meeting was adjourned.]