PUBLIC MEETING

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

Thursday, December 15, 2016
10:03 a.m.

COMMISSIONERS PRESENT:

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P R O C E E D I N G S

[10:03 a.m.]

CHAIR ROSENBAUM: All right. I am going to get the room together and ready to go.

Good morning, everybody. Welcome to a very cold December, our last meeting of the year. We have a very full schedule, so I want to start us right off. First up is highlights from the new edition of MACStats, a wonderful Christmas gift for those of you who are still shopping, on top if it all.

[Laughter.]

HIGHLIGHTS FROM NEW EDITION OF MACSTATS

* MR. PARK: Thanks, Sara.

MACStats is one of our major publications each year, and it compiles data on the Medicaid and CHIP programs from a variety of sources, including federal and state Medicaid administrative data, federal and state budgets, and national surveys.

We update these data periodically throughout the year, and as more recent data become available, we post them on the MACPAC website, and at the end of the year, we publish the collective set of exhibits together in a single

publication. And this published data book for 2016 just was released last week.

I'd like to acknowledge the contributions of the entire staff, particularly Jessica Morris for her work in producing and reviewing exhibits, as well as Kathy Ceja and Angelica Hill for all their hard work in the production of the book and the website material.

I will now turn it over to Madeline to present some of the highlights from this year's MACStats.

* MS. BRITVEC: Thank you, Chris.

So MACStats is comprised of five sections and a technical guide. Today's session will review some key takeaways from each of these sections, which include an overview of Medicaid and CHIP enrollment and spending, trends within Medicaid and CHIP enrollment and spending, as well as state-level data broken out by eligibility group, type of service, and other factors.

We have a section on state eligibility thresholds for beneficiaries and lastly survey data on measures of beneficiary health, use of service, and access to care.

Over 25 percent of the U.S. population was enrolled in Medicaid or CHIP for some portion of the 2015

fiscal year. Eighty-one million were estimated to be enrolled in Medicaid, and approximately 9 million in CHIP. Medicaid share of the state budget was 15.3 percent, whereas elementary and secondary education held a greater share at 24.1 percent.

Similar to 2013 and 2014, Medicare held a greater share of the national health expenditures at 20.4 percent, compared to Medicaid and CHIP at 16.8 percent. However, private insurance continues to hold approximately a third of all national health expenditures.

This slide shows the major components of the total federal outlays from 1965 when Medicare and Medicaid were first implemented to 2015. As you can see, Medicare and Medicaid have grown over time, but Medicaid has continued to attribute a smaller share to the federal outlays, and fiscal year 2015 is no exception.

Medicaid accounts for 9.5 percent of federal outlays, and Medicare accounts for 14.6 percent. Together, CHIP and the exchange subsidies account for approximately 1 percent of the total federal outlays.

Medicaid and CHIP had an enrollment growth of 0.2 percent from July 2015 to July 2016 after experiencing high

growth rates at about 10 percent in the previous two years.

However, in the past, enrollment trends vary based on eligibility group. For example, children experienced the largest absolute increase since 1975 at 21 million children, but those eligible on the basis of disability quadrupled over these four decades.

This next graph illuminates how the trends in spending growth are complemented with the full-year equivalent enrollment growth. The growth trend lines for spending and enrollment run roughly parallel to each other, particularly during the expansion and recession from 1986 to 1991 and recessions between 2000 and 20023 as well as 2008 to 2010.

Medicaid's portion of the state budget depends on whether or not federal funds are included. When including federal funds, Medicaid is about 25 percent of the overall state budget. With just general funds included, as in what states raise through taxes or other means, Medicaid was approximately 19 percent of the state budget, and Medicaid is approximately 15 percent, when including just state funds, so Medicaid and health-related provider taxes as well as local funding.

There was an increase in Medicaid spending in 2014, the bulk of which is shown through federal funds, mainly because of the newly eligible adult group -- the adult population receiving 100 percent of the federal match, which is displayed on the exhibit. You can see that the top dark line, which includes federal funds, increases in the past year, while the bottom two lines, which exclude federal funds, plateau.

This exhibit emphasizes how vital it is to recognize the different methods of reporting the Medicaid share of the state budget.

Use of managed care continues to grow as well. Spending rose from 37.5 percent on capitation payments for managed care in 2014 to 43.1 percent in 2015. Enrollment in comprehensive managed care increased as well from 55.3 percent in 2014 to almost 60 percent in fiscal year 2015.

Those eligible on the basis of disability and age 65 and older accounted for a quarter of the enrollees but two-thirds of program spending. Net drug spending increased by over 27 percent from fiscal year 2014, but drug rebates reduced gross drug spending by almost 50 percent.

On this chart, the differences in spending categories very by eligibility group. You can see that the disabled population on average cost $18,000 per enrollee, and average spending for aged beneficiaries was over $15,000. An average disabled enrolled cost six times that of a child or more than four times that of an adult. This demonstrates the importance of the enrollee mix when either calculating or contemplating the average overall spending per enrollee.

Another important aspect of this slide is the variation of service mix. As you can see, the majority of spending for the disabled and aged eligibility groups went towards long-term services and supports, LTSS, and for children and adults, the bulk of spending went towards managed care.

The national health interview survey reported that in 2015, 46 percent of those enrolled in Medicaid or CHIP have an income below 100 percent of the federal poverty line, or the FPL, which was $11,880 annually in 2016 for the lower 48 states.

Almost two-thirds of Medicaid or CHIP enrollees have incomes less than 138 percent of FPL, and in 2016,

more than half of states covered the expansion adult group, up to 138 percent, which was about $16,394 annually.

In terms of eligibility, the criteria for those eligible under the basis of disability and for age largely remain stable between 2015 and 2016.

This next slide presents research found through the national health interview survey. Children and adults were less likely to be in excellent or very good health than either those under private insurance or those who were uninsured. Those same children report seeing a general doctor at similar rates as those with private coverage. Overall, children and adults covered under Medicaid report having a usual source of care, similar to those privately insured, but were more likely to experience access barriers, particularly in the form of delayed care or trouble finding a doctor.

That concludes our presentation. We appreciate your patience going through all of this material. I know it's a lot to handle, and we'll turn, figuratively, the mic back over to Anne and Sara.

CHAIR ROSENBAUM: Thank you.

Any questions or comments?

Marsha.

VICE CHAIR GOLD: Yeah. I just want to sort of commend the staff for the work that has gone into MACStats. I was here working with some of the Commission staff at the beginning when there were no MACStats, and so I know what has gone into making it what it is. And it's just a tremendous resource for everyone. It's a great job.

CHAIR ROSENBAUM: Any other comments?

I had one thing I should note. I'm always struck by -- and, of course, it's shown up in our MACStats before, but the breakout of benefit spending per full-year enrollee, what I always find so striking, which I think a lot of people just don't really appreciate, but we spend a lot of time bringing to people's attention, is that within the population of people with disabilities, the great majority of the spending is actually not for long-term services and supports. It's for things that we might call normal acute care spending -- hospitalization, medical, drugs -- and they just use more. They use greater amounts and more. But it sort of goes to this point that so much of the role that Medicaid plays is not just providing totally different categories of services from those that

might not be in regular insurance, but actually providing a lot more of certain services, even ones that show up in a regular insurance plan but are used in much greater amounts by this population. And I think it's one of the sort of little known facts of Medicaid that I find often sort of fools people, so it's very important to keep emphasizing this point, I think.

FUTURE OF CHIP AND CHILDREN'S COVERAGE: DISCUSSION OF DRAFT RECOMMENDATIONS AND VOTE

* CHAIR ROSENBAUM: All right. Thank you so much. We are now going to turn to a discussion of the Commission's draft recommendations on CHIP and the future of children's coverage under CHIP.

This is a voting meeting, and as a result, our adopted conflict of interest rules apply. They were adopted back in the spring, in May of 2016. The conflict of interest policies, of course, is at the website, and I want to, on behalf of us all, give sort of an overview of the implementation of the conflict of interest policies and the process we follow to comply with those policies in the lead-up time to this vote.

Let me just note that, of course, as is evident

in our statute, MACPAC's Commissioners represent a wide range of backgrounds and disciplines, and their selection to serve is based in great part on the viewpoint diversity that they bring to their service.

At the same time, we have adopted a conflict of interest policy in order to ensure that certain kinds of reportable interests, should they rise to the level of a potential conflict, will be disclosed during a voting meeting. So it's understood. It's in our DNA as a Commission that we represent a wide array of viewpoints, and all of us in one way or another bring what's called reportable interests to the table.

The only thing we are concerned about is whether any of those reportable interests rise to the level of a potential conflict of interest.

So, to this end, MACPAC's policy on Commissioner conflicts of interest, which was adopted during our May 2016 meeting, requires the Commissioners report certain interests, both at the time of their candidacy and annually thereafter, and that we update them annually. These reportable interests form the basis of the information that may be evaluated under our policy in order to determine if

any interest, any reported interest rises to the level of a potential conflict of interest in connection with a vote on a proposed recommendation.

Under the policy, the MACPAC Chair appoints a conflict of interest committee that to the extent possible represents a mix of us all. So we've assembled a committee that represents a cross-section of all of us who sit around the table here, and in advance of the meeting, at which a proposed recommendation is going to be put to a vote, the committee reviews the reportable interests on file for each Commissioner and any other information that the committee deems relevant. So we literally, as a committee, meet to review the reportable interests of our Commissioners, and the purpose of the review is to determine whether any reportable interest on the part of a Commissioner may be more likely to constitute a conflict of interest and to evaluate whether such interests may in fact constitute a conflict. So it's our job to look at everybody's reportable interests and then to decide if anything rises to the level where potentially we're looking at a conflict.

So the question is, What's a conflict of interest? Under our conflict of interest policy, an

interest, reportable interest has to be particularly, directly, predictably, and significantly affected by the outcome of a recommendation vote. So this is not just a generalized interest in a vote. This is a particular, a direct, a predictable, and a significant interest in the outcome of a vote.

So, for example, if an interest is a particular interest, that's an interest where the outcome of the vote must have an effect on the financial interest that is largely distinctive to the individual or entity in which the individual holds some sort of an ownership interest.

If an interest is going to be directly affected, it is an interest where there would be a close causal link between the recommendation, if adopted, and the effect on the financial interest or the individual or the individual's entity.

For an interest to be predictable, the recommendation must affect financial interests in the sense that there is a real as opposed to speculative possibility that the recommendation, if adopted, will affect the financial interest.

And, finally, an interest is one with a

significant status if the outcome of the vote could increase or decrease an absolute amount, the financial interest of the individual who has the interest.

So it is not just a general relationship to a vote. It is a very specific, predictable interest in the vote.

Conflicts identified by the conflict of interest committee must be publicly disclosed at the meeting.

So, on November 3rd, the MACPAC Conflict of Interest review committee met and determined that for purposes of our CHIP vote today, under the particularly, directly, predictably, and significantly standard that governs our deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest; therefore, no Commissioner will engage in any disclosure today.

All right. Let me just also take a minute at the beginning before Joanne and Ben take us through the materials to explain what is going to happen.

We will be presenting the recommendations. The recommendations will be transmitted as a package of recommendations.

Throughout the summer and fall, we have deliberated intensively and carefully on CHIP and its future. It has been a very rich deliberation. This deliberation is coming at a time of enormous change in health policy nationally, changes that have raised many additional complex issues as part of the deliberations background.

We have concluded as a Commission, based on our fall discussions, that there are two aspects to this package that remain to be resolved with this morning's vote, and those two aspects are whether or not to hold a maintenance of effort requirement through a set period of time, whether to allow that maintenance of effort requirement to change in certain ways, and in a highly related fashion, whether to leave the federal contribution to the state CHIP programs at the level that it stands at today or whether to begin to reduce that federal contribution.

Now, there are also many other parts of this recommendation package that raise ongoing issues and questions, and following the presentation by Joanne and Ben, we will go around the room and each Commissioner will

speak for about 90 seconds to 2 minutes regarding both the maintenance of effort and the federal contribution rate as well as any other considerations that the Commissioner might have. And based on the expressed views of each individual Commissioner, we will then proceed to a final vote on a package. The vote may be an approval; it may be a dissent. But each Commissioner will state his or her views as we move around the room.

So, with that, I am going to turn matters back over to Joanne and Ben to walk us through the final package.

* MR. FINDER: Thank you, Sara.

We are back, and we are returning today to the topic of CHIP and children's coverage.

On our agenda for today, I will begin by reviewing the context that will serve as a backdrop for your deliberation on the future of CHIP and children's coverage. After that, I'll provide an overview of the analyses in support of your deliberations and some of the key findings that have emerged from those analyses.

From there, I will turn it over to Joanne to review the draft recommendation package on the future of

CHIP and children's coverage, and after that, we will call a Commission vote.

MACPAC's deliberation on CHIP and the future of children's coverage began in 2013 when the question of the program's funding beyond 2015 was in the fore. As was the case then, the Commission considered CHIP within the broader context of children's health care coverage.

This slide highlights key points the Commission has made in reports, issue briefs, comment letters, and other publications during its deliberation.

As the Commission and many others have noted in the past, there's been bipartisan support for CHIP since its enactment in 1997.

CHIP is a relatively small program sandwiched between other coverage sources. For example, there are about 8.4 million children that had CHIP-funded coverage in 2015, which includes both separate CHIP and Medicaid expansion CHIP, compared to 36.8 million who had Medicaid-funded coverage.

CHIP provides coverage for children whose family income is too high to qualify for Medicaid but who lack access to care that is adequate or affordable.

The Commission's vision for the future of children's coverage began to emerge in 2014 when the Commission began to think more broadly about how to meet the needs of low- and moderate-income children in an evolving coverage environment. In making its recommendation in 2014, the Commission described principles and its vision for the future of children's coverage. Those principles and vision have continued to apply in MACPAC deliberations over 2015 and 2016.

They are that children's coverage must be affordable and comprehensive and that maintaining state flexibility is important. And as a backdrop for your deliberation, it bears mention that there's uncertainty in what changes health insurance markets will face in the coming years.

Throughout the deliberation, we, the staff, have presented to you a number of analyses, both external and original MACPAC research. For example, the March 2015 report included a chapter on eligibility, enrollment, and the likely impact on children's coverage if CHIP funding were not extended. In this work, we found that CHIP has reduced uninsurance among low- and moderate-income

children. The uninsurance rates among CHIP-eligible children has decreased from 22.8 percent in 1997 to 6.7 percent in 2015.

I mentioned earlier that 8.4 million children had CHIP-funded coverage in 2015. About 89 percent of these had family income at or below 200 percent of the federal poverty level.

In an earlier analysis, we found that if CHIP funding were not renewed, about 1.1 million children would become uninsured. That was about 30.9 percent of children that would have lost separate CHIP coverage. Some children also moved to ESI or exchange coverage under current law.

Our March 2015 and 2016 reports found that CHIP is more affordable for families than other sources of coverage. For example, we modeled the expected out-of-pocket spending of CHIP-eligible children enrolled under different sources of coverage, including CHIP, employer-sponsored insurance, and exchange coverage. We found that the expected out-of-pocket spending was lower in CHIP. It averaged about $158 annually, including both premiums and cost-sharing requirements, compared to $891 on average in employer-sponsored insurance and $1,073 in exchange

coverage.

In March 2015, we looked at covered benefits in CHIP, Medicaid, exchange plans, and employer-sponsored insurance. There was variation within each source of coverage, but overall we found that each source covers all the major medical benefits, like inpatient and outpatient care, physician services, and prescription drugs. Medicaid and CHIP covered children's oral health care, but these benefits are typically offered separately in exchange and ESI products; and about half of employer-sponsored insurance plans did not cover pediatric dental.

Previous MACPAC research found that children with CHIP coverage had greater access to care compared to uninsured children, and there are several other studies that have similar findings.

So as we reiterate the key findings from our previous work, we hope that they serve as helpful context for your deliberation today. And now I'll turn it over to Joanne.

* MS. JEE: Okay. So as Ben said, a lot of analysis, and there's a lot of context behind this recommendation package, and I'm going to walk through the

recommendation package for you. I'm not going to read the full text of each of the recommendations because they're in your meeting materials, and they will be displayed on the slides. But we'll just sort of try and pretty quickly walk through what they generally are.

So the first recommendation talks at a general level about the need to extend federal CHIP funding beyond the end of fiscal year 2017, after which under current law there is no new federal CHIP allotments.

Commissioners, you all have noted the concerns with the affordability and adequacy of other available sources of coverage for low- and moderate-income children and the need to continue to work toward addressing those concerns, as well as the importance of moving towards a more seamless system of coverage that Ben mentioned. However, as you know, policymakers and lawmakers are looking at the future of coverage generally, and as that deliberation occurs, you all have expressed the importance of continuing federal CHIP funding. So that is the first one.

The second recommendation is on the time frame for the extension of that federal funding, and we have

heard from you that the extension should be for five years through fiscal year 2022, and that five-year time would provide time to undertake the considerable work that lies ahead to address those concerns that you have pinpointed as well as give time for the discussion and debate to occur more broadly.

I should also say that the five-year period would be helpful to states in that it provides some greater budget certainty in that period.

Okay. So this next recommendation is the one that Sara referred to where there is still a decision to be made as to what the specific recommendation is. There are two options here for you. During the October meeting, you discussed at some length the idea of a phased approach to the maintenance of effort whereby there would be some modification in sort of the later years. But since then, a lot has happened -- because that was in October -- and we've heard from some of you some concerns about the complexity of that kind of approach and concerns about really wanting to protect access to children's coverage.

So the two options that we put before you are: one, to retain the current law maintenance of effort -- and

these are all things that you all have discussed previously -- but to retain the current law maintenance of effort and the increase to the federal CHIP matching rate for the five-year period of the CHIP funding extension. So that would be through fiscal year 2022.

The second approach on the slide here is that phased approach, and just briefly, again, what you discussed previously was in years one through three of the funding renewal period, to retain the current law maintenance of effort, as well as the increase to the CHIP matching rate; and then later in years four and five of the extension period, to introduce some ability for states to modify their programs, so modify the MOE, and to make some sort of reduction to the federal CHIP matching rate. And we will come back to that, as Sara said.

But moving on to Recommendation 1.4, Recommendation 1.4 is to eliminate waiting periods in CHIP. This is a recommendation that the Commission first made in March 2014, and so we are including that back in this package this year as well. And at the time, you laid out four primary reasons to eliminate the waiting periods, including reducing uninsurance among children, and you also

noted that there was no clear evidence about the effectiveness of waiting periods in deterring crowd-out of private coverage or substitution of private coverage, which was one of the key reasons why states adopted waiting periods. Additionally, eliminating waiting periods would simplify enrollment policies and reduce administrative burdens for families and states.

So like Recommendation 1.4, 1.5 was one that was made also in March 2014, and this one is to eliminate CHIP premiums for children and families with incomes below 150 percent of the federal poverty level. And just as a point of reference, for a family of four in 2016 that's $36,450. Eliminating these premiums would help to reduce uninsurance among this group of children and would align CHIP and Medicaid policies on premiums.

Recommendation 1.6 is for Congress to establish demonstration grants, including for planning and implementation, to support states that are wanting to develop and test models of coverage specifically for children. And these models would be designed using existing state plan and waiver authority. That's how we understand you to think of it. And the goal, of course,

would be to create greater seamlessness of coverage, and, of course, that coverage would be comprehensive.

The grant activities would support things such as market research and analysis, needs assessment, and stakeholder engagement, among others, and would help states in their undertaking of these activities for which they might otherwise have a hard time with resources.

There is precedent for demonstration grants, such as in developing state plan amendments to establish health homes for Medicaid enrollees with chronic conditions, as well as the Real Choice Systems grant program and the State Innovation Model initiative.

Recommendation 1.7 calls on Congress to permanently extend authority for states to use Express Lane eligibility for children in Medicaid and CHIP. MACPAC sent a letter to the Secretary of Health and Human Services in March 2014 in which the Commission expressed its support for this proposal, so again, this is something you all have spoken on before, and so we're incorporating that here. Currently, the Express Lane authority expires at the end of fiscal year 2017.

Recommendation 1.8 relates to 1.7. It calls on

the Secretaries of Health and Human Services, Agriculture, and Education to report to Congress on legislative and regulatory changes that would be needed to permit states to use Medicaid and CHIP eligibility determination data and findings to determine eligibility for other designated programs, so it's basically ELE in reverse, to establish bi-directionality of ELE which currently doesn't exist.

Recommendation 1.9 is the extension of a set of programs that were established by CHIPRA. These are the Medicaid and CHIP outreach and enrollment grants, the Childhood Obesity Research Demonstration Project, and the pediatric quality measures. These programs currently are funded through fiscal year 2017, and just very quickly to walk through, as you know, the outreach and enrollment grants support states, tribes, and community-based organizations in a range of outreach and enrollment activities. These funds have also supported a national outreach and enrollment campaign, and we have heard from state officials that without these funds, they believe that they would have to scale down their outreach and enrollment activities just due to their own budgetary constraints.

The Childhood Obesity Research Demonstration

grants -- you heard this in October, but just to refresh your memory -- fund efforts to identify health care and community-based strategies to combat childhood obesity in children ages 2 through 12 who are enrolled in Medicaid and CHIP. They are evaluating multi-level and multi-setting approaches that integrate primary care with public health strategies to address behaviors and reduce childhood obesity.

The third piece of this is the pediatric quality measures, which were established to improve and strengthen the initial core set of quality measures. Currently, grantees under this program are assessing the feasibility and usability of measures at the state as well as health plan and provider levels, and extension of this funding would help to continue this work.

So as has been the practice, we turned to our friends and colleagues at the Congressional Budget Office, and they have provided us a cost estimate for the recommendation package. I will note that there is still that open question on the recommendation on the MOE and the matching rate, and so, of course, whatever decision you ultimately come to will affect the final cost estimate. So

the number that's on the screen for you here is sort of the outer bound of what they think that could be. And so that is $13.2 billion over the five years and 18.7 over ten years, and I should just emphasize that it is an estimate and, depending on what the final legislative language is, could affect the ultimate cost.

Let's see here. The other piece of this is, of course, the question of offsets, and as you discussed at the last meeting, we have been asked to do that, and your discussion was to include a general list of offsets that have been identified in legislative proposals or the president's budget proposals, all of which have a cost estimate already attached to it -- or a savings estimate, excuse me, attached to it, and to provide that list without providing any sort of endorsement of any particular proposal because, as one of you said, you know, those all require some additional analysis to fully understand their impacts. But we have that list that's in your meeting packet, and so that is what we understand to be your intent, is to provide that list.

Okay. So next steps. I'm going to turn it back over to you all, and we would like to hear from you on any

specific wording changes to the recommendation language if you have any, and just so everybody knows, after the vote today, the final and revised recommendation language will be made available to the public. It will be posted on the MACPAC website. And then staff will go back and work on the language, the more full language of the recommendation, which includes the rationale and the context pieces, which will be included in a report in January, which will also be on our website and, of course, sent to the Hill.

CHAIR ROSENBAUM: Thank you very much. So now we are going to move into the first step of this two-step process to get the views of each Commissioner overall and on the specific questions that remain outstanding. What I'd like to do is start with Gustavo, come up the line through Herman. We'll come over to Brian, go down the line to Alan and then Marsha, and then I will conclude.

COMMISSIONER CRUZ: Thank you and good morning. Thank you, Ben and Joanne, because this has been a really sort of tough, comprehensive period in discussion of this very sort of important program that I think it behooves us to protect.

In terms of the general package of

recommendations, I think it's a very comprehensive package. I strongly support it. I always come back to why are we doing what we're doing, and this we're doing for a group of children, 8 million children that have the potential to really sort of fall between the cracks. We have programs for very poor children. We have insurance coverage, private insurance. We have to date what are called the exchanges. This group of children in particular are children that don't necessarily fit between one group and the other. And Congress has been very good in providing a set of benefits and coverage to these children that actually, as you have analyzed and we have discussed, is not comparable to any other. It's really very comprehensive. It covers not only a whole range of these issues and conditions, but things like oral health and vision, which I think is very, very important.

In terms of the decision of Recommendation 1.3, which I think there are two options, I strongly support Option 1, which is to keep the MOE and the five-year period -- and increase the CHIP matching rate for a five-year period of CHIP funding extension. I think it has worked. I think we are entering into a period of change, of -- we

don't have a policy, a clear policy direction on what is happening, and, again, we have a group of children that we have to protect. I think the matching rate and the maintenance of effort have worked, have increased coverage for children, and I think we should not go back.

Thank you.

COMMISSIONER GEORGE: I strongly support these recommendations. As a parent of a child who receives CHIP, it gives me great peace of mind knowing that if he gets sick, I am not looking at a financial hardship by taking him to the ER or wherever we need to go for that. So maintaining this program is absolutely, positively crucial for these children whose parents are working families trying to make ends meet, but they still fall below the ability to be able to provide health insurance for everybody.

I know in our case, we're looking at about 20 percent of our income is on health insurance just for my husband and I, so it's quite tremendous.

As far as draft recommendation 1.3, I am leaning towards option no. 1, maintaining the MOE and the matching rate. There's so much certainly going on right now that I

think to have this stabilized for the states, for families, it will provide the most benefit for who we're trying to assist, for all these children that need coverage, so that's it.

COMMISSIONER DOUGLAS: Well, again, I want to thank the staff again for a great job on the analysis and all the rationale for the recommendations.

So, overall, CHIP has just had -- and the data show it -- a tremendous impact on uninsured, and I'd say even more than that, a tremendous impact on just the way states have viewed their children's coverage across CHIP and Medicaid and really drive innovation and quality and access for all kids' coverage beyond CHIP being a small program.

Overall, when I look at the package, what I come to is that I support this recommendation, but I support it with really significant reservations, and I'll talk a little bit about that.

But, first, the reason that I support it, as I think it's essential that we extend CHIP authorization -- and we need to extend it for the five years, given we need to understand how we're going to transition to a new

comprehensive coverage system for kids, and that's going to take time. And I support it because it's really important, this opportunity, to test new approaches on what that new system looks like and give states that ability to create some level of innovation on testing new overall coverage systems for kids, and that is a nod to the states and flexibility on how to be innovative.

Where I have my concerns -- and my concerns are really this program evolved and started as a state-federal partnership. It was about testing the ways to drive kids' coverage through a state-federal partnership.

Several of the recommendations, in my view, are moving this program to more of a federal program and particularly MOE. So I do, of the two, support option 1, but I do that feeling that neither option really gets fundamentally at the ability of states to have more flexibility on the MOE and does not recognize that states need to look at kids' coverage and holistically within the broader Medicaid program and the many decisions that they have to take in managing the program and really blocks off one piece to make decisions on other parts of the program, and in a fundamental way, I don't think that's the best

approach for overall Medicaid and CHIP administration.

The FMAP, as the report shows, there hasn't been much change in coverage or quality, given increased FMAP. That being said, if we're not going to change the MOE -- and neither of these do -- then I don't think we can change the FMAP. So I agree with it, although I think we should have looked to a transition down at the FMAP and the MOE.

The final pieces I have are the recommendations 1.4 and 1.5 related to the waiting periods and the premiums, which we haven't discussed. I realize previous Commissions had, but again, continue to move away from state flexibility and really driving from a federal standpoint the decisions for states to make.

And for those reasons, again, I support this, with reservations, for option 1. Thanks.

COMMISSIONER COHEN: In 1997, Congress made a bipartisan compromise in order to prioritize coverage for children, and I think it was a good choice then. And I think that is the spirit in which I support the whole package, including the maintenance of -- the MOE and the increase in FMAP.

Like Toby, I have some reservations about those

later parts, but I think, in general, the thrust of our priority here should be to ensure that kids' coverage is maintained in a way that it's really improved dramatically in the last nearly 20 years and to ensure that in a period of both policy and market flux that we may be entering into over the next 5 years that there aren't unintended consequences on the coverage of children.

My reservations about the MOE are just that it's a really blunt instrument. I have no problems supporting a requirement that states with such substantial federal support would maintain high coverage levels and high-quality coverage levels. That is not my concern with the MOE. I think that is a good choice.

My concern is that it's very blunted and also limits the ability for states to do things that processes and procedures and systems changes that could be more efficient and innovative, and so that's really my concern about the MOE, but the fact that it will protect coverage, quality, and levels for children, I think, is good. And, again, in that context, while I have reservations about really changing this program virtually into an entirely federally financed program without greater thought about

what that really means or what that should look like in the long term, I think the increased FMAP is really necessary when we don't know what states will be facing and we are requiring them to maintain a certain level of coverage.

So it is, I think, on the whole, a very positive compromise to protect children's health coverage, and I'm very delighted to support it.

COMMISSIONER GORTON: I do not support this package of recommendations, and while I concur with many of the individual recommendations, I am constrained to dissent from the package as a whole. My dissent should not be interpreted as a repudiation of the CHIP program, as I support and applaud the important access to health care it has provided to millions of children over the last two decades.

At this point in time, I believe Congress should leverage its current focus on health policy to consider what has enabled CHIP to maintain unwavering bipartisan support for those two decades.

Key success factors, chief among them a child-centered focus and state flexibility should be incorporated into the insurance reforms it seeks to enact in the next

session. Congress should explicitly and mindfully address the need that all America's children have for comprehensive, affordable, high-quality health care.

I agree that Congress should extend federal CHIP funding for a transition period, but I disagree that that extension should be for five years. The next Congress will undertake comprehensive health reform and is expected to replace or repeal elements of the ACA. Perpetuating CHIP as a freestanding program means that many families who do not qualify for CHIP will continue to pay higher premiums for less comprehensive exchange coverage. Rather than extending CHIP for five years, Congress should use the upcoming legislative opportunity to ensure that there is what the Speaker has called "a better way" designed specifically for all the children of working families.

I also disagree with the recommendation to extend the current CHIP maintenance of effort. The MOE freezes states in place and renders them unable to adapt to the changing health insurance plans they confront.

Furthermore, I am entirely opposed to extending the enhanced FMAP rate. An E-FMAP of 100 percent federalizes what should be a state-directed program and

leaves states with no skin in the game. I see no evidence that these billions of dollars of unrestricted funding have produced any meaningful change in children's health outcomes. These funds should be redeployed by Congress for some more useful, well-documented purpose, such as reducing the premiums paid by working families for their children's health care coverage.

I am supportive of the remainder of the recommendations and, in particular, of creating and funding a demonstration grant program to support state innovation in children's coverage.

Thank you.

COMMISSIONER CARTE: I come at this decision mostly through the context of the information that Commissioners had at the last meeting that children's coverage has reached new historic highs, and CHIP, in my mind, was designed to try to bridge that insurance gap that they've experienced.

The staff have toiled long and hard, as you heard Joanne and Ben note, over the past three years to look at some of the challenges of trying to align CHIP so that we could have more seamless coverage or that it could be

replaced entirely. Those challenges are mostly in three areas: affordability, benefits comparability, and the coverage levels that each state is able to set according to their needs to create seamlessness.

Because of these areas and these issues, I will support the entire package, mostly addressing the first three elements. The extension is necessary. The time frame of five years, I was with Director Anne Schwartz when she heard CHIP directors from all over the country talk about the need for having stability and predictability, and now we face even more heightened uncertainty.

The maintenance of effort, I know that my state and a host of others currently face such severe budgetary challenges that I would fear that without the maintenance of effort and because CHIP is a block grant that children's coverage would face certain cutbacks.

And I also endorse the rest of the package either because the Commission has already spoken on it earlier. I believe that these are important considerations that should continue.

COMMISSIONER GRAY: I also applaud Joanne and Ben, in particular, and Anne and all of the MACPAC staff.

This is, I think, a really strong package of recommendations, well written and thoughtful, particularly given the wrestling that we did with considering this important issue.

I strongly support a five-year extension of CHIP and the maintenance of effort and the enhanced FMAP funding to go along with it.

Access is critical. If one believes that every child in our country deserves access and particularly access to high-quality care, then CHIP is an unqualified success story.

Also, in addition to its improvement of access in an extraordinary way over the years of its existence, it has also been a great help, as has been alluded to earlier by our parent representative, to reduce financial burden on a demographic of our population that perhaps -- more popularly described as the "working poor." This is a rational, I believe, and justifiable investment in our children and in the future of our country, therefore.

And I believe that the Commission should make recommendations that significantly provide stability and security right now during -- security for children's

coverage right now during a time of really great uncertainty, so I support the entire package in option 1 with enthusiasm.

COMMISSIONER BURWELL: I support the overall package, but I have serious reservations about the maintenance of effort and the enhanced FMAP. So, therefore, I would vote for the second option.

My own personal view is that I think the maintenance of effort should expire in the year 2020, after the first three years, and that the enhanced FMAP should gradually be reduced down to the original CHIP-matching rate that occurred prior to the 23 percent bump. I do this primarily due to my views that I do think Medicaid is a federal-state partnership, and I think both those provisions over-federalize the program. And I think for the overall success of Medicaid, it has to be retained as a federal-state partnership.

COMMISSIONER ROGERS: Let me move up. At this point in time, with the uncertainty of what is going to happen in the area of health, I strongly support the recommendation to extend for five years and with the MOE to ensure that children continue to have health coverage.

Every child and human being in this country deserves a right to have health insurance, regardless of economic status. I strongly support this recommendation.

Thank you.

COMMISSIONER MILLIGAN: I want to begin by commending the MACPAC staff as well, and I want to also commend my fellow Commissioners. I've learned a lot from you. I have seen a lot of open-mindedness. I have seen a lot of diligence about this work, and I do want to thank all of you as well.

Let me just do this in order. Of the two options, I am more supportive of option 1. I will support the final package. I have significant reservations. I won't belabor a lot of what I think others have said, but I want to focus on a few points.

The first point is when CHIP was created in 1997, it was layered on top of whatever the state's Medicaid eligibility standards were at the time, and what that meant is that CHIP led to a lot of variability in coverage around the country.

There are children at 220 percent of poverty who can access CHIP in some states but not in other states.

There is tremendous variability, and I continue to note that CHIP was a great -- and continues to be a great program for coverage of children, and it has, as others have noted, reduced the uninsurance rate and led to great health outcomes. But I think that CHIP, as that standalone program, should not be construed as creating equity and coverage around the country, and it should not be construed as creating a comprehensive solution for children's health coverage because of those sort of disparate eligibility levels around the country.

One of the appendices that will be in the final report notes this, and I just want to comment that to me, CHIP is not comprehensive health reform for children.

I do want to note that, as the Commission has said before and as I have said before in other comments about this, my preferred outcome ultimately is comprehensive health reform for children in a way that is more equitable across the country, more seamless with Medicaid and access to insurance and other venues for children, and that I look forward to the day that a lot of the benefits of the CHIP program are retained, but the CHIP program itself can sunset in favor of comprehensive

national approaches that are more equitable for children.

I want to note that the reason that we're voting on CHIP today is that there is a clear decision that needs to be made by Congress because of the dates CHIP itself faces, but as I support option 1, I do think that nothing precludes Congress from striking comprehensive reform that is better for children across the country than a stop-gap program that has created these inequities in various -- across the country. And so I am hopeful that shy of five years, something else can come along with the appropriate lead time and implementation time to protect children without running the full course of the five years that we may end up voting on.

I want to end with two comments. The first is, from my vantage point, I do see some of the comments that Brian and Toby and others have mentioned about this MOE for five years and this enhanced federal contribution for five years, and other parts of the package inhibits state flexibility in ways that trouble me.

I do think, though, if you're going to require the means of effort, there needs to be contemporaneous and coextensive extension of the enhanced contribution rate

because if you have the MOE in place without that enhanced rate, then the effect of that is to mandate that state's appropriated funds, because they have an MOE in place. They are losing federal funds, and they have constraints in managing that. And so I do think those have to be coextensive.

And the last comment I'll make is we will include in the final report in one of the appendices a list of potential offsets. As a group, we haven't evaluated those. We haven't weighed on those, but I do personally think, as part of our role, it includes being good stewards of federal funds. And I personally think there are offsets on that list that are good health policy that would pay for the recommendation we're going to be voting on alter today and that are not detrimental to coverage.

So I'll stop there. Thank you.

COMMISSIONER SZILAGYI: I'd like to echo what many Commissioners have said, first of all, that Joanne and Ben and the staff have been remarkable in the data, the options, the way they've laid out the information for us to make decisions, and I want to thank you.

I also want to echo what Chuck just said, that

the other Commissioners have been also remarkable in terms of the thoughtfulness and their willingness to engage in dialogue and creativity. And I, too, have learned a huge amount.

I will be very brief because other people have said what I was going to say, but I strongly support the recommendations with no reservations, and I strongly support Option 1. And I'll just make a few comments.

I agree that my dream is also comprehensive health reform, but we aren't there, we won't be there in a few years. And I think we have to face some realities.

I feel strongly, the way every Commissioner has said, that it's an achievement that we are at historic low uninsurance rates for children. Every administration since the late 1990s should be commended, Congress and states should be commended about this. And CHIP is one of the reasons for that. CHIP may not be perfect, but it has resulted in a tremendous reduction in lack of insurance for children and better health outcomes for children. And I think it's not an accident that this has happened. It's because of the way CHIP was structured, and that does include the MOE.

So given the success and the realities and the changing uncertainties of the marketplace, I do feel that the old physician adage of "Do no harm" applies to children right now, and it applies to CHIP.

So I do strongly favor extending CHIP and extending it for five years, even though I have the same dream that Chuck and others do, which is comprehensive children's health reform.

Now, about the MOE, I've actually shifted my feeling from entertaining Option 2 when we last met to strongly favoring Option 1, and for three reasons:

One is that over the last couple of months, it has become increasingly clear to me that the marketplace is going to be very uncertain and unclear and dangerous for children. And I do not think that the alternatives will be affordable.

The second reason has to do with my own internal wrestling of certainty versus uncertainty with respect to children. So if we go with Option 1, there is a certainty about it; there is a protection about it. If we go with Option 2, there is an uncertainty about it, and maybe uncertainty could lead to good things, but I do not want to

wager my best on uncertainty for children.

And the third reason is complexity, that we were trying to thread a needle here in Option 2, that we were trying to figure out a way that we could increase state flexibility but not lower the health insurance coverage for children. And I do not think that that needle can be threaded right now. So I strongly support continuing the MOE for five years.

In terms of the enhanced match, for exactly the reasons that Chuck just mentioned, I do feel that if we are holding states to the MOE, even though the MOE is not perfect -- and I really do believe in creativity and innovation and state flexibility -- I do think states deserve the enhanced match given the economic uncertainties.

Two other quick points. I think Recommendation 1.6 about creating a federal children's demonstration program is a really important recommendation, and it could enable creativity and innovation at the state level. And I commend us for doing that.

I guess I had three other points. The waiting periods and the express lanes, there is clear evidence to

support our prior recommendations about that. I think there's very clear evidence about that.

And, finally, costs. When we showed the picture just a few minutes ago about the budget, the federal budget, you could not even see the CHIP line. It was invisible, the costs are so low. So I do recognize that this is an increase in cost, but it's low compared to the total cost of the federal budget. And in terms of the offsets, I do agree with both the concept of the list of offsets and not favoring one particular offset at this time because we haven't done a deep dive in terms of which offset might be the best.

So, overall, I strongly favor extending CHIP for five years and also Option 1.

COMMISSIONER THOMPSON: I will absolutely support the package. I do have a preference for Option 2 of the MOE and FMAP options that are available to us.

The reality is that I think everybody sort of in large part has kind of expressed the same questions or concerns and then just kind of land in a slightly different place in terms of what conclusion that leads them to. So let me just talk for a minute about FMAP and MOE, which

we've talked about in prior meetings, I've talked about in prior meetings.

I really feel like the Option 2 that we have about the two phases was itself a modest compromise to what we initially discussed, which was allowing MOE to expire and allowing the FMAP to revert to its original CHIP matching rate. And that was in response to, I think, a very healthy conversation among the Commissioners about concerns and also very strong, consistent comments from the public that we heard, which was that the elimination of MOE and the reduction to original FMAPs would precipitate some decisions in states because of the kinds of challenges that Sharon alluded to earlier. And that could be substantially cause a reduction in children's coverage, and we didn't want to live with that, especially without having another existing coverage program to catch those kids. And, you know, I think of myself as a pragmatist. I can dream with the best of them, but I'm sort of like here's the world that we're in today, and the question that we asked ourselves is: Is there a coverage option available for these children that are currently being covered through CHIP that can provide coverage as comprehensive and

affordable? And we determined the answer to that was no. And maybe there will be at some other time, and so we talked about potential off ramps, and we talked about other kinds of ideas that would allow for the program to adapt and adjust to changes in the overall environment. And I think in some ways we just kind of ran out of time in thinking about what some of those permutations would look like. And it's true that it introduces a level of policy and program complexity to our conversations that maybe this Commission isn't the right forum or format to really grapple with. But I would like to have seen us express at least in some fashion a desire to explore flexibilities under MOE, a desire to see some reduction in the federal match, even if not to that original CHIP matching rate, at least to a point that would ensure that states are contributing some amount of dollars. And for that reason, that would have been -- that would be my preference. But if the majority of the Commission determines that they want to produce a package that has MOE continuing and FMAP continuing, I will still support the package.

COMMISSIONER RETCHIN: So my view of the recommendations and the vote have really evolved in the

last 45 days, and I'll just briefly go through why my thinking has changed.

But, first of all, I support the package with serious reservations about its costs and about the implications. I originally was very in favor of more flexibility from the states' view as well as a reduction in the FMAP. I don't see the evidence that the enhanced FMAP has really had a major effect.

That said, my interest in that was seeing the FMAP indexed. I believe in the future it's not inextricably tied to the requirements from the MOE. It really is a countercyclical effect for the fiscal health of states, and I think Congress should be exploring an FMAP formula that is not three years in the rearview mirror. That could be done through unemployment rates and the like. And then the MOE should be reviewed in terms of its flexibility overall for the states, but I don't think that the tie is only with the MOE requirements and the FMAP.

That said, I am sensitive to the effects of the enhanced match in three states which may have different economies, and so the tension of the conflict between these has really been on my mind, but I was persuaded in this by

two elements to actually vote for Option 1. The two elements are, first and foremost, the changes in my view in the last 45 days of the stability of the individual market, and I think it actually is even more vulnerable and will be more vulnerable in the coming days. So I think with all due respect to Ben and Joanne's excellent work, I also think that's in the rearview mirror, and I believe that more than 1.1 million children would go uninsured if today we were to withhold CHIP funding.

And, second, I will say that I've been persuaded by the movement particularly of my fellow Commissioners, and I'll especially point to my fellow physicians, both of whom are pediatricians, as well as to the dental expertise we have on the Commission. But you all have persuaded me, and that's why I've shifted away from Option 2 to Option 1 and will support that recommendation.

COMMISSIONER LAMPKIN: So I add my thanks to not only all the hard work but also the patience the staff has displayed with us as we've really wrestled with some of the thornier parts. I do wholeheartedly support the extension given the urgency of the timing decision that needs to be made and the lack of good alternatives for the children who

are currently in CHIP.

On the question of the MOE, my thinking continues to be motivated by the fact that this is a federal-state program, and Option 1 to me, and especially in conjunction with prior recommendations that we're repeating essentially federalize the program. I think we have something like a dozen states who are at 100 percent enhanced FMAP right now, and most of the others well in the 90s.

I liked Option 2 in the October meeting as a compromise between letting the MOE expire altogether and something like Option 1. However, I do have a math background, and I can count, and so I realize I'm in the minority there and we're likely looking at voting on a package that includes Option 1, and I would support that package.

COMMISSIONER WEIL: Well, others have said it, but I'll say it also. As a first-year member, I'm really proud to have participated in this process, am impressed with the quality of the staff work and with the quality of the deliberative process that the Commissioners have followed to get to this point.

I want to begin by saying I wholeheartedly

endorse Recommendation 1.1. The need for the CHIP program and the case for extending it has been clearly made, and that is really to me an important statement to begin with.

As a general rule, I'm not a fan of taking provisions that were adopted on the premise that they're going to be temporary and then extending them repeatedly or indefinitely, and the MOE and enhanced match provisions fall into that category. But like others, I see us in a period of great uncertainty, and I think that stability for children and their families and for the states administering the program, there's tremendous benefit to overcoming that uncertainty. So I embrace the extension of the MOE and the match rate as a way to keep the CHIP program in place, and I think the level of uncertainty we have right now makes five years a reasonable time horizon.

I think like others I conceptually align myself with the aspirations expressed by Commissioner Gorton, but I am skeptical about how quickly the health policy environment will settle, and I'd rather the debate begin with a platform of solid coverage for kids and then move from there rather than hold out the hope that we'll get there.

So with respect to the two options, again, others have expressed how their thinking has evolved, and I'd say mine is similar. I think Option 2 arose out of three different threads: one was the belief that maybe there needed to be technical changes to MOE because it's too rigid; another is the belief that it would make sense to eliminate the MOE to give states flexibility; and the other was that MOE need to be -- the enhanced match has to somehow be tied to MOE because you shouldn't force on the one hand without paying for on the other hand.

My perspective on this is that we were unable to come up with language that is really a technical fix to MOE. A lot of the thinking about lifting the MOE -- eliminating the MOE was the confidence that states wouldn't change their eligibility. But that's a bet I'm not willing to take with kids, and so I believe the MOE needs to stay in place. I don't think the enhanced match has to indefinitely be tied to the MOE, but, again, the uncertainty of the context makes that a reasonable pairing.

So given the choice between Options 1 and 2, I find myself going to Option 1, largely because I think the modification -- it's too unclear what the modifications to

MOE would be, and stability is the underlying principle that I want to adhere to in the environment that we're in.

That said, I do think that we need to be open to structural changes that would achieve really truly continuous coverage for kids. We've got a growing number of states where children's coverage rates are in excess of 95 percent, and we ought to break down the barriers across programs. So I think the demonstration authority is critical. That feels to me very different than an MOE issue, so I'm supportive of that as part of the recommendation as well.

VICE CHAIR GOLD: Very impressive set of comments. I'm listening carefully to what people are saying. I also want to support the package and am pleased to support the package. It's had a lot of hard work. Children have been a bipartisan issue for a long time, and this clearly talks about children. As a Commissioner and a health services researcher, I've been impressed with the strength of the evidence on children's -- the positive effects that CHIP has had on children's coverage and feel that it's important to maintain.

Ideally, like Chuck and Peter, I'd like it swept

into a broader effort to improve children's coverage and am glad there's the option for demonstrations in our package to see about doing that. But that hasn't -- it's not clear when that'll happen, whether it'll happen, and so practically, with so much in flux, I think that an extension over a lengthy five-year period is critical to protecting kids, and I strongly support that. Of course, if something better comes along, it could always be introduced earlier.

The other issue is that I've been impressed with testimony -- just my big thing when I do research is looking at implementation, and everything I hear from people is always it takes longer and it's harder and it's more expensive. I've been impressed with listening to people talk about the legislative climate in different places and the calendar and the lengthy legislative time horizon that many states operate under. And so I think it's really important to give states some predictability, and a longer extension will do that. I thank you, Sharon, for making that point very clear to us and for other testimony we've heard on that effort.

In terms of the MOE and the additional funding,

you know, the higher matching rate, I, like other people, have gone back and forth on this and I think share the discomfort with the blunt instrument of these policies. On the other hand, they're all we have right now, and I think where I came down is when we started looking at alternative language in 2, it just looked very bulky to me. It looked uncomfortable. I think we weren't sure what it would accomplish. And I stuck with the policy point that I think is usually straight, is to keep it simple. So I'm in favor of Option 1, which I think is the better of the options that we have before us now.

CHAIR ROSENBAUM: Thank you. Well, it's been a privilege for all these years to sit on MACPAC, but especially this year. All of my colleagues -- the colleagues on the staff, the colleagues around the table, the Commissioners have been quite extraordinary. You know, you think of children's issues and you say, "Oh, those are simple," and of course they are as complicated as any set of issues, particularly in a nation built on principles of federalism.

I'm not going to reiterate what was said. I share deeply the observations made by Chuck, Kit, and

Peter, about the fact that we are here today, talking about funding for this small but very important program, because we are lacking what we really need, which is a comprehensive system for assuring affordable care for children, that is of high quality. And I feel, as one of the old-timers, that it's worth just sort of recapping briefly how we find ourselves in this situation.

We are here today because of a fundamental weakness in the original Affordable Care Act. When presented with the opportunity to create a really strong system of nationally uniform federal subsidies for families with children, with ties to a very good benefit package, lawmakers did not take that option. They instead continued CHIP for a period of time. The issues were to be resolved. I have written extensively on this point from a policy perspective.

The system that was set in place in the legislative blueprint and then implemented is one in which the subsidies are inadequate, in which families with children are locked out of subsidies entirely, if, in fact, the wage-earner has access to affordable coverage, in which terrible shortcomings exist in the benefit package,

particularly in the area of oral health, but it doesn't stop with oral health. There are benefit limits that should not apply, in my view, when it comes to pediatrics, and it's because we did not grapple with the question that we're all sitting around the table talking about six years ago, that we have had to go through these extensions.

The Commission made this very point in 2014. Obviously, nothing happened, and so, as several people have pointed out now, the necessities of the clock mean that here we are again, having to extend CHIP again, rather than grappling with the much bigger issues that we had a chance to address in 2010, and did not.

I wholeheartedly support a five-year extension. Like Marsha, I assume that actually, although a transition time is needed, Congress may see fit to shorten the extension, along with the incoming administration, and so we may make the transition faster than we thought. During this transition time, like Marsha, I decided, after actually leaning towards the second option, to make it very simple and to just say during this transition we maintain a maintenance of effort as it exists today, and we maintain the federal funding arrangement as it exists today. So I

am in favor with the extension with Option 1.

So that brings us to the point where we know what the -- you can tell us now what the final package parameters will be.

MS. JEE: So we did prepare two optional slides, and so now we know where you are. We're trying to pull up the actual language of 1.3, which would have the MOE and the 23 percent increase to the CHIP match extend through the five-year period of the CHIP funding renewal period, so through 2022.

I can read it, maybe a--

Okay. So I'll just read it, and it's a little long, so --

In order to provide a stable source of children's coverage while approaches in policies for a system of seamless children's coverage are being developed and tested, and to align key dates in CHIP with the period of the program's funding, Congress should extend the CHIP maintenance of effort and the 23 percentage point increase in the federal CHIP matching rate currently in effect through fiscal year 2019 for three additional years, through fiscal year 2022.

Do you want me to go through the entire package, or did you just want that last --

CHAIR ROSENBAUM: I think --

[Overlapping speakers.]

[Laughter.]

CHAIR ROSENBAUM: -- so we can just focus on this. And the question is whether this recommendation, as currently drafted, captures, essentially, where the majority was. In my -- I mean, I have to say, in my view, given what we all expressed, I think this captures -- not only does it capture the majority view but it captures it well. It states the recommendation well. But others may have additional comments on the wording of the package.

[No audible response.]

CHAIR ROSENBAUM: Hearing none, let's vote.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. I will call the roll, because we're required to do this under statutory authority, and we have heard folks' reservations and concerns, which staff will work on incorporating in the text of the report that goes around the recommendations, and I've made a lot of notes and I'm sure Joanne and Ben have as well.

And so your vote is yes, no, abstain, and, thankfully, everyone is present today, unless someone decides they need to step out. So I'll just go down the row.

Brian Burwell.

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sharon Carte.

COMMISSIONER CARTE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Andrea Cohen.

COMMISSIONER COHEN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Gustavo Cruz.

COMMISSIONER CRUZ: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas.

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Leanna George.

COMMISSIONER GEORGE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Marsha Gold.

VICE CHAIR GOLD: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Christopher Gorton.

COMMISSIONER GORTON: No.

EXECUTIVE DIRECTOR SCHWARTZ: Herman Gray.

COMMISSIONER GRAY: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin.

COMMISSIONER LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan.

COMMISSIONER MILLIGAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin.

COMMISSIONER RETCHIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Norma Martinez Rogers.

COMMISSIONER ROGERS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi.

COMMISSIONER SZILAGYI: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Penny Thompson.

COMMISSIONER THOMPSON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Alan Weil.

COMMISSIONER WEIL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sara Rosenbaum.

CHAIR ROSENBAUM: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. So we have 16 in favor, 1 voting no, and that will be presented in the report as we transmit it to Congress.

CHAIR ROSENBAUM: Thank you all. We now have time for public comment. Should we have any public comment

at this point?

PUBLIC COMMENT

* [No audible response.]

CHAIR ROSENBAUM: Seeing no public comment, we are in recess until one o'clock. One o'clock? Yeah, one o'clock.

[Whereupon, at 11:34 a.m., the meeting was recessed, to reconvene at 1:00 p.m., this same day.]

AFTERNOON SESSION

[1:01 p.m.]

CHAIR ROSENBAUM: All right. Good afternoon, everybody. We are at the 1 o'clock point in our agenda, Tab 4, Program Integrity in Medicaid Managed Care, and Jessica will be introducing our panel, and thank you so much for taking the time to join us.

PROGRAM INTEGRITY IN MEDICAID MANAGED CARE

* MS. MORRIS: Thank you. Good afternoon, Commissioners. During our October MACPAC Commission meeting, a number of Commissioners expressed interest in hearing directly from federal and state representatives that focused on Medicaid managed care program integrity. Therefore, for today we have invited both federal and state experts here to present to you regarding their program integrity efforts, particularly in the context of the Medicaid managed care final rule, which was released in May of 2016.

More specifically, we have asked the panelists today to provide you with an overview of current program integrity efforts as well as new initiatives that have yielded results and to discuss whether states and plans

have the tools that they need to be successful in these efforts.

You may recall additionally that at the last Commission meeting we talked about in our presentation ongoing work that MACPAC staff are doing in the area of program integrity and on the following objectives: to identify the strengths and weaknesses of existing federal and state PI oversight efforts, to address if the managed care final rule's provisions will establish sufficient PI support, to address concerns regarding the proper use of federal funding, and to evaluate whether there are additional or alternative steps the federal government can take to prevent fraud, waste, and abuse.

Through this work we've interviewed both federal and state partners in program integrity. Both of the federal panelists here today or their representatives took part in that study. We also spoke with several states which we mentioned, and our work on this is being completed as we speak. We're preparing to discuss the results of that study at the January Commission meeting.

Therefore, that brings us to our panel. Our first panelist is James Golden, who serves as the director

of the Division of Managed Care Plans for the Disabled and Elderly Health Programs Group within the Center for Medicaid and CHIP Services. He is responsible for leading the development, implementation, and oversight of federal policy to ensure that Medicaid managed care programs provide accessible, high-quality care with consumer protections and financial accountability. Dr. Golden and his team provide direction and guidance to states as they operate managed care programs. Prior to joining CMS, Dr. Golden served as the Minnesota Medicaid director and state HIT coordinator and led the Division of Health Policy at the Minnesota Department of Health.

Gary Cantrell, at the end, serves as the Deputy Inspector General for Investigations. In this capacity, he serves as the senior official responsible for supervising the functions of the Office of Investigations at the Health and Human Services HHS OIG, Office of the Inspector General. OIG is at the forefront of the nation's efforts to fight fraud, waste, and abuse in Medicare, Medicaid, and over 100 HHS programs. Mr. Cantrell manages, directs, and coordinates the operation of resources of the Office of Investigations, which includes a workforce of 600 employees

comprised of investigators, analysts, forensic examiners, and administrative staff.

From the states and our state panel, our state perspective today comes from Keith Gaither. He is the director of managed care operations for TennCare, Tennessee's $10.6 billion Medicaid managed care program. TennCare functions as the largest health insurer in the state, providing coordinated physical, behavioral, and long-term coverage to 1.2 million Tennesseans. Mr. Gaither is responsible for managing TennCare's relationship with its three managed care companies, CHIP contractor, and the state mental health and children's services agencies. Those responsibilities include MCO contract compliance and enforcement, behavioral health operations and integration, and program integrity.

Each panelist will give a brief presentation, and then there will be time for the Commissioners to ask questions and a discussion.

I'll now turn it over to James to go ahead and get started.

* DR. GOLDEN: Well, Commissioners, thank you for the opportunity to come and talk about the Medicaid managed

care reg. We love to talk about the reg, and program integrity is undoubtedly our favorite part.

[Laughter.]

DR. GOLDEN: You know, I guess I would say a couple of things at a high level. When we think about the reg -- and you've probably seen this in presentations, and I think it's in some materials in your packet -- we often identify four or five very high level objectives that we had as we thought about all pieces of the regulation. And one of them was to really strengthen program integrity and improve financial accountability and transparency. And so it was a very clear goal as we thought about all of the perspectives and all of the various pieces of the regulation.

The other thing that I would say is, you know, when you look at the regulation, there is a subpart, Subpart H, which is specifically program integrity, and I think that one of the things that we've noticed is, as people look at the regulation and in the preamble and everything that went with it, just because of its sheer size, they tend to look at it in a very siloed fashion. Right? And so if you want to think about program

integrity, I think people immediately go to Subpart H, the 600s, to see program integrity. But there are many, many parts of the regulation that were specifically thought about with regard to how to improve the accountability and transparency that sit outside of that section.

So I thought one of the things that might be helpful in the brief overview that I was planning to give was to talk about what I think about whenever I think about how the reg has improved program integrity, and the first six of them actually aren't even in the program integrity section.

So the first thing that the regulation did that I think is helpful is it put a lot of additional clarity and specification around the requirements, the data, and the documentation that's necessary for actuarial soundness, and that protects on both sides to make sure beneficiaries get the services that they're entitled to without wasting tax dollars.

The regulation standardized a medical loss ratio calculation. It standardized it in the same way that it is done in the commercial market and Medicare Advantage. That will allow people to make comparisons both across states as

well as across product lines.

The regulation really attempted to enhance some of the monitoring requirements as well as the annual reporting that comes out of the monitoring requirements, and it's really that monitoring and being able to look both at what your program is doing within a state and how that might compare to what other states have in similar areas that really helps to provide some context for thinking about what you're doing in your state in program integrity.

Another area that I don't think was really a change in policy, but it was certainly a change in the clarity of the regulation, dealt with subcontractors. And I think that one of the things that we see in managed care is obviously the state contracts with the managed care plan. But oftentimes that managed care plan might subcontract with another plan or another vendor to do parts of their benefits or part of their administration, and it's not infrequent that that plan also subcontracts.

And one of the things that we really wanted to be quite clear about is that it had to be written contracts that were unambiguous with regard to what was being delegated, and to the degree that program integrity aspects

or other requirements of the contract are being delegated, it had to be clearly articulated, and the state's contract with the original managed care plan, that plan is going to continue to be responsible for all of the activity under its subcontracts. Again, that was always the policy, but I think it's a lot clearer now.

Another thing that we did throughout the regulation was try to improve data and the data that's available both for states and oversight bodies. You know, the high-quality data and encounter data in particular are really the lifeblood of administering and operating a program. You know, it's absolutely critical to understand what is going on in your program to know what the encounter data and claims that you're getting are showing.

And so we did a number of things to try to improve that. One of the things that we put into the regulation is that states need to have mechanisms to review and that elevate their encounter data. They also need to develop quality assurance protocols to ensure that the encounter data is complete and accurate.

We also added a requirement that all managed care plans need to submit an audited financial report that is

unique to the Medicaid contracts to help tie out the ledger and the claim data. And the state also needs to do an audit at least once every three years of both the financial data and encounter data that is submitted from the managed care organizations.

Another provision that we looked at was to try to think about how to strengthen fraud, waste, and abuse and program integrity at the provider level, particularly at the network providers within the managed care plans. A couple of big provisions around that. Certainly as the Commission is aware, on fee-for-service both in Medicaid and Medicare, there has been a screening and enrollment requirement where providers need to be screened and enrolled at least once every five years. There was no such requirement on Medicaid managed care. We have essentially extended the fee-for-service requirement exactly as it is for fee-for-service onto Medicaid managed care. I know that has received a lot of attention. And to the degree that it is updated in the portion of the regulations that would address fee-for-service, it will automatically update for Medicaid managed care. So it will stay aligned. We really cross-referenced over to that piece of the statute -

- or to the regulation. Sorry.

A couple of other things just to mention. The regulation, of course, requires a prompt referral from managed care plans to the state when there is any potential fraud, waste, and abuse in its provider network. We also added a provision that allows the state to require via its contract with the managed care plans to have the managed care plans suspend payment to network providers when there are credible allegations of fraud that might come to light in some other venue. Right? So it might come to light either through fee-for-service or through other managed care plans.

One of the things that we have heard as well is that there are various times where perhaps there is abuse, maybe there's fraud in the provider network that is not really looked at a lot; there's not a lot of investigation of it. And then what happens is the provider isn't renewed when the cycle comes up. I would say that one of the things that we did put into the regulation is the managed care plan needs to inform the state whenever there is a change in a circumstance with a provider that would leave them unable to be enrolled in Medicaid, and that would

include, of course, termination or non-renewal of their provider agreement.

The final piece that I would say with regard to what's in the regulation deals with the treatment of recoveries. I think that has been an area that has had a lot of variation across the states and thinking about what to do with that. And the basic idea is you have a situation where a managed care plan has paid a provider; it is an overpayment; it shouldn't have been made. Maybe it's fraud, maybe it's just an overpayment. And the question is: When the managed care plan becomes aware of that and goes back and collects it from the provider, what happens to that money?

In some cases, states would allow the plan to keep it and then use the amount to adjust the capitation rates looking forward. In other cases, the state would take the money back via contract, and the plan would lose it so that they had more incentive to try to prevent it up front.

There was very little agreement in the community around what to do with that, so what we wanted to do with the regulation -- we couldn't bridge the difference between

all of the various approaches, but we wanted the contract to be unambiguous so that when OIG or state auditors or MFCUs came in, it was quite clear what was supposed to happen. So contracts need to describe exactly what the retention policy is for the recovery of overpayments. It needs to specifically with call out fraud, waste, and abuse. It has to detail specifically the process, timelines, and documentation for the plans to report to states. And then it also has to have a process, timeline, and documentation associated with the actual payment when the state needs to receive a payment.

The other thing that we did in the regulation is to require that all of that information around overpayments and recoveries be used as part of the development and setting of capitation rates.

So those are the highlights of what's in the reg. I guess the only other comment that I would say is that I think the regulations are pretty good. We worked -- or at least I feel that way.

[Laughter.]

DR. GOLDEN: We tried to work with everybody both in the development up front as well as after the comment

period and during the comment period. We worked closely with our colleagues in OIG in the Center for Program Integrity. We took a lot of feedback from state program integrity directors and MFCUs, and we really tried to incorporate all of the various points of view. And my feeling is that for where we are today, the regulations and the statutory provisions are probably at the right spot for what the regulations are. I think the success will be in how well those can be implemented. I think from both my experience having been in a state and having worked with a number of states, the program integrity is really dependent on the degree to which the state is able to have a strong hand overseeing its contract, have good, open communications with its plans, and are really trying to find best practices to implement what we have as regulations.

And so at a high level, I would say that that's kind of what I think about the reg and program integrity.

MS. MORRIS: Finishing our federal panel.

* MR. CANTRELL: So it isn't often the case when you're with the IG's office that your talking points align so closely with the Centers for Medicare & Medicaid

Services. We're sometimes at odds. But this is not the case here. As he said, they worked very closely with us on the Medicaid managed care regs, and a lot of the areas that I was going to address have been touched upon already in terms of the regulations and how they are going to impact them.

In my experience in 20 years with the IG's office, largely looking at Medicare but also more and more looking at Medicaid over the last several years, there are just a few pillars of program integrity that have to exist before you can be successful. Data is first among them, I think, and we hope that this new reg will help improve the body of the data we get both at the state level across from all the various plans but at the federal level as well.

We've had tremendous improvement in the access to Medicare data over the last several years, and our office as well as the Center for Program Integrity is taking full advantage of that to, first, identify fraud trends and then, second, align our resources, for us limited law enforcement resources, in those areas where we can have, we believe, the greatest impact. And it's something that supports when you have that timely access to data, any

fraud prevention or detection efforts and investigative efforts can proceed more quickly. So those that have worked with law enforcement know that those cases can take a long time. The better data we have available to us, we can move along more efficiently and quickly to resolve a case that's been referred over for law enforcement, which I think benefits both the program and law enforcement at the end of the day.

We also use data now to measure impact. Instead of just counting restitutions and recoveries and convictions and civil actions, we're much more interested in determining whether those efforts are having an impact on behavior. And so we're looking at claims before and after we focus on certain areas of Medicare, for example, to see if we're changing the dynamic in any way, reducing payments in areas where we've seen high fraud. And so those are all things that I think are critical to be applied in the Medicaid arena, Medicaid managed care arena as well. We need strong Special Investigations Units throughout, you know, at every plan. They need to have access to data and good communication with the states. The state agencies need to have good communication with law

enforcement so we're triaging and working together to figure out who should be addressing what issues and concerns because I know it's true at the Medicaid Fraud Control Units, it's true at the IG's office, certainly law enforcement isn't the only solution in fraud. I think we all know that. But if we don't have sufficient administrative remedies and provider screening and suspension efforts, if we're always waiting on law enforcement to take those efforts, we'll be waiting longer than we'd like.

So I think we've learned to work a lot more closely with the CPI over the years in managing and determining when administrative action is appropriate, when law enforcement action is appropriate, when both are appropriate. And that's a difficult equation, and it's a case-by-case basis, but it's something that is more easily done with strong program integrity as well as great data and strong relationships with law enforcement.

You know, we see there's -- we currently have very little access to Medicaid data, and we don't have very good -- we just received Medicare managed care data at CMS, so this is still an area that for us still is somewhat of a

black box. We don't know what's going on in the world of managed care as well as we do in the rest of Medicare.

But what I do know is we -- I work very closely with the private sector through various task forces and, in particular, the Health Care Fraud Prevention Partnership, which is a federal-private effort to share data across private and public. And I hear the same things, whether they're operating in the private space, whether they're operating as a managed care plan for Medicaid, managed care for Medicare, or some other aspect of health care.

The fraud concerns that they see are the same fraud concerns we see in Medicare. There's lots of overlap. It isn't as if one sector has figured it out and has eliminated fraud at this point in time. The fact that we don't see as much in terms of fraud referrals, I think, is a product of, in some cases, insufficient data, not necessarily because there's less fraud in the managed care arena.

As we get greater access to managed care data, we want to spend more time addressing fraud in these areas, and it sometimes looks different, but the areas of prescription drug, fraud is a big concern for us. I think

it expands across private-public managed care, fee-for-service, Medicare, Medicaid.

In Medicaid, in particular, we have been focusing on personal care services, working with Medicaid fraud control units. This is an area that's been a particular concern for us, relatively low dollar, dollars in terms of fraud, but sometimes high impact, and it suggests -- we have some recommendations we've made to CMS around this arena, which is largely a Medicaid issue, relating to screening of personal care attendants, for example.

We don't really know who we're employing to take care of the Medicaid beneficiaries in terms of personal care services. We don't have any good way to measure the quality of those services, and we've seen example after example where there's fraud committed, where services aren't being provided, but being billed for, where there is, in essence, billing for these services and providing insufficient care in patients who have lacked the type of oversight and services and had harm resulting from that. We've seen patients really who just -- whether they be family members or people paid through companies, we've seen fraud at various levels in personal care services, and

that's something that our Medicaid fraud control unit partners see across the country as well.

I'll finish on this, because I think you've touched on most of the things, other things I was going to address, but as I said, we're expanding our efforts to work with Medicaid, especially Medicaid fraud control units.

You may have heard of the strike forces, which started out with the label "Medicare Fraud Strike Forces." We're in nine cities. It's a cross-government task force to address high-concentration fraud areas of Medicare.

Every year, we have one to two national takedowns. This past year, we had a national takedown, 300 individuals charged, nearly $900 million in alleged fraud. What's new about this last year, it was the largest, but it had the largest participation of Medicaid fraud control units. That was a direct result of our concerted effort to reach out to the states, to the state law enforcement agencies, and have them participate in our efforts on a national level to address these fraud concerns.

We know, as I said before, fraud affects all these programs. It's no longer appropriate for our talking points to focus on nine cities in the United States in

Medicare alone. This is a national problem that we see, and it certainly affects Medicaid. So we've reached out and extended our partnership to the Medicaid fraud control units across the country to join this national effort, and there's a lot of interest in doing so, as well as the health care fraud prevention partnership, public-private partnership. We're getting more and more state agencies joining in, and that's going to be critical, I think, moving forward for the success of that effort, which is intended to share data across public-private in order for us all to be better informed.

Thanks.

MS. MORRIS: And that's a good segue to our state panelist.

* MR. GAITHER: Well, I guess I'll start with something you may not hear said very often. It's that these regs are actually pretty good.

[Laughter.]

MR. GAITHER: And actually, I'll say that because we were already doing most of it. So it wasn't a big lift for us because we have been in managed care since 1994, and you guys may know a little bit about Tennessee. We did it

probably the wrong way for a while. So we've figured out how to do things the correct way.

I was talking to James about this. We've been to the MII quite often and shared with other states our processes, and hopefully, that informed some of the work there.

If managed care is working well, your exposure to fraud and abuse is lowered a little bit, just because of the controls they have in place. An example I will give you is we had a national recovery contractor for several years. They really couldn't find very much looking at our global data. So, on a global data level, the MCOs are doing what they need to do.

The question is they're finding it, they're stopping it, but we didn't know who it was, and we weren't prosecuting very many people. So we had to implement quite a few reporting requirements, and some of those are in the regulations here.

I think moving forward, states need to rethink how they look at program integrity. It's not just running some data reports, looking for outliers. You've got to look at different kinds of data now, like terminations,

just nonrenewal contracts, actually looking at providers who have a certain number of claims that recoup from -- you know, you may not actually call something fraud, but you just recoup the money from the provider and move on.

So we get reports from the MCO saying how much they recoup by provider class and going down the detail there, so it's a different type of data that you're looking at these days.

As James mentioned, you've got to be very in the weeds with your providers because you're a step away from the transactions now, so you've got to have very strong contracts. I know the states are sharing that information with each other, but I think there's a lot more opportunity around states sharing their technical expertise and strengthening those processes they have because that's where all this is going to keep it -- strengthen integrity in the program.

CHAIR ROSENBAUM: All right. Thank you so much. This was excellent. So let me open up the discussion.

Yes, Peter.

COMMISSIONER SZILAGYI: Yeah. It was very interesting. Thank you.

I have a very naive question to start off. I was, for more than 20 years, very involved with the largest Medicaid managed care plan in upstate New York, on the board, and we talked about this occasionally, and we never got out of the starting block for the most part because we couldn't identify what the extent of the problem was.

Could you enlighten me about how big of a problem in terms of percent of the budget or dollars is fraud, and how much variability does it appear to be across states?

I told you it was a very naive question.

MR. GAITHER: You see lots of very different numbers. If you added them all up, Medicaid would cost nothing, if you added up -- saved all the fraud that's out there.

I don't know a number. I do know as a proxy, maybe you could use what states anticipate they're going to save through managed care because some of that is the fraud and abuse activities that are out there, but it's not a small number. I don't have a good number, though.

MR. CANTRELL: We don't have a good number either. That's a question that is often asked, but it's obviously very difficult to measure fraud, which is an act

of deception. Claims may look appropriate on their face because they've been manufactured to look legitimate, and so it's a difficult thing. I think there are efforts under way at CMS, in particular, to begin measuring fraud in certain areas, but we don't have in the IG's office an accepted measure for fraud.

CHAIR ROSENBAUM: There are the PERM numbers, but, Penny, can you shed light on this at all from your --

COMMISSIONER THOMPSON: Oh, I wasn't going to go there.

CHAIR ROSENBAUM: Oh, good. Okay.

COMMISSIONER THOMPSON: Can I ask a few other questions, though, and jump in?

CHAIR ROSENBAUM: Sure.

COMMISSIONER THOMPSON: I wanted to ask, Jim, you two questions about provisions that were proposed in the rule but not finalized and maybe ask you to talk about what your thinking is about that. One of them is about the MLR and how to account for program integrity expense as part of the MLR, and then the second is about CMS authority to withhold or disallow dollars, in part, when it finds issues with managed care overpayments or compliance issues. Can

you talk about those too?

DR. GOLDEN: Sure. So --

CHAIR ROSENBAUM: You might just remind people, who aren't so familiar, what the MLR proposal was and where you landed at the end.

DR. GOLDEN: Yes.

So, in the Notice of Proposed Rulemaking for MLR, there was a provision that would have put in the numerator, so it would have counted positively for a health plan's MLR, the amount of dollars that they were spending in executing a portion of the compliance provisions inside of the compliance portion of the regulation and up to a half percent of total premium. And the idea of that when it was proposed was to try to attempt to get plans to invest more into program integrity and have that count positively toward their MLR, which, of course, is required to at least be targeted toward 85 percent.

I would say that we got a lot of feedback on that, and it was very all over the board in the sense that, obviously, plans thought it was a good idea, and I think a number of others did.

I do think there were others who didn't think it

was such a good idea, that it was just, more or less, take expenses that existed and count them in the MLR.

At the end of the day, I think what was one of the biggest decisions that -- reasons for making the decision that we did was we really wanted the MLR to align as closely as possible across all of the centers of CMS. So you have Medicare Advantage. You have the commercial market through CCIIO and Medicaid through CMCS. And I think we really wanted to be able to have numbers that were as comparable as possible, and what we ultimately did was tie our definitions to what is in the commercial market. So, as NAIC and others re-debate this issue, because it was a lot of debate back originally, if there's a change, it would really impact all of the MLR calculations, uniformly, and at the end of the day, comparability seemed to win out on that issue.

The second issue you raised actually is a slightly different issue. In general, what our authority is with regard to contracts is either all or -- it's all or nothing, for the most part. It's either you approve it, or you disapprove it, and disapproving it is rather consequential to states because these are often, obviously,

the largest contracts in the state, billions of dollars. And it's a very draconian penalty and one that one doesn't get taken very lightly.

And so the only exception -- I will say there is one exception to it, and it is with regard to encounter data. To the degree that there are problems with encounter data, you can do a partial deferral based on not having complete or accurate encounter data.

But the reason that it was proposed but not finalized is, at the end of the day, after we looked at comments and considered it with counsel, we concluded there wasn't adequate statutory authority for finalizing that provision. So, to the degree that there might be a need or a desire to do a partial deferral or disallowance for a small piece of a program being out of compliance with the regulations, we would need additional authority in order to make such a provision.

COMMISSIONER THOMPSON: Okay. Thank you.

I think, Jessica, that's something that we should take a look at.

Keith.

MR. GAITHER: I thought I'd just make one comment

on the MLR thing. If you ask a plan to start defining what they call program integrity, so it hits the MLR in a favorable light, it becomes a much larger number, and I think it's more prudent to hold the states accountable to managing their contractor than letting an MCO classify some activities they do as medical. That can get really dicey in the grand scheme of things.

COMMISSIONER THOMPSON: So everyone talked about encounter data. Can you give us an update as to where we stand in terms of getting better encounter data from the states on Medicaid?

DR. GOLDEN: I can, but I'd like to start actually earlier in the story because I think that encounter data is a little challenging because it's really a byproduct of a very long business process. A provider submits something to the plan. They adjudicate it. They put it into their warehouse. The state says, "We want to collect it. We want to use this format." It has to come out of the warehouse, be repackaged up. It comes usually to the front door of the state agency, probably hits either their MMIS or another system, gets unpacked, gets analyzed, gets put into the warehouse. Then it's used.

To the degree it then comes to the federal government, the federal government says, "We'd like that out of your warehouse. Here is the format." It gets repackaged up. It would come to CMS. We unpack it and then put it into a database, and then it's ready for us.

And I think that, obviously, at the end, one of the things is how good is the data that we had that would be available to CMS or to OIG. It's highly dependent on all of those various steps along the process, including the degree to which a plan is working with those providers, making sure there's good coding, that you're doing all of that up front.

One of the things that we tried to do in the regulation was to try to push on states to try to get better data from the plans themselves, and I would say that one thing that has been highly effective in the market is many states have now gone to a provision in their contracts where they look at on a quarterly basis, the encounter data they're getting from the plans, and they compare that to the health plan's general ledger. It has to be within a certain percentage. One state has within 1 percent. Failure to meet that gives you a 1 percent penalty in your

capitation rate. And I know there are at least 14 states that have a similar provision.

Many of the states have said that after they put that in, much of their data improved rapidly and almost overnight, and so I think one of the things that my area has really been trying to do is think about how do we work with states to improve what they're getting from managed care plans, so that what they have in their databases and warehouses is in better shape to be able to share with CMS.

With regard to CMS, obviously, Penny, it's T-MSIS, the replacement for MSIS that is there. I don't have the numbers off the top of my head, but I know more and more states are submitting, and we are working quite hard internally to think about how to use the data and to put it together into dashboards.

Ultimately, that data, as it's used, whether it's for programmatic activities or oversight, the use of the data will ultimately be what improves the data through that long chain I described.

CHAIR ROSENBAUM: Thank you.

I have Toby, Kit, Stacey, and Chuck.

COMMISSIONER DOUGLAS: Question for Gary. If you

could talk a little of just the interactions between DOJ and the states and OIG, especially as it relates a little bit bigger to the intersection between a lot of Medicaid provider fraud and activities, fraud or criminal activities outside of health care, human trafficking, drug trafficking, others that at least in some states are seeing a big connection, and just looking at the providers in certain ways are just pawns and a bigger, bigger issue going on, and using data analytics to really look at these associations that go beyond just the claims data but the broader reach, and then fundamentally what actions DOJ is taking at that level, wherein states are feeling they can't really deal with this when it's bigger than just health care.

MR. CANTRELL: Sure. I'd say that the relationship between OIG, DOJ, and most of the states, if not all -- certainly, we are welcoming the state law enforcement agencies to work with us, and we work with them. It's really good, and it's improved over the last two years by getting them involved in some of our national -- the states involved in some of our national efforts.

Our strike force, which I mentioned before, is

led by a criminal division, which is headed out of D.C. but has resources throughout the country, and I think they recognize, the U.S. Attorney's offices around the country recognize, and we recognize that the states have to be involved in this national effort to address health care fraud, and so that is absolutely happening.

I don't have the specific number, but I think around a third of our cases are worked jointly with Medicaid fraud control units.

So often we will prosecute those cases. If there's a Medicare dollar and a Medicaid dollar involved in the case, we might prosecute that case federally. If it's 100 percent Medicaid case, we will work with them, federal law enforcement with state, attorneys general to prosecute cases locally. So we have several avenues for addressing Medicare and Medicaid fraud, both state and locally, and sometimes attorneys are cross-designated to prosecute Medicaid cases at the federal level.

In terms of the other part of your question, beyond health care, that's certainly a tricky -- that's a trickier question to answer. We believe health care fraud, the proceeds of that are used for a variety of things,

often just to lie in pockets. Sometimes the proceeds, we don't know exactly how they are used. We know a lot of individuals, fugitives travel overseas to avoid arrest, and some of the funds travel overseas.

I haven't seen specific cases related to a Medicare/Medicaid fraud relating to human trafficking. I wouldn't suggest that it doesn't exist, but I haven't seen that. But we do see connections throughout the variety of HHS programs, where funds are misused for, I'll say, nefarious purposes outside of their intended use. Human trafficking isn't something we've gotten heavily involved in, though.

Did you have some specific example?

COMMISSIONER DOUGLAS: It's the same entities. They might be in multiple -- it's not that they're using the dollars for that, but these are actors that cross over into other --

MR. CANTRELL: I think one of the things that you're suggesting is there needs to be, beyond the claims data, another layer of analytics that occurs connecting other resources. So we in OIG and at DOJ are interested in doing that, and we have some capacity to do that. It is

tricky. There are many other data sources that allow us to do kind of network analysis to find out who this provider deals with outside if Medicare, find out who his patients see outside of this provider, and connect dots beyond business ownership dots that aren't necessarily connected in the claims, and then ultimately connect to other possible crimes, organized or not.

So that is an area we are developing and continue to grow in. We're partnering with other organizations to increase our capacity to do that. It isn't something we have inherently built into IG yet because we don't have right now our primary data sources, the Medicare claims data. We need to leverage other agencies' data to be able to make some of those connections that you're describing, and we are actually working closely with the FBI, with cyber task forces, with the Department of Homeland Security. They have various task forces around the country that are set up to share data, so we're sharing some of that Medicare-related data, fraud data, so that we can see if there are connections across the community.

I hope that helps.

CHAIR ROSENBAUM: Kit.

COMMISSIONER GORTON: Thank you. Really interesting to hear how the efforts to network and work across jurisdictions are coming together. That's encouraging.

Changing gears just a little bit, a lot of interest these days in all of the programs around value-based purchasing, and ACO models, and partners between plans and providers, and I wonder if you all have perspectives about how fraud, waste, and abuse plays out in these settings, how to get on top of it. Just anecdotally, historically, there's been some sense that provider-sponsored plans are perhaps less energetic about chasing bad provider behavior than they might be, and do you think this will play out there?

And then from the data perspective, I guess I'm interested, when people have the opportunity to improve their earnings by delivering less care, how do you think about overseeing that so that care is not being underprovided by people who now have a financial incentive, not to deliver services?

MR. CANTRELL: So I'll say, first, this is not an area of expertise for me. These are all questions that I

think we're grappling with in the IG's office, currently, and continue to analyze.

One direct impact, I think, is the new -- many of the new models, encouraged relationships across providers, and many of the anti-fraud laws discourage those kinds of financial relationships -- the Anti-Kickback Statute, Stark Law. So our office -- our Office of Counsel, not my office -- has been looking at this and looking at, you know, waivers of the Anti-Kickback Statute, developing safe harbors that would allow for these new value-based and new relationships that are -- to be tried, and without there being criminal liability for complying with this new program.

So that's an area I think we're going to continue to watch. You know, so it certainly affects our office directly, as these anti-fraud laws are, in essence, waived for certain groups of providers, and for the benefit, and hopefully in value of the services.

But, you know, the other questions you asked, I think, are questions that we're still, you know, grappling with. I don't have anything to say from an investigative perspective on the incentive question that you asked about.

You know, I fall back on something, you know, is typical of law enforcement. Whatever the structure of the program, we end up seeing some type of fraud in the program. It may look different but there may be more or less of it. But we will be certainly monitoring and looking for those that might take advantage of it, and, you know, we will continue to do so.

DR. GOLDEN: You know, I think in many ways your question is a variant on one that we have today, even before some of the value-based purchasing -- what am I buying and what am I paying for with that? And I'm not sure that it's -- I think it's different under value-based purchasing but I'm not sure that it's that different, and I'll give some examples. Right?

So we deal with that question a lot when we're looking and reviewing capitation rates, and you have situations today where you might have a plan that has a capitated arrangement with a provider group. You know, I think it's many of the same types of questions that are in that. I'm not sure that's as much value-based purchasing as a very older type of arrangement. What am I paying? What am I paying on a unit cost? How do my unit costs

under there compared to outside of that, on the market? Right? I think those are things that haven't always been very clearly teased out in encounter data.

I think that what we see in a number of value-based purchasing arrangements -- you know, ACO style, in particular -- is there's almost always a quality component associated with that, and I think the question is, is that quality component adequate to address what some of the concerns might be around incentives and underutilization.

And then the final thing I would say is, I think it ties quite closely to the need to have good encounter data for other reasons than just program integrity. I think my experience in dealing with providers has been that they are often quite suspicious of some of these arrangements, and one of the most challenging pieces for the state plans and the providers to come to agreement on is what will be the data source of truth, and who is going to be the entity responsible? Usually they want the state to be right in the middle of that, even in a Medicaid managed care arrangement.

And so I think that highlights the importance of really working across the entirety of the system to ensure

that you have good data, because otherwise I don't know to answer that under value-based purchasing, or even more ho-hum arrangements that are more fee-for-service today.

COMMISSIONER GORTON: Thanks. I would just -- it's interesting because sometimes you hear people aspirationally talk about value-based purchasing somehow getting us into a post-transactional data world, and it's like, no, you encountered it; it's here to stay. So if anybody thinks that we're not going to code and assign unit costs to units of service just because we've got this different rubric, they'd better think again, because--

VICE CHAIR GOLD: That's what they used to say for HMOs --

COMMISSIONER GORTON: Yeah. It doesn't work.

CHAIR ROSENBAUM: We have several people on the list here still, and I'm mindful of the time, so let's go to Stacey, Chuck, Norma, Marsha.

COMMISSIONER LAMPKIN: So thanks. Thanks very much. This is enormously interesting.

I had the opportunity two or three years ago to be embedded as an in-house actuary in a Medicaid --

COURT REPORTER: Could you talk closer to your

mic?

COMMISSIONER LAMPKIN: Sorry. I got called on that earlier today. Don't like hearing the echo.

-- to be the in-house actuary in a Medicaid program that was going to statewide Medicaid managed care, and to talk to the NPI unit at the agency, and to talk to the state MFCU about capitation, how that works. I remember one particularly painful conversation about how to value damages to the state of a fraudulent finding in the context of a capitated managed care plan. It was interesting conversations.

But in all of that, we talked a lot about aligning capitation rates with the contract requirements, what you can do with the capitation rates and what limitations there are, and solving all these problems through how you structure the capitation rates.

So with that kind of background I have a couple of questions, still. One is, what does an effective state PI do with respect to primary analytics anymore -- you know, algorithms, and so forth. You talked about data sharing across sectors. And then with respect to -- so that's one question, and the other one is, given the

limitations of the capitation rates, what other solutions exist at the state or federal level to address lack of activity on the part of the MCO, with respect to doing what they should be doing on fraud?

MR. GAITHER: I'll take the second one first. We only have three MCOs in our state, so we can really focus on what they're doing. That's one of the main management steps we've taken. If you have 12, you really can't figure out what's going on. So we meet with them every quarter and go over the reports they've sent in, and they have to file a fraud and abuse plan each year. So we go through that, and we go onsite and audit their activities, and make sure they're doing things. And we can issue corrective action plans if they're not doing what we want, and those things can have liquidated damages attached to them if they don't follow through with those.

So we have some pretty strong things in our contract that we can leverage to get what we need out of them. So it just takes a lot of hands-on management, basically.

The capitation one, is that kind of a related question?

COMMISSIONER LAMPKIN: Just where do you end up with respect to what activities the MCOs are doing, and primary analytics in particular --

MR. GAITHER: Right.

COMMISSIONER LAMPKIN: -- the algorithms and so forth, versus what the state retains and does, either working cross-sector through the data-sharing or even just across MCOs.

MR. GAITHER: We do -- we that encounter data the MCOs have and aggregate that to do statewide analytics, because obviously like time bandits, it's easier to catch those if you have all of the data aggregated.

So there are some things that we can do that the MCO can't do, and we still do those, but then they still provide most of the analytics, and they do a lot of front-end claim editing and record reviews, which is a whole new, you know, world for Medicaid plans, doing front-end auditing and record reviews before they even pay claims. So that's when you get into, what did you find that you didn't pay for, and telling us about that kind of stuff, and that gets more complicated.

CHAIR ROSENBAUM: Chuck.

COMMISSIONER MILLIGAN: It's actually a good segue to one of the questions I wanted to ask. So I'm formerly with a state Medicaid program, currently with a Medicaid MCO, so just some context.

There's a lot of prepayment review, as you just mentioned, and there's many permutations on that theme. There still seems to be a bias in how reporting gets done to states and then upstream about recoveries, as opposed to avoidance, and maybe there's a belief that avoidance is more fictitious or doctored instead of actual recoveries, where you can show the dollars. But it has perverse incentives. And so when our state, for example, compares the program integrity activities of each of the four MCOs in our market, they have a bias toward liking to see recoveries and a bias against linking to see cost avoidance, but cost avoidance is more efficient on many levels, in terms of prepayment review, in many service areas.

And I'm wondering, in light of the reg and in light of the framework here, whether that bias is going to get exacerbated or addressed.

MR. GAITHER: That's a good question. I think

each state is going to be different, obviously, and we try to value -- or we understand that prepayment review and avoidance is -- it's better not to pay to begin with, obviously. That number can be really large sometimes so it's hard to value what's just usual stuff that happens versus really diligent review of claims. There may be some more conversation needs to happen with plans and the states around that.

They may actually like recoveries better because that's actually something you can prosecute. If you never paid it, it's hard to prosecute someone, so that may be part of this as well. So maybe a rethinking of how we look at prosecution of fraud and abuse and what we do around that as well.

COMMISSIONER MILLIGAN: Sorry. I just had to insert --

CHAIR ROSENBAUM: Go.

COMMISSIONER MILLIGAN: Do we have time for two more questions?

CHAIR ROSENBAUM: Absolutely.

COMMISSIONER MILLIGAN: Okay. Sorry. I don't want to overstay my welcome.

The second question -- I wanted to come back to what Kit said about ACOs, and I'll give a very specific example from our health plan. We've got shared savings contracts in place with some of our large providers. The structure -- you know, I'm not going to give away trade secrets here, but the structure, in general, is, it's based on total cost of care. So we set a baseline on a per member, per month for our members panel to a large provider. And if they manage the total cost of care, that establishes a savings pool, and their slice of that pool is driven by how many HEDIS targets they hit in that contract. So with some providers you might have seven HEDIS targets. Each of the targets has to show improvement from the baseline year to the measurement year. So they have to improve, and that dictates what percent of the pool savings they get. If they don't get any pool savings, you know, there's -- if they cost more money, we just -- you pay fee-for-service, it's only upside, you know, they get paid normal, you know, unit-based stuff.

So the shared -- the payments of that pool are not encountered, exactly. What is encountered is the reduced ED visits and inpatient stays, and what drives the

total cost of care reductions, but it does create a weird incentive for us, and in terms of this oversight framework, are we setting aggressive enough targets? How are the shared savings payouts going to get reflected in rates? Is it a stark violation because it might look to somebody like we're really just paying a provider to be preferred with us and kind of nudge their patients to choose us in open enrollment?

I'm interested in your thoughts about all of that in a program integrity framework, to whatever extent you can take on that big question.

DR. GOLDEN: Really, I do think it gets to something that Kit was saying earlier, in the sense that there are strengths and weaknesses to the various data sources. Right? So encounter data, to the degree you're getting it for all of the encounters in those arrangements are probably very good for what your utilization is. For a variety of the HEDIS measures it's probably quite useful for a calculation, or at least partial calculation.

You know, I think that one of the challenges to value-based purchasing, which permeates then to program integrity, is where do payments that are legitimate

payments associated with medical activity that fall outside of the claim structure, how do those get systemically captured and reported?

Now, of course, for rate-setting purposes, we would expect to see those types of things coming out of the financial data, coming out of the ledger, right, and so it is being coded. I think one of the challenges is when you have a large provider that has total cost of care arrangements across a wide array of both services and individuals, trying to think about what some of the unit prices is almost impossible. Right? And so it creates a variety of problems down the road.

But I do think that that is one of the reasons, in the regulation, that we tried to focus on the full set of data that we anticipate that both state and federal bodies would need to do their various responsibilities, because some of the data will only be in your financial data. Some of it will, you know, will be utilization over here, spend over here, and that's just going to be something that we're going to have to figure out how to do. You know, as an industry, you're thinking about it. Clearly the states are thinking about it, and we need to as

well.

CHAIR ROSENBAUM: Oh --

COMMISSIONER MILLIGAN: I'm done. No, I'm done. I'm done.

MR. GAITHER: One thing that occurred to me about these conversations is that attribution is a big part of this too. If you attribute patients to a provider and that provider may fire some of their patients, the ones that aren't cooperative or the difficult ones, that's another type of fraud that you have to look at. And Tennessee is getting into patient-centered medical homes, and we don't have any ACOs yet in Medicaid but someday we'll get there.

That's a whole different level of fraud, as well as sometimes your payment incentives are contingent on quality measures, like you talked about. And as we get more towards quality measures that are not claims based -- they're more about stuff that's in the electronic medical records and things like that -- you've got to start wondering, did they really do those quality measures so that they could -- you have to cross a threshold to get the money, and by fudging on my quality in the activities that I'm doing, to make sure I can get to that bonus payment.

So there's a whole different level of fraud that can go on from there.

CHAIR ROSENBAUM: Marsha.

VICE CHAIR GOLD: Yeah. This, I think, is a narrow question. It's for James Golden, and I wondered if you can elaborate a little on the decisions in the regs on the application of the fee-for-service Medicaid provider standards for Medicaid. And the reason behind it is that I always thought -- and this was an argument we'd made for years -- that managed care organizations had an advantage over places like Medicaid that took any willing provider, because they did credentialing, which is there where they had to look at it, and they look at the standards, and it's certainly in part of the HMO accreditation requirements. I'm not sure every state in Medicaid requires it.

And so I guess I'm trying to figure out, Medicaid may know if someone is a fraud, both otherwise I didn't think Medicaid did much. So how -- am I wrong as to what managed care plans are doing, or were they not -- are they not doing what they thought they are? Is Medicaid doing more than I thought?

DR. GOLDEN: Well, I think that the -- so you're

really probably talking about the screening and enrolling with regard to that.

VICE CHAIR GOLD: Yes. It's called credentialing when it's --

DR. GOLDEN: Well, I think one of the things that we tried to be clear about in the regulation is I think we viewed them as three kind of distinct approaches where really the screening is what is currently in Chapter 455, which is really checking across databases to ensure that the person doesn't have -- that they're licensed, that they would otherwise not have some exclusion. There is, I think depending on the state, anywhere from 8 to 17 databases that the person -- that a state would check to ensure that they're eligible for participation.

We had a number of situations where there were problems where the provider was not enrolled with the Medicaid agency, and the state just had a lot of problems in dealing with the plans with some of those types of providers. So we really wanted to make sure that that was done kind of at a minimal level.

With regard to what the plans are doing around credentialing, undoubtedly there's variation. Undoubtedly,

to your point, some of it would overlap. I think every credentialing process looks at is the provider licensed, right? Are they licensed in the state that they need to be in? Do they have any actions against them at the medical board? Those types of things are there.

But I do think that plans have other variation in their credentialing process that are very much about: Does this provider meet the quality that I might be interested in? Is there a risk that they will entangle me in litigation? You know, there's a variety of things that are certainly looked at credentialing, and we leave that up to the states. But I do think that, you know, really working with oversight bodies, I think they felt it was pretty important to try to do that, the baseline evaluation on the screening.

VICE CHAIR GOLD: Does that mean that if they're not a participating provider in regular Medicaid, they can't be in a managed care plan?

CHAIR ROSENBAUM: Exactly.

VICE CHAIR GOLD: Which is -- but that's -- there were a lot -- there were at least some -- it depended on the state -- that wouldn't be willing to do it in Medicaid

that did.

CHAIR ROSENBAUM: That's right, yeah.

DR. GOLDEN: They simply have to -- they have to be enrolled with the Medicaid agency, meaning that they have to -- in their 1902(a)(27), there are two requirements. It's agree to audits and documentation, I think, of your -- the claim or the services. So they have to be enrolled and sign that agreement with the state agency. They do not need to see fee-for-service clients if they do not want to.

CHAIR ROSENBAUM: But they have to [off microphone] themselves.

DR. GOLDEN: Right.

VICE CHAIR GOLD: So do you consider just having the plan have to -- they have asked you to run them through the screener? Because it sounds like you were trying to piggyback on what the plan -- get more providers into traditional Medicare -- Medicaid?

DR. GOLDEN: Well, this was really just about making sure that the people that were in didn't have some other disqualification that was there. Seventeen states today already enroll their Medicaid managed care providers

in their own system. And in those states, there's a mix of how it's done, right? In some cases, they ask the plans to do the screening. In other cases, the state agency does it.

The other thing that I would say about that particular provision is a state can rely on some other things, right? So they can rely on a Medicare screen if that is done. They can also rely on the Medicaid fee-for-service if you have a state that has mixed delivery systems. They can also rely on another state's Medicaid's screen as well.

So in many states, there won't be a lot of providers that wouldn't be caught up in one of those other screens because they're serving clients in some of those as well.

CHAIR ROSENBAUM: Right. Sharon, and then I have a couple of questions. Then we'll --

MR. GAITHER: If I could add one thing?

CHAIR ROSENBAUM: Yes, quickly.

MR. GAITHER: One big advantage is when a state registers those providers, they get the ownership and disclosure forms. So if I find one provider that's having

an issue, I can find an owner that has ownership in several other providers. But they have that data at the state level. And if I want to kick a provider out, I just turn their Medicaid number off, and they're out everywhere.

COMMISSIONER CARTE: Just quickly, Mr. Gaither, your earlier comment about states looking at the encounter data and relating it to MCO bookings and a few other discussions made me think. Do you all have any concerns about states' capacity to look at their managed care or data analytic capacity in general as it relates to all this activity? Do you have any observations or see a need for some minimum? There's such great variability, I think.

DR. GOLDEN: Is it easy?

MR. GAITHER: Well, if the data is standardized coming in from the MCOs, it's kind of like the same as your fee-for-service data that you're getting. So your program integrity unit can treat it the same, although when you get in these different reporting requirements around terminated providers and things like that, it's a different skill set that your staff need. And I'm not familiar with what other states do around program integrity. I tell them what we're doing most of the time.

DR. GOLDEN: I guess I would say, to answer your question, I think running a state Medicaid program is a lot of work, and it's awful hard, right? I'm sure Toby and Chuck and others can attest to that. And so I think that one of the challenges for states is just the sheer amount of activity they need to do to run their program and the complexity of the program that they're running.

I do think that certainly in managed care, I think what you see for success is highly dependent on how kind of the state overall thinks about it. To the degree that I'm operating a Medicaid managed care program, where I'm running it as the state, even though it's through managed care, I'm setting the policy; I'm trying to accomplish key objectives for covering people, getting quality care, running a program that has good program integrity to it, and I'm going to have a tight grasp on how that's operating. I think for those states it's a lot easier to stay on top of stuff. If you think about it as we're going to hand this off and let someone else run this without as much thought into some of those programmatic activities, I think that creates an opportunity for a lot more fraud, waste, and abuse as well as other just

challenges in operating it.

But I do think that states have a lot on their plate in trying to put forth both not only the Medicaid managed care rule but some of the other requirements that have come out.

CHAIR ROSENBAUM: Sort of to that end, I have a couple of questions. The first one is I'm curious as to whether you all have thought about -- whether you feel that there's any extent of rethinking you need to do in light of the Escobar decision. And the second question is our discussion this afternoon has been all about the role of managed care entities as agents of the state essentially carrying out state functions. I'm wondering where you all are on the issue of fraud by the managed care entity, and specifically my great concern always is the misrepresentation of specialty networks. And I'm wondering what in the construct that you use at the state or federal oversight level would deal specifically with the problem of representation of a network that actually is pretty much nonexistent and which issues are now going to rise for state and federal governments to an Escobar level of an affirmative representation at the time of a signing of a

contract.

MR. GAITHER: Well, I can tell you what we do with networks. We get a file from the plans each month with all of their providers on it, and we audit the contracts that go behind that. We also on a sample basis call those providers to confirm that they're in the network and that they're taking new patients.

It gets a little more tricky around how quickly can a patient get into that provider, so you have those kind of tensions around access. But the actual reality -- Is that provider in the network? -- we do audit that independently of the MCOs to make sure that's accurate.

CHAIR ROSENBAUM: And is that treated as a program integrity issue? I guess that's the question. You know, is that simply a -- not simply. Is it treated as a compliance issue, or does it sort of fall into the program integrity end of things?

MR. GAITHER: I think it would depend on how many errors we found. If there were just one or two and there seemed to be some paperwork issues behind that -- but if it seems to be systemic, that would be a fraud issue.

CHAIR ROSENBAUM: All right.

DR. GOLDEN: Yeah, I think inside the reg there's a number of things that we tried to do to address that around access. You know, with regard to network adequacy, many people point to Section 438.68 because it has the words "network adequacy" in it. I have long argued it is the wrong section of the reg to be looking at. The primary section to be looking at is one that is 206, which is --

CHAIR ROSENBAUM: Yeah, I agree.

DR. GOLDEN: It says that under the contract the managed care plan needs to be able to have all services available through their network in a timely fashion. And the importance of 206 is the very next section, 207, because one of the requirements of 207 that has been there but then we strengthened in the regulation is that the managed care plan needs to provide documentation to the state of how it meets what the state's requirements are. So states have the ability and the right to set what their network adequacy requirements are, what the timeliness requirements are. But then the plans need to demonstrate that they're meeting those.

CHAIR ROSENBAUM: And that's exactly where the Escobar question comes in. I mean, because at that point

you have an affirmative representation that you're in compliance.

DR. GOLDEN: Exactly. And the other thing that we did with that is we asked the states to document how they analyzed it in order to see that they too agreed that what was submitted met that. And then the final piece that we did that is analogous to the access reg on fee-for-service is in the definition of actuarial soundness, we also said that the rates have to be adequate in order to meet the standards of 206 and 207, as well as 208, which is really more about care coordination. And so we would actually expect to see some of those things in the same way that we would see it under the access reg coming through rate certifications and contracts and documentation that would be at the state level around the affirmative demonstration by the plans.

CHAIR ROSENBAUM: Yeah, it's this line between a compliance issue and a program integrity issue. I'm never quite sure, you know, where it comes in, but this has been very helpful.

Any last questions? It's been a wonderful panel.

[No response.]

CHAIR ROSENBAUM: Well, thank you very much for coming. We now are on a 15-minute break.

MR. GAITHER: Thank you.

* [Recess.]

CHAIR ROSENBAUM: All right. We are ready to roll again, and we are not behind Tab 5, and we are up to access.

DR. BERNSTEIN: We are.

CHAIR ROSENBAUM: Amy and Martha.

ACCESS TO CARE IN MEDICAID: RESULTS FROM NEW MACPAC ANALYSES

* DR. BERNSTEIN: And Kirstin.

So we're switching gears now a little bit. We're going to the access portion of the Medicaid and CHIP and Access Commission, leaving out the "Payment" this afternoon.

As you know, our statute says that we should review policies that are related to accessing the Medicaid and CHIP program, and while we'd really like to look at access in terms of achievement of specific metrics and measures, that's really hard to do for a variety of reasons, among them as was evident from the access rule and

the request for information, there aren't standard metrics that everyone agrees to. The survey data often can't be used at a state level, and data aren't always consistent across states. So most of the analyses that we do examine process and utilization measures and not so much access as outcomes in relation to need because, as I said, that's very difficult to do.

So what we generally end up doing is looking at utilization or other outcome measures and comparing across states, payers, groups to see if they change over time and if they're similar to other populations.

So, in this session, you're going to see three -- you're going to hear, also see on the screen, three different presentations that sort of approach access measurement from three sort of different perspectives, and we have just completed all of these. These are hot off the presses.

So, first, we're going to present on how states are currently monitoring access in their fee-for-service populations and how they plan to do so in compliance with the final equal access rule that was released in November of 2015.

States are required to submit their draft access monitoring plans by October 1st, 2016, and almost all of them have done so.

So Martha Heberlein here will first present results from a MACPAC survey that queried all states, except for, I think, one, which she'll describe that doesn't have any fee-for-service, and what populations they serve under fee-for-service and how they were monitoring access to services in those fee-for-service populations as of May 2016, before the rule has taken effect.

We asked states which populations were covered under their fee-for-service payment. For example, some states really only covered their duly eligible population or some covered children and some don't. Some covered disabled population. So we sort of needed a denominator for who was in their fee-for-service population, and we asked about three types of access measures, beneficiary experience, accessing covered services, utilization of covered services, and provider supply.

And Martha has also done an initial assessment of the access monitoring plans that have been submitted, and she will describe them at a high level.

Next, Kirstin Bloom will -- Blom. Sorry. I've had a long conversation with her. Blom. And I've gone back and forth. Blom rhymes with plum. Okay.

[Laughter.]

DR. BERNSTEIN: Okay. Kirstin will present data on non-emergency medical transportation services.

Our hot-off-the-press MACStats that you heard about this morning show that -- and I'm sure you've all perused them and have memorized everything in them -- show that Medicaid enrollees are more likely to report delay and care due to lack of transportation services compared to privately insured people. Medicaid is one of the only payers that cover this service, which is considered a mandatory state plan service. However, it's difficult to actually quantify NEMT services and to compare use across states due to variation in transportation services covered, benefit design, copayment policy, service limitations, and coding of the services on claims.

There's also not much in the literature on how effective NEMT actually is in increasing access to services. Nonetheless, it is a mandatory service, and states are beginning to question whether they actually need

to continue providing the benefit, and several have requested waivers of the NEMT services for the new adult group in particular. And Kirstin will be discussing that.

The analysis that she is going to present uses data from the Medical Statistical Information System, fee-for-service data, and looks at the number of enrollees who use NEMT and how service use varies across eligibility groups.

We also contracted with Burns and Associates to produce case studies of use of NEMT in two states, and she will describe the results of that analysis as well.

Our third study that I will be presenting focuses on a comparison of access and quality measures between Medicaid and privately insured enrollees. The analysis uses Medicaid fee-for-service data and private data on what we are calling potentially preventable events, or PPEs -- I'm going to go back and forth, so if I say PPE, it's a potentially preventable event -- potentially preventable hospital readmissions, potentially preventable hospitalizations, and potentially preventable emergency department visits. These measures were developed by the 3M Corporation, which used expert input and published research

to define the events, and they have a very complicated software program that you sort of put your data into, and it spits out various things, measures.

While not all of these events could in practice have been prevented, large differences in rates between Medicaid-covered and privately insured individuals may indicate that there are more access or quality problems for the group with more preventable events. So whatever it is they're measuring, if there's more, they're measured the same way. So if there's more in one population than another, that may be a flag.

We also compare nondisabled Medicaid enrollees to privately insured individuals because Medicaid covers a larger share of disabled people, obviously, and people with more complex health conditions, and that may influence the results as well as the total number of events and the total number of preventable events.

And this is one of the first studies that we know about that actually compares Medicaid enrollees and privately insured enrollees using the same methodology with this many cases.

These three studies presented today add to

MACPAC's body of work on documenting Medicaid enrollees' access to care using a variety of data sets and measures. A summary of the work to date, including report chapters, tables, the MACStats that you saw this morning, and issue briefs, including the three that were released a couple weeks ago that you were e-mailed is in your binder, as well as a cheat sheet of sort of various important things that have happened in Medicaid access over the years, legislation, court cases, and such.

To date, this body of work shows that Medicaid enrollees have much better access to care and higher health care utilization than uninsured individuals, but on a number of measures, Medicaid enrollees have lower utilization than privately insured individuals.

On other measures, utilization is similar, but Medicaid enrollees report more difficulties obtaining the care, longer wait times, longer wait times for appointments, problems finding providers who will treat them, problems obtaining transportation, which we'll discuss, or longer waiting times.

So, with that, that's sort of a road map for how the rest of the afternoon will go. I am going to turn it

over to Martha, who will talk about access.

ACCESS MONITORING UNDER MEDICAID FEE FOR SERVICE

* MS. HEBERLEIN: Thank you, Amy, for that introduction.

As she mentioned, I am going to begin our access conversation this afternoon, focusing on how states are currently monitoring access to services for their fee-for-service Medicaid populations and how they plan to do so going forward in compliance with the new equal access rule.

So, to start, I'll provide some brief background on access monitoring in fee-for-service Medicaid and the need for ongoing monitoring. Then I'll present the results from the MACPAC survey that asked states about the populations they serve in fee-for-service Medicaid and how they're monitoring that Amy mentioned, and then go over some of the state access monitoring review plans, which have been submitted to date.

So, to begin with some background, the Social Security Act requires Medicaid payment levels be sufficient enough to enlist enough providers so that the care and services available are comparable to those of the general population. This requirement is often referred to as the

equal access provision, but until 2015, CMS had not issued regulations to guide states in meeting the equal access provision, and so this absence of federal guidance really led to substantial variation in both the processes and standards that states were using to do that.

Furthermore, the adequacy of payment rates was often determined primarily through lawsuits from either providers or beneficiaries.

On March 31st, 2015, in the Armstrong v. Exceptional Child Center Case, the U.S. Supreme Court ruled that the Medicaid statute does not provide a private right of action to providers to enforce the equal access provision. So this ruling really increased the importance on CMS's access to adequate data to really assess the potential effect of any provider rate change.

So the final court ruling also required that states provide more information, so that CMS can better monitor, measure, and ensure access to care for services paid under fee-for-service methodologies.

And on November 2015, for those who were here, we presented on the rule in the December meeting that year. The CMS rule issued, in part, in response to the Armstrong

ruling required that each state develop an access monitoring review plan, and I'll go over the features of those plans and what we've seen so far in those plans after I go over the survey results.

So we're going to start a little bit with why we need to monitor access in fee-for-service. The importance of monitoring access really remains, despite the fact that many states continue to shift populations from fee-for-service to managed care. The use of fee-for-service varies considerably by state, but the majority of states still provide some services on a fee-for-service basis. And as of fiscal year 2015, 55 percent of spending in Medicaid nationally was towards fee-for-service.

States and the federal government have an obligation to ensure that the beneficiaries are able to access services and that the payments are in line with the principles of the equal access provision.

The ability to monitor access also provides a level of accountability for state and federal spending.

Finally, the populations that remain in fee-for-service Medicaid, such as children and adults with disabilities or duals, as Amy mentioned, are among the most

vulnerable. So assuring their access to services may be even more important, given their high health needs. So that's why we're doing it.

In anticipation of the new rule to monitor access, MACPAC was interested in understanding the approaches that states were currently taking to monitor, assess, and improve access for the populations they were covering in their fee-for-service programs.

So, under a contract with RTI International, they fielded a survey of state Medicaid programs to collect information on how states are currently monitoring access to fee-for-service populations as of May 1st, 2016, so before the rule went into effect.

As Amy mentioned, the survey focused on three aspects of access that states may be measuring: beneficiary experience accessing covered services, beneficiary utilization of covered services, and provider supply. States were asked to report on the populations, types of services, and providers for which these data were collected. We also asked about the types of data collected, the frequency of data collection, and how states used those measures.

The survey was fielded from August 8th through September 20th, and the idea was that as states develop and refine their access monitoring review plans that the survey would provide MACPAC and others with additional details that may not be available in those plans and sort of provide us a baseline of what states were doing.

So 37 states responded, which we were very pleased with, and of those states, all of them provided services on a fee-for-service basis to at least four of the ten populations listed. And 27 of the states provided services on a fee-for-service basis to all of the populations, and I'll show you that on the next slide.

Five states did not report collecting any of these types of measures. It may be the case that because the reference date of our survey was prior to the rule implementation, they had not yet developed a plan to monitor access in fee-for-service. It may also be the case that the nature of the survey questions did not adequately capture what they were, in fact, doing in their states. And as I'll discuss later, all of these five states, except one which was exempt, did submit access monitoring plans, so they at least plan on doing something going forward.

So, as you can see from -- no -- or maybe not see from this slide -- here are the populations that states are currently covering in fee-for-service, and I just want to note that this includes those populations that receive services paid on a fee-for-service basis when they're carved out of managed care and also those in primary care case management arrangements.

So, Commissioners, there are additional findings in the memo in your binder as well as some appendices tables that provide state-by-state data, but sort of here are the high-level findings, and this is all out of the 37 responding states.

So, of the three general types of access measures, 29 states reported collecting data for one or more of the measure types that related to beneficiary experiences accessing covered services. So 26 states collected data relating to beneficiary receipt of services. Twenty collected data on timely receipt of services; for example, the ability to find a provider that accepts Medicaid. Nineteen collected data on the specific barriers to receiving services, such as lack of transportation, and 16 collected data for all three of these beneficiary

experience measures.

Twenty-nine states reported collecting data for measures of beneficiary utilization of covered services, and 21 collected provider supply measures for either the state overall or specifically for Medicaid fee-for-service populations.

States most commonly collected data on the ratio of participating providers for the population, provider participation in Medicaid, and the overall number of providers in the state.

So overall, in most cases of measurement, there was little variation in the number of states collecting data for particular populations. For example, regarding the beneficiary receipt of covered services, the vast majority of states reported collecting data for each of the 10 possible populations that we asked about.

In terms of services and providers, states most often collected measures related to primary and specialty care, behavioral, and dental health, and given prior analyses that we and others have done that suggest these areas may be where access to services could be an issue for the fee-for-service population, this finding isn't really

surprising.

We also asked about the types of data collected, the frequency of data collection, and how states used those measures.

Across the measures of beneficiary experience and utilization, states most often use claim data, beneficiary surveys, complaint hotlines, and stakeholder meetings. They used these data to assess the adequacy of access, often comparing the data to prior years or national Medicaid averages.

A number of states also reported these data publicly just to show what was going on in their programs, while a smaller number of them used them to provide feedback either to providers or to guide corrective action within their programs.

To assess provider supply in Medicaid and across the state, states most often used provider enrollee data, comparing them to prior year information. States used these data to assess the adequacy of access and report publicly as well as to guide state policy to increase provider supply within their state.

So shifting gears and moving on to the state

access monitoring review plans, which is certainly a mouthful, as I mentioned at the beginning, the final rule required states to submit an access monitoring review plan to CMS by October 1st, 2016. The plan must have been developed with the Medical Care Advisory Committee as well as provider and beneficiary input and made available for at least a 30-day comment period. CMS will review the state plans for compliance with the requirement but won't formally approve them.

The rule includes additional parameters for the plans. For example, they must include the measures and the data sources and methods that the state will use to analyze access within their Medicaid fee-for-service program. The analysis must also take into account state-specific delivery systems, beneficiary characteristics, and geography.

In making a determination of whether access is sufficient, the plan must also consider the extent to which beneficiary needs are met, the availability of care through enrolled providers, changes in beneficiary utilization, characteristics of the beneficiary population, and actual or estimated payments from other payers.

The state must also conduct an analysis for each provider type and site of service at least once every three years for the following services listed on this slide: primary care, specialty, behavioral health, prenatal and postnatal services, and home health services.

States must also examine access for any services which the state or CMS has received a significantly higher than usual call volume of beneficiary, provider, or other stakeholder complaints, as well as any services for which the state has either reduced or restructured payment rates.

When access issues are identified, states must submit within 90 days a corrective action plan with specific steps and timelines to address the issue within 12 months. These issues can be addressed through a variety of means, including but not limited to increasing provider rates, improving provider outreach, providing additional transportation or telehealth services, or improving care coordination, so really leaving it open to the remedy, depending upon what access issue is found.

So as Amy said, we took a look at the initial draft plans that we could find. There were 46 of them. So these are sort of our high-level initial findings.

A number of state plans described the current efforts to monitor access, which primarily rely on consumer complaint hotlines and advisory committee meetings, which aligned with some of what we found in the survey. Plans also described state initiatives to improve access, for example, through delivery system reforms such as accountable care organizations or telehealth, or provider incentives such as loan repayment programs, so things they're already undertaking to improve access.

Most states included baseline data as required across the five service areas, and some states included additional data areas such as dental or transportation, where they had self-identified access issues. States varied as to whether the baseline data reported was from utilization data from claims, self-reported access measures from beneficiary surveys, or provider enrollment figures.

And while some states provided trend data or made regional comparisons as part of their baseline reporting, most states did not provide a standard that would be considered sort of adequate access. So, overall, only a handful of states included explicit standards or benchmarks to which they would compare the data. For example, a few

set a provider to enrollee ratio, others looked at the National Committee for Quality Assurance or network adequacy requirements for managed care, but for the most part a standard was not included in the plan.

Most states often -- also reported very little in terms of concrete steps that they would take to address access issues when they were discovered, although the plans typically discussed the state's intent work with CMS to address the issue within the required time frame. So they acknowledged that they would do this but that the plan would be sort of developed depending upon what they found as the potential issue. They acknowledged that any potential access issue would likely require investigation in order to determine the most appropriate response.

A few states that actually identified access issues in their plan, as they were looking at the data, did talk about some concrete steps that they were going to take to address them.

So based on the survey results and our initial review of state plans, as you all know, there is considerable variation across the states in terms of what states are currently monitoring and how they plan to do

this going forward. So while a small number of states provided really detailed plans and appear to have a robust monitoring system in place, a large number seemed to have little in terms of existing, ongoing efforts beyond a hotline, and some plans that were submitted lacked concrete details, in terms of how they were going to monitor access. So there is wide variation.

A number of states voiced concern about the burden of the access monitoring plans. Some with large managed care populations raised concern regarding the burden of monitoring the typically small and often idiosyncratic individuals or populations that continue to receive their services through fee-for-service. There were also concerns relating to the availability of data and standardized metrics, as Amy talked about before. For example, a number noted the widespread inability to obtain comparison data on payment rates, either from neighboring states or especially from private payers.

The state responses also point to the ongoing administrative capacity issues that the states face to collect, analyze, and report the data, that further impedes monitoring access.

So, finally, while in most states it's difficult to know, based on their existing data that they reported, whether or not the payment rates are sufficient, it's not even clear whether or not they would have the tools in place to respond, should they find an access problem. For example, especially remedies that are outside the purview of the Medicaid program, such as larger provider supply issues.

So with that, depending upon your interest, there are a number of avenues that we could explore for future work. For example, we are awaiting the final report on the survey, so once we receive it we can certainly take a deeper look at the data in there. So we could look, for example, within a state, how many states are doing certain things and whether some states are doing a lot to monitor and some states are doing a little.

We could also conduct more in-depth analysis of the access monitoring review plans, cataloging, for example, the data sources that states are using to monitor access. We could also combine it with some of the other work that Amy and others have done in the past, that looked at where existing access issues are and whether the plans

or the survey data would really lead states to adequately identify and address those issues.

So thank you, and I look forward to your discussion and suggestions for our work.

CHAIR ROSENBAUM: Thank you. Gustavo, you can start us off.

COMMISSIONER CRUZ: I have a particular question. I was looking at the tables, Table A3. Can you elaborate on the difference between receipt of covered services and receipt of timely covered services?

MS. HEBERLEIN: I can. Let me get out my survey instrument so I can tell you exactly what we asked.

So the receipt of covered services was basically are you asking beneficiaries, or are you collecting data on whether a beneficiary receives a service that is covered? On the beneficiary receipt of timely services, we asked about specific measures that they might be collecting. So we asked, did the state collect any data on the following measures -- your ability to find a provider, your ability to find a provider that accepts Medicaid, ability to obtain an appointment, flexibility of provider office hours, time between scheduling and appointment, travel distance to a

provider, in-office wait time, or other. So the beneficiary utilization -- receipt of covered services was just are they receiving that care, and then the timely services was, there was more specific services that we asked about.

CHAIR ROSENBAUM: I have Toby -- Peter, Toby, Sheldon, Brian, Stacey, Marsha.

COMMISSIONER SZILAGYI: Wow. Very nice work. Thanks.

Just a couple kind of clarifying questions. Regarding the 37 who responded -- and I see the table here, but I didn't do this in my head -- do you -- what percentage of all U.S. -- I mean, are these -- some of the large states responded. So does this represent, you know, 80 percent of all Medicaid -- fee-for-service Medicaid enrollees across the United States, or it may be helpful to sort of describe who this represents.

And I also didn't really do a deep dive on this, but are these the more wealthier states, or -- you know, is there a bias in the 37, in terms of the types of state? So that's one question. Do you know the answer to that?

MS. HEBERLEIN: No, and it didn't seem -- nothing

-- when I looked at the respondents, nothing jumped out at me about those particular states, but I did not look at the share of fee-for-service that those states represented. But that's certainly something we can do.

COMMISSIONER SZILAGYI: Florida and Texas are not on it, so some of the large states --

MS. HEBERLEIN: Yes.

COMMISSIONER SZILAGYI: -- are not on here.

MS. HEBERLEIN: Mm-hmm.

COMMISSIONER SZILAGYI: Another question I had is, did any states identify foster care as one of the special populations? I mean, I know we have, you know, children -- a couple of categories of children, but that would be an area, since there's sort of a commonality about foster care across the United States, that would -- and we have published on foster care -- but that would be an interesting area, and I don't know whether they have called that out in some of the states. Or did we ask that?

MS. HEBERLEIN: We didn't ask specifically whether foster care kids were included in the fee-for-service population or -- but they did -- some states -- we -- they could report other populations. So we can look at

the responses to Other and see which states might be -- if any foster care kids were specifically called out.

COMMISSIONER SZILAGYI: Because that is a population where there's a lot of concern about access and quality, because of the special issues of foster care, even though some -- more and more of them are being placed into managed care, but many are -- remain in fee-for-service.

CHAIR ROSENBAUM: Toby.

COMMISSIONER DOUGLAS: I just wanted to, on the conclusions, just -- I can't emphasize enough just the concern around the burden on states with all this new work. I know we've talked about it before, but just the administrative capacity of states to take this on, you know, coupled with all the managed care changes, you know, state staff.

You know, these are -- this isn't easy stuff and sophistication of state staff that come from, you know, all over state government without the technology and the tools, which is why many states have transitioned their populations to managed care and do have small populations, but then to rebuild what they've expected of managed care plans to do, it's just -- it's something we need to keep on

assessing the capacity and, you know, how states are able to get the right resources within, you know, an overall government structure that looks at staffing the same, types of staff and analysts the same, whether they're working in the Department of Motor Vehicles versus Medicaid.

CHAIR ROSENBAUM: Sheldon.

COMMISSIONER RETCHIN: I think this is -- first of all, congratulations. This is really well done.

So I think this is really an important area that -- and I don't want to say that the Commission has overlooked it, but it is remarkable that the -- and, you know, for, I guess the first two years I was on MACPAC, I actually thought the second A stood for Advisory. So it goes to show you -- because it does for MedPAC. So this is an area where it just seems to me we need to develop more of our effort, and I'm really glad we're -- that the process is unfolding so that we can monitor access in fee-for-service Medicaid, just as fee-for-service Medicaid disappears.

[Laughter.]

COMMISSIONER RETCHIN: But it seems to me that one area where we could contribute, so that, as Toby

suggested, the burden -- administrative burden on states is inexorable and continues to grow, is the methodology. That is, you know, you've got a potpourri of things here. States are all over the map. Some are doing hotlines and I can't imagine that hotlines should give us any solace or comfort. But maybe they do. I don't know. But it seems to me that -- I mean, there's literature out there, and maybe, just maybe, we could go into one state or a couple of states and help out, and actually compare methods, so we standardize. I know that it's costly, but actually do a random sample, and look at the unmet needs of beneficiaries in an area where there may be a signal, so that we would have a screening device where we could actually uncover access to problems with unmet needs. I know, heaven forbid, but I think this is really important.

CHAIR ROSENBAUM: Brian.

COMMISSIONER BURWELL: I have a couple of clarifying questions. I do think this is an area where we can make some contribution in terms of recommendations about how measuring access plays out.

States were require to submit their plans in October, and submit reports every three years. What is the

first date for which they are required to submit a report?

MS. HEBERLEIN: Well, the plan itself included -- was supposed to include baseline data, so that's part of what I presented.

COMMISSIONER BURWELL: So they were supposed to act -- it's not just a plan. It was supposed to be an analysis.

MS. HEBERLEIN: Right, and the plan -- so the plan should include the baseline data as well as the methods and the approach that the state was going to use, and collect those data going forward. And then my understanding is that, in three years, they need to --

COMMISSIONER BURWELL: So in 2019, they are required to submit another report.

DR. BERNSTEIN: Or if there's any change in payment that would require them to submit a revised report about what effect that effect -- that payment would have on access.

COMMISSIONER BURWELL: Okay. One of my concerns about this whole process -- and I agree with Toby, this is not an insignificant exercise by states -- is kind of the lack of methodological uniformity across the states. It

seems the states can use a variety of methods for measuring access. So what we're going to get, at the end of three years, is, you know, 50 different reports on access, which will impair our ability to make any comparisons across states.

So I know that CMS has hired a TA contractor to provide the review of these plans and provide technical assistance. I think that on an ongoing basis we should kind of monitor how this is going on. And I also agree with Toby, like, is this really a worthy -- I mean, if we don't get good data at the end of the day, why, you know, invest all these resources in doing this?

So I just think that's something that we are well-positioned to comment on.

CHAIR ROSENBAUM: Stacey.

COMMISSIONER LAMPKIN: In the similar vein of the effort it takes to put this together, I was a little surprised to hear -- I think I'm remember only two states were exempt from providing the plan. And so it made me curious about how we and the rule thinks about populations that are not eligible for full Medicaid benefits -- family planning, waiver enrollees, medically needy populations,

participants in Medicare savings plans that aren't eligible for full Medicaid benefits. Do they -- are they treated as recipients receiving fee-for-service, where this kind of access is part of the dynamic? How does that work?

I just wonder if this is where, you know, given the states' limited resources, is this really where we get a big bang for the buck from states that have mostly gone to managed care, even for long-term services and supports? It surprises me only two states were exempt.

So can you comment on how we think about -- are those the smaller idiosyncratic populations that you were referring to?

MS. HEBERLEIN: Some of the states that voiced concerns about, like, not very many people being left in their fee-for-service programs, some of it was emergency Medicaid, so services only for individuals receiving only emergency services, and then other states called out their Native American populations. And so I think it depends greatly on the state who remains in their fee-for-service program, but those are two that come to mind for me.

COMMISSIONER LAMPKIN: Were there particular standards for qualifying for an exemption for this, with

respect to the kinds of populations and services?

MS. HEBERLEIN: So we asked -- in the proposed rule, I believe, CMS asked for comment on whether there should be a standard for states to be exempt, and they did not put an exemption policy out in the final rule. I don't think that they could come to -- I don't think they found a standard for which they were comfortable. That's my assumption.

So what they said -- the two states that were exempt were Vermont and Tennessee, and they were told that because they had 100 percent in managed care that they did not need to submit a plan. So the standard was 100 percent.

CHAIR ROSENBAUM: Marsha.

VICE CHAIR GOLD: Yeah. This is an important area that I've done a fair amount of work. I think most of the work that's been done traditionally in Medicaid is focused more on managed care, but this is fee-for-service, and I think, actually, CMS has been looking at how to bridge -- bring the two together. I think that's something we talked about.

There's an area that I think this -- two points I

wanted to make. One is that there really only are a certain number of sources of data that you can use for these things. I mean, most of the time they're either from claims, they're from the equivalent of CAHPS, so a beneficiary survey, or they're from complaints. And there may be a couple others I missed, like you can look at prenatal care with the birth certificates, or something like that.

So I think there really is a methods issue, and there's really, potentially, valuable to put the populations together with the data sources. Because I was really struck by the state small numbers issue. I mean, most of the analysis tends to focus on the generic kids and adults, and you have enough numbers there, you can use those sources. When you get to, you know, people with intellectual disabilities, or mental health disturbances, or other things, it becomes much tougher, because they're smaller numbers, you can't afford, often, to survey them, or maybe you can in some states; it depends. And they're harder people to get information on, and there aren't enough in the claims.

And I'm wondering if we can -- and that's

probably where a lot of the burden is on states. I mean, it seems like one could come up with a more uniform, national way of looking generally at access from data that exists at federal levels or in most states, but some of these subpopulations are harder to get at.

And I wonder if there's a role we can play in sort of making that distinction, and if there's a way to look at states that do more on some of the small numbers things, figure out what the alternatives are. I don't know if you just get a focus group, periodically, of parents, or of people or caregivers with some of these populations and talk to them, or what is there a way, because I don't know that, other than through claims, there's enough -- you know, there are some real challenges and it can get really difficult for the states, and I'm not sure that's been appreciated enough in some of this, and we could potentially help.

CHAIR ROSENBAUM: Well, I'm going to move to Sharon, Chuck, Penny, Andy, Norma. There is -- which I don't think has come out fully, but would -- a long history here as to how we backed ourselves into basically this particular cut on access, which might be worth talking

about -- not right this second, but a little bit.

And I do want to interject for people, given our high degree of interest in this topic, and we're going to hear more this afternoon, and of course that the A does stand for Access, whether we want to think about a chapter in the March report that pulls together the access work and the strengths and the limitations of the current monitoring effort.

So I just -- we don't need to stop and do that now, but I want to come back to it.

So, Sharon.

COMMISSIONER CARTE: Well, I'm glad that Marsha mentioned the CAHPS, because to Brian's point about the value of needing, you know, uniformity to be able to draw some conclusions, I know that CAHPS also has fee-for-service versions. So I think if there's, you know, a way to make that more uniform -- I don't know if you had any detail down to that level, of some states were using a CAHPS and fee-for-service.

MS. HEBERLEIN: We did ask whether -- of the states that were using beneficiary services, or beneficiary surveys, we asked what they were using. And so we have

those data, but they're not reported here, so we can pull those together, because we know whether the -- and whether or not they're using HEDIS measures. So we have some of that from the survey.

COMMISSIONER CARTE: I think that would be good if you'd do that, because that would be an important thing to think about.

COMMISSIONER MILLIGAN: I noticed Anne's excitement about the March chapter comments, so that was great.

I actually just have two comments more than a question. Do you mind going to Slide 3, Martha? Yep, I think that's the right direction.

Thank you. So I think my comments, one to each of these two bullets, and I think if we do get to a chapter, this is some of the flavor I would hope would be included contextually, okay?

So my first comment is about that first bullet, which is the goal of a lot of this was to ensure that Medicaid participation meant access to a network comparable to general public or -- the language in the statute is a little cleaner than that, but it's -- but I don't know what

that means anymore, comparable to the general public. The general public, there's narrow networks, there's a lot of health savings accounts, there's a lot of out-of-pocket, there's a lot of tiering. I think in many ways Medicaid networks are broader than the general public, and I don't know what that benchmark means anymore, because it's such a moving target itself. This language was written in the law when commercial insurance was traditional indemnity, and so I just think that we're comparing ourselves to something t doesn't exist.

COMMISSIONER DOUGLAS: Can I just say --

CHAIR ROSENBAUM: Mic.

COMMISSIONER DOUGLAS: And the population is left in fee-for-service. They aren't in the general -- these are very, very --

COMMISSIONER MILLIGAN: Right.

COMMISSIONER DOUGLAS: -- you know, unique populations.

COMMISSIONER MILLIGAN: Yeah, which gets to some of those small numbers issues we -- there aren't a whole lot of ICF/MR type providers in the commercial insurance.

So I just think that contextually it's worth

noting that there's a standard out there, but it's hard to know what that comparative point is.

My second comment is about the second bullet, and I do think this is -- to me, it's an important contextual place. A lot of the origin of this, of CMS getting very active in this area, was Ninth Circuit decisions Toby knows well having to do with states doing provider rate cuts and litigation about whether that was going to result in providers abandoning the Medicaid program and/or the Medi-Cal program and in a way that would impair access. And CMS in a lot of their briefing in that litigation said, "Federal courts, stay out of it. We got this. We'll make sure that states do the right thing."

And so, contextually, this is a difficult area for CMS to do in terms of oversight, and I think it's going to be an evolving area. I mean, this is in some ways a first cut of where we're going. But I think contextually it's a good thing that CMS is stepping up to the requirements, even if some of them are difficult to manage and the methodologies are hard and what are we talking about, to keep executive branch oversight of this federal-state relationship and to keep it from being something

where court by court across the country would weigh in about that kind of thing.

So I think that's -- anyway, that's my view of kind of the political science here, and I think it's contextually important to the background part of whatever chapter might come out of this. And I'll stop there.

CHAIR ROSENBAUM: Well, and just to complete this thought, because this goes to the third bullet. The third bullet is sort of a reflection of the fact that, to the extent that CMS might have wanted to start with a minimum data set of standardized measures that all states would collect around populations, customized to the populations who were likely to be in fee-for-service, that was also seen as, you know, sort of a bridge too far. So now in some ways we're seeing the consequences of this whole train of events starting with a strange statutory construct, the results of a rate-setting case in long-term care, and the absence now of standardized measures, and people sort of scratching their heads and saying, "What populations, what services? Is this even useful?"

And so it's a chance for us in the March report not only to present on the results of the survey, but to

think some -- it would, you know, take some work because it's a deeper reflection. But, you know, is this the right construct for going forward in Medicaid?

COMMISSIONER THOMPSON: Chuck made exactly the points I was going to make, so you can skip me.

CHAIR ROSENBAUM: Oh, okay.

COMMISSIONER COHEN: I will just pile on and say Sheldon's comments I thought were very wise, as have many others been. It seems like we are in a place where we have a high burden for low value set of sort of data that's being collected, and when I think about the number of people hours that are probably spent in regional offices and at CMS reviewing sometimes even like small changes in payment or other things sort of up front to sort of imagine what the consequences would be and then think about the amount of resources that are spent by CMS in monitoring what the actual consequences are, it's just completely disproportionate.

So I am with Sheldon. This strikes me as something amenable to a federal resource solution, at least to sort of build a framework for states to do something in a standardized way.

COMMISSIONER MARTINEZ ROGERS: I'm not going to repeat what she said, but just echo what she said, and I was going to actually address the very same issue.

COMMISSIONER CRUZ: I am going to pile on that, because I think this is a really very important issue. I agree with Sheldon and Brian. But one of the problems with this is the measurement of access. I spent most of my academic career trying to measure this, looking at everything from availability of providers to race, ethnicity, acculturation, income, and it's a very sort of diffuse and difficult issue to access. And I was wondering and suggesting it could be a great contribution -- and I believe we actually discussed this in one of the meetings last year -- from MACPAC to actually sort of -- utilizing the analytical and intellectual powerhouse, to sort of suggest measures of standardizations and measurement -- standardization of measurements. That's what I wanted to say. And sort of suggest to the federal government how to do this and define what access is. I mean, we really have such a diffuse notion of what access is to care, and it depends on the providers and the populations we measured. We can narrow it to the population that Medicaid serves,

but I think it would be really a very sort of important contribution to the field and to the issue of access to care in this country.

CHAIR ROSENBAUM: And just to remind people, our earliest reports actually dealt with this issue, so we have kind of come full circle and the time to come back to these issues.

COMMISSIONER GORTON: So I think dealing with this in a March report makes sense, but it's probably a March of '18 report so that we have the time to do the work properly before we get out in front of ourselves, since I heard earlier today that the March report has to be pretty much in its final form in January, and last I checked that's only three weeks away.

EXECUTIVE DIRECTOR SCHWARTZ: Well, we can bring a descriptive chapter in January, and you can decide whether you want it or not. You are absolutely correct that you are not prepared to make recommendations in January.

[Laughter.]

COMMISSIONER GORTON: So I just wanted to say that.

The second point that I wanted to make is I think we need to be careful here in terms of our charge to be an evidence-driven advisory body, not to be making a whole bunch of unstated normative assumptions, such as anything that can be measured should be measured and there is some right way to do this, because I don't think there's any body of evidence that shows either of those two things. And in terms of anything that can be measured should be measured, at what cost? And what is the opportunity cost of paying for that as opposed to paying for something else?

So I do think that we have a responsibility to, if we're going to write about this, pose some of those questions so that people can think about them, and then we could choose to make a normative recommendation if we want. I'm not opposed to that, but we ought to label it as such.

And under the normative recommendation, while I would hate to miss an opportunity to recommend federalizing yet another segment of this program, it seems to me that if we accept at least the potential that there might be more than one right way to do this and that set of right ways might, in fact, vary across state contexts, you know, it's one thing to say if you're going to count noses, then count

noses; if you're going to count belly buttons, count belly buttons. But it's quite another to say you have to count this color belly buttons and code it in that way and add it up in this way and produce these kind of reports and here's what we're going to do with them. So it strikes me that we need to have some circumspection about going full tilt down, you know, a national database and whatever else.

And that leads me to the last piece, which is there is a potential solution to this, but -- and this is something that could be reasonably federalized -- it would also deal with the provider directory accuracy problems that we are going to try to address, again, through the rule, and that is, if some one body would collect the information on all the providers and put it in one place and the providers could update that one database in a reasonable way, then we could all go and count noses and belly buttons, and we would be able to figure out whether everybody in Tuscaloosa County had access to the same number of people or not.

And so as long as we're dependent on individual health plans trying to be one of 15 parties knocking on a provider's door saying, "By the way, you haven't updated

your panel listing in the last three years," we're not going to solve this problem, let alone get to the place of how close are you to public transportation, are you able to provide services to people with significant physical disabilities, what cultural and ethnic capabilities do you bring to the table, blah, blah, blah, blah, blah. And those are all important things, but we simply can't do them under the current construct, and certainly state administrative budgets are not crafted to be able to do that.

COMMISSIONER WEIL: I share the concerns expressed about administrative burden and particularly the shrinking fee-for-service program and also the difficulty of what is comparable access, as Chuck mentioned. But I do want us to be careful here. This is a new enterprise, and I'm thinking about the evolution of the adult and child quality measures where, far from perfect process, but as I recall the process, it began with AHRQ taking measures that were currently in existence, in use in states, creating a subset from that, then building an infrastructure to try to expand measure where they weren't being used, gradual increase of voluntary use by states, and I don't remember

when that started, but we must be in year seven or so by now. And this is brand-new.

So before we say high investment, low yield, and some people interpret that as, therefore, don't do it, I'd like us to pause and say big investment, low yield so far, probably needs some narrowing somewhere down the road. Our job is to try to figure out when that point is, but I don't think we know yet what it is. And I just didn't want to overinterpret the concerns about administrative burden.

VICE CHAIR GOLD: Kit, I'm going to have to disagree with you on one thing, because I am evidence-based, and I'm not -- I think it is up in the air what we do nationally, what we shouldn't do. I have been studying access since I think I wrote an article on it in 1970 or 1975. There's a whole research literature on access. The measures aren't perfect, but they're actually further along than the quality measures, and there are some basic measures. They don't get to these small-number populations at all, which is part of the issue. And even getting to a state level with some of them is hard. But we do have data in the National Expenditure Survey on a national level. National Health Interview Survey has some data. And it was

temporarily expanded to give some states. Some states have some data. I've done a lot with California in looking at access. There's been a whole lot of work on preventable hospitalizations.

So I don't think we have the answer to how to deal with this, but I don't want to leave the impression that we're going into a new area that no one has talked about before, because, in fact, it was more heavily studied than quality for many years.

CHAIR ROSENBAUM: Can I ask one really narrow question as opposed to sort of the higher-level, broadly scoped discussion we've been having, which has been really important? Can you tell me who the pregnant women are? I mean, there may be some states that carve pregnancy out of managed care or would be women with disabilities who become pregnant or in a state with a medically needy program, we have some spend-down women. But to me, this -- the reason I'm asking is it's sort of emblematic of the problem here, which is figure -- I mean, a lot of the people we're talking about are people getting all kinds of long-term services and supports. Those were, by and large, the Douglas people, the Armstrong people. They are sort of

outside the purview of the typical managed care plan.

And so I'm wondering if we could even sort of use the pregnancy population as an example of the fact that you are, in this approach to access monitoring, capturing a narrow slice of a much bigger issue. I wouldn't know what to make out of the pregnancy data here because I assume that in most states now, most births happen to people enrolled in managed care. But I could be completely wrong.

COMMISSIONER DOUGLAS: Well, I can say in California actually it's about 50-50, because you have -- remember, you've got a lot of undocumented immigrants who receive pregnancy-only benefits and are not enrolled in managed care.

CHAIR ROSENBAUM: Right. Is it state funded or just the emergency slice?

COMMISSIONER DOUGLAS: Pregnancy, it's, you know -- you know, from CHIP it's funded. So most of it is funded through --

CHAIR ROSENBAUM: And they would be getting care -- women who fall into that category also would be quite unique in their characteristics and would be getting care at very selected places, presumably.

COMMISSIONER DOUGLAS: Yeah. And the other issue is the transition time.

CHAIR ROSENBAUM: Yeah.

COMMISSIONER DOUGLAS: So a lot of women get on to Medicaid because of their pregnancy. It takes awhile to transition into managed care.

CHAIR ROSENBAUM: Right.

COMMISSIONER DOUGLAS: So by the time that they transition into managed care, they might be in their third trimester.

CHAIR ROSENBAUM: And that goes to this point of can you -- I mean, what you can tell by scoping out the pregnancy group in here is quite a unique set of access issues because of the unique characteristics of this population rather than general statements about access for women who are members of plans, become pregnant, who are sort of the counterpart to those of us with, say, employment-based coverage who are members of plans and become pregnant. And so I just think it sort of offers an example of --

VICE CHAIR GOLD: It's an odd example, though, because it uses --

CHAIR ROSENBAUM: Well, no, but that's --

VICE CHAIR GOLD: -- birth certificates. You can go back to some of the birth certificate data and look at the prenatal care those women had.

CHAIR ROSENBAUM: No -- right, but that's not my question. The point is that when you -- that our access construct, as we've sort of backed into it, is a construct about -- not about the broad general population often. It's a construct about very important subgroups of beneficiaries that may be extremely important to follow through on. But I'm not sure that I could draw any inferences about access among pregnant women from the fee-for-service access barriers of these particular subgroups of pregnant women.

And so, I mean, echoing Kit's point and the point that Toby made and knowing sort of the etiology of this particular set of rules, as Chuck and Penny have pointed out, I just think we ought to be forthright in whatever we say to Congress about the limitations of what we can infer here. And pregnancy does offer the chance to illustrate the challenge. So that's the only point I wanted to make.

All right. We are way over on time for this

session, but this has been great, I think a really important discussion, so let's move on to transportation.

USE OF NON-EMERGENCY MEDICAL TRANSPORTATION

* MS. BLOM: Good afternoon, Commissioners. Today, I am going to talk about non-emergency Medical transportation.

This is a required benefit in Medicaid. I am going to go through the financing, benefit structure, and delivery models. I'll review also two analyses, which Amy mentioned. The first is an analysis of utilization and spending that we did using MSIS calendar year 2012 data, and then we're going to look at two case studies that a contractor did for us looking at NEMT utilization in Indiana and Vermont. I'll also touch on policy issues relevant to NEMT, including program integrity, state efforts to waive the benefit for the new adult group, and the possible future role of new transportation technologies in providing these services to Medicaid beneficiaries.

NEMT is a required Medicaid benefit found in regulations, where states are required to ensure necessary transportation for beneficiaries to and from providers.

Generally, federal and state rules require that

states use an appropriate form of transportation, that NEMT providers have a Medicaid contract with the state, that the beneficiary be in the vehicle, and that the beneficiary be taken to an appropriate location.

This benefit is designed to remove transportation barriers to accessing care by providing transportation to and from medical appointments for Medicaid beneficiaries who have no other means of transportation.

A lack of transportation can limit access to care, especially for the aged and the disabled and people with chronic conditions who may not have the ability to provide or purchase their own transportation.

Common barriers to transportation include things like not having a valid driver's license and not being able to travel alone.

As Amy also mentioned, MACPAC has found that Medicaid and CHIP beneficiaries are more likely to delay care because of transportation than people with private coverage, and you can find statistics on that in our most recent issue of MACStats. For children, we found that about 4 percent of children in Medicaid and CHIP delay care, compared to about 1 percent with private coverage.

And there's a similar differential for adults. About 6 percent of adults on Medicaid delay care, compared to about 1 percent with private coverage.

In terms of federal financing, states can choose to claim reimbursement from the federal government for NEMT spending, either as an administrative expense or as a medical assistance expense. The federal medical assistance percentage, or FMAP, differs depending on how states choose to report the spending.

For administrative expenses, the FMAP is capped at 50 percent in statute, but for medical assistance expenses, states receive their regular FMAP, which as you know ranges from 50 percent to about 74 percent, depending on the state.

Generally, also, if a state claims spending as a medical assistance expense, any Medicaid spending, then that spending is subject to additional Medicaid guidelines, such as the requirement that beneficiaries have their free choice of available providers.

The structure of the NEMT benefit varies by state, per usual in Medicaid, but generally includes a broad range of transportation services, including services

in taxis, buses, public transportation, or personal vehicles.

States may charge nominal copayments. In 2012, five states charged copayments from about $1 to $4, or they may limit the number of trips that they'll pay for in a given month or year.

In terms of delivery models, there are several delivery models that states can use, but the most common is the brokerage model. This was established as a state option in the Deficit Reduction Act of 2005, and as of calendar year 2013, 39 states were using this model.

Under a brokerage model, a state contracts with a transportation broker who manages the benefit, including arranging the trip, scheduling the trips. Generally, the broker then contracts with local providers to provide the trips. States must choose the broker through a competitive bidding process.

The DRA option allows states to claim NEMT spending as a medical assistance expense without being subject to the additional Medicaid guidelines, such as the free choice of providers. This enables states to receive their reimbursement for the NEMT spending at their regular

FMAP, which can be much higher than the admin FMAP.

Other delivery models that states may use include fee-for-service, where states or a local authority will arrange for the services directly and pay for them directly, or managed care, where states could include the NEMT benefit in their managed care contract. Also, of course, states can use a combination of any of these models.

Some states also coordinate with other programs to provide the NEMT benefit. For example, the state of Maryland provides grants to local health departments who provide NEMT trips.

Our MSIS analysis, again, as I said, we used calendar year 2012 MSIS data to analyze utilization and spending in the benefits, but as with any analysis that is using claims data, we had to make choices to address the limitations of that data, which included limiting spending to fee-for-service because of problems with the completeness of the encounter data.

It's difficult to identify all NEMT services in MSIS because of variations in how states report on this spending, so we established a selection criteria to

identify NEMT-related claims. There's more detail on this in the methodology section of the paper that's in your binders.

Also, I should note that the ACA expansion population, the new adult group, is not included in this analysis since we are looking at 2012 data.

Our analysis identified about 1.8 million Medicaid beneficiaries who used NEMT during calendar year 2012. An NEMT user is defined as a person who had at least one NEMT claim. We found that about two-thirds of Medicaid NEMT users were either disabled or aged, and about 42 percent were dually eligible for Medicare and Medicaid.

The number of users varies by states, but New York accounted for the highest percentage, with about 21 percent of that 1.8 million, and several states reported fewer than 1 percent of the total, including states such as Utah.

This slide shows the distribution of Medicaid NEMT users by eligibility group for the states in our analysis that had identifiable codes, and here, you can see that two-thirds were aged and disabled. You can see that by far the largest category of users was the disabled at 41

percent.

On the spending side, we found that the federal government and the states spent about $745 million on NEMT services delivered through fee-for-service in calendar year 2012. More than 80 percent of that spending was for services for the disabled and the aged, and about 60 percent was for services for dually eligible beneficiaries.

This slide shows the distribution of that spending across eligibility groups, and you can see the disabled make up about half, and the aged account for about one-third.

As I said, we contracted with Burns and Associates to do case studies in two states. Burns looked at MMIS data for calendar year 2015 in Indiana and Vermont. They looked at the NEMT users who use the benefit the most, defined as people who had 30 or more trips in a calendar year. The case study has allowed us to examine more recent data than was available for our national analysis. Burns and Associates chose these two states because of their data availability and because of the contractor's prior experience working with them on NEMT.

The two states differ in several ways, including

geography. Indiana's population is a mix of urban and rural, and Vermont is largely rural. They also differ in terms of managed care penetration, with Indiana having a mix of managed care and fee-for-service, and Vermont operating under a global waiver, a managed care-like model.

They also differ in terms of their approach to the Medicaid expansion under the ACA, with Vermont expanding under traditional Medicaid and Indiana using an alternative plan, which included a waiver of the NEMT benefit for the new adult group.

Despite the differences between the two states, we found that Medicaid beneficiaries who used NEMT the most in both states were similar. Most were disabled or aged. Very few were children, and behavioral health-related diagnoses were among the top ten most common diagnosis codes on claims for services accessed by those users on the same day as their NEMT trip.

So we can see both in the MSIS analysis that we did for 2012 and in these two state case studies that some of the highest cost and highest need beneficiaries in Medicaid are the primary users of the benefit.

In our research, we identified several policy

issues relevant to NEMT. Program integrity is something that both GAO and the HHS OIG have looked at. GAO considers the NEMT benefit to be at risk for fraud and abuse related to enrolling providers and verifying beneficiary eligibility. For example, GAO heard from state officials about trouble verifying beneficiary eligibility for Medicaid and about verifying their need for NEMT services.

States also told GAO that they had trouble verifying that the trips were actually to medically needed services. For example, pharmacies at Target or Walmart, stores which also sell non-health-related products, were destinations for multiple trips to pick up prescriptions, even though those prescriptions could potentially have been picked up in a single trip.

The HHS OIG also considers NEMT vulnerable to fraud. In a series of state audits, which it began in 2006, the OIG found inadequate oversight and improper payments for trips because claims for services did not comply with state and federal requirements. In some cases, that led the OIG to recommend that states refund dollars to the federal government.

For example, in a March 2015 audit of California's NEMT program, the OIG recommended a refund of just over $400,000 for services not billed at the lowest cost type of medical transportation adequate for the beneficiary's needs, which is a state requirement.

Recently, states have sought to waive NEMT for the new adult group. Indiana and Iowa received approval from CMS to waive the benefit for that group. Their waivers are designed to align their coverage for new adults with coverage available on the private market, which would not generally include a transportation benefit.

Both states evaluate the impacts of their waivers on access to care. Indiana contracted with the Lewin Group, which found no significant impact on access to care, and concluded that similar transportation problems can occur regardless of access to the benefit. However, concerns were raised about the scope of the Lewin evaluation, with some suggesting that it was too narrow because it focused only on missed appointments and did not take into account the failure to schedule an appointment because of a lack of transportation. A separate evaluation is planned for Indiana.

The results of Iowa's evaluation have been mixed, with results actually showing a greater unmet transportation need among beneficiaries with access to NEMT. However, researchers have noted that those results could be premature without knowing more about why the beneficiaries had an unmet transportation need. That evaluation is ongoing as new data becomes available.

Other states have also taken action on the NEMT benefit. Arizona and Kentucky have both applied to waive it for the new adult group. Arkansas established a prior authorization requirement for NEMT, for the new adult group, and waived the benefit entirely for new adults receiving ESI premium assistance who had not demonstrated a need for services.

My last bullet on new technologies. So states have begun experimenting with services such as Lyft and Uber to provide transportation to Medicaid beneficiaries. For example, in New York City, some Medicaid beneficiaries are getting transportation services through Lyft. The emphasis of these experiments appears to be on improving beneficiary experience and lowering costs, but it's very early. It's too early to evaluate the results, but it's

something we plan to keep our eye on.

So, with that, I am happy to take questions.

CHAIR ROSENBAUM: Can I just ask a question? I am the opposite of Stacey. When I see numbers, I go crazy. 1.8 million people, and we spent $745 million?

MS. BLOM: And the 745 is an incomplete number because it only includes fee-for-service.

CHAIR ROSENBAUM: So do we know something about the mode of transportation or the nature of transportation? I mean, I'm assuming, given the demographics of who is using the service, that there are a lot of people who need very special forms of transportation, of course, and I would be the first to confess I have no sense at all of what the cost would be for that kind of transportation. But it does seem like an inordinately large number. So do we know more behind that number, other than the characteristics of the patients?

MS. BLOM: We don't know a lot, but we do know that the transportation that this population uses is expensive. Paratransit services are quite expensive.

CHAIR ROSENBAUM: Very.

MS. BLOM: I think one study recently found some

cities to have charge of like $50 per ride.

CHAIR ROSENBAUM: It might help in our work to be able to give people a flavor of this --

MS. BLOM: Yeah.

CHAIR ROSENBAUM: -- because it's such a huge number for such a small group that you really want to convey to people that we're not talking about sending a normal taxi.

MS. BLOM: Right, right.

CHAIR ROSENBAUM: Sorry. So I was just struck by that.

Questions? Comments?

Yes, Penny.

COMMISSIONER THOMPSON: Can I just ask the question about the five states where we didn't seem to find any MSIS claims related to NEMT? And I'm presuming that they don't have NEMT waivers.

MS. BLOM: Right. They don't.

COMMISSIONER THOMPSON: Did we call them and say where are your NEMT claims?

MS. BLOM: We did not call them. So that occurred because of our selection criteria. So lots of

states have state-specific codes for NEMT that are difficult to identify, or they put their NEMT claims into unknown codes. So we did our best to come up with a logic to try to pull in as many as possible, but we did end up with five missing. But that is something that we could do.

DR. BERNSTEIN: Well, and some of them don't have claims. They just give money to another organization, like a public health department, so they're not submitting claims. They're just paying, you know, Maryland public health department to provide the transportation, and then they don't get claims back.

COMMISSIONER THOMPSON: Which is another issue.

CHAIR ROSENBAUM: Yes.

COMMISSIONER THOMPSON: Those kind of ledger-based programs, but okay. So it would just be helpful if we could explain this a little bit. If it's a local code, it seems like it's the kind of thing that we could just find out, and if they're using the ledger system, that would be helpful to know too.

CHAIR ROSENBAUM: Toby.

COMMISSIONER DOUGLAS: I was just going to say on the last point, on the technologies, I would say that we

should view -- it intersects back with the program integrity too, at least from a plan perspective as well as a state. It's not just about the consumer experience but about the accountability.

Part of the problem with NEMT is it's so -- there's no transparency into the timeliness, the accuracy, whether trips actually happened. To the extent that you can create use, you know, an Uber-like platform for technology, to really have that visibility into those types of metrics, it's really going to improve.

And then I think the only other piece is there is a lot of inconsistency across states as well as municipalities on just the types of transit, of what can be used. So there might be more efficiency of using, again, Uber-like transportation, but it's not allowed for certain types of populations.

I don't know it really well, but I think that's another piece we need just to explore. There needs to be more work on that.

CHAIR ROSENBAUM: Stacey.

COMMISSIONER LAMPKIN: Just if we are thinking of prepping this and particularly fee-for-service analysis for

publication and you haven't already, is there some way to do a little cross-validation against CMS 64 expenditures at the state level to understand the completeness or incompleteness to help put some parameters around --

MS. BLOM: Yeah. We can look into that. This was a little bit tricky because of the variation in the coding. It's just all over the place, but yeah, that's a good idea.

CHAIR ROSENBAUM: All right. I think we are up to our last segment of the day. Amy, take it away.

POTENTIALLY PREVENTABLE EVENTS: COMPARING MEDICAID AND PRIVATELY INSURED POPULATIONS

* DR. BERNSTEIN: I'm back. Hello again.

So you've seen sort of two different perspectives, a state monitoring perspective and specific service. Now I am going to present an analysis that actually compares Medicaid utilization and outcomes to private utilization and possibly outcomes, depending on how you want to count utilization.

So, as I said earlier, we're going to talk about potentially preventable events, as defined in the software developed by the 3M corporation. Potentially preventable

events are health care services that might have been avoided had better care been provided to them. So it could be care that was improperly provided in a hospital, thus, necessitating a hospital readmission, or it could have been ambulatory care that could have been provided prior to a hospital admission at all or a hospital emergency department visit, so that that visit would have been prevented.

Studies have found that a significant portion of health care use may be attributed to potentially preventable events or sometimes called unnecessary care, and for example, a study in Minnesota that used this 3M potentially preventable event methodology found that in 2012, Minnesotans experienced an estimated 1.3 million potentially preventable health care events accounting for approximately $1.9 billion in costs and 4.8 percent of their total health care expenditures in that state, just one study but an example.

So it can be useful to look at these events for several reasons, including comparing rates among populations or across populations, such as children or persons with disabilities, to see if rates are higher in

some populations than others, or comparing these rates across payers or diagnoses, to see if there were certain diagnoses that warrant further intervention, or groups that further research should be done to see, you know, sort of what the issue was that was causing these high rates.

I should note here that just because an event, that we identify from administrative or claims data, is designated as potentially preventable, doesn't mean it was absolutely preventable and could, you know, definitely have been prevented. I mean, we have the information that we have from the claims, and administrative data. It could well be that more information is required to know if this was really a, you know, crucial event that could have been prevented, and often, as we saw in our emergency department analysis that we did several years ago, a lot of these events are due to the fact that the patients couldn't receive care in the ambulatory setting, and therefore they were admitted. Now, that could be called potentially preventable, but the emphasis there is on the "potentially."

COMMISSIONER GORTON: Can I just jump in on that methodological piece, please, because it's important that

people understand that when 3M built this tool it was designed to look at a population level. Right? So we're not talking about Mr. Jones ended up in the emergency room.

DR. BERNSTEIN: Right.

COMMISSIONER GORTON: We're talking about rates across the population. And so the tool knows that it's talking about administrative data which are incomplete and which don't contain, for example, any information about social determinants and what supports people have, and that sort of thing. And if you study this -- this is one of the few places I ever did any research -- if you study this -- I don't do it anymore so I must not have been very good at it -- but if you study this, what you know is that whatever the number is, you can't eliminate more than probably about 30 percent of it.

So when you -- when a managed care company puts together an intervention to try and limit preventable events, you're trying to cut it by 30 percent, not to take it down to zero. So I think it's important that people have that context.

VICE CHAIR GOLD: Thank you, Kit. That's correct. Sara had to go out for a few minutes so I'll be

moderating this. Yeah, go ahead.

DR. BERNSTEIN: So, that said -- and thank you for clarifying that further -- there are several states that are using this methodology in their administrative data, both their Medicaid populations and in their all-payer state databases.

So today I'm going to present our analysis which compares, as I said, rates of three potentially preventable events.

So we contracted with both the Urban Institute and Truven Health Analytics, separately, because we wanted to see -- well, anyhow, I'll go on -- to compute these rates. We contracted with Urban to compute rates for the Medicaid population, using MAX data, which I'll talk about in a minute, and we contracted with Truven to look at the same measures, using the same methodology, and this allows us to compare these rates, and as I mentioned earlier, due to the size of these databases, which were huge, especially using this complicated software, this is one of the first analyses that actually compare these rates for the privately insured and Medicaid populations.

So getting to the methodology. For -- the Urban

Institute used 2011 data for 32 states that had Medicaid fee-for-service data that were -- we considered good enough to use for the analysis. We did not use encounter data because, as has been mentioned several times, there weren't enough states that had complete enough encounter data to be able to be used. Truven used its 2011 MarketScan database, which captures about 30 percent of privately insured people in the country, with private, sometimes called commercial insurance, for the same 32 states.

For both populations, both the Medicaid and the private populations, we excluded enrollees aged 65 and older, because most of them have Medicare, and if we're looking at hospitalizations, most of them are paid under Medicare, and we were looking at Medicaid data on the MAX side, so that would not have been good. We excluded dual eligibles for the same reason. We also excluded people with nursing home care, partially because of resources constraints. We would've had to go to the institutional file, and also those people have a different health profile, and there are more of them in the Medicaid population, so we just chose to exclude them from both groups.

We also excluded Medicaid enrollees who had limited benefits, such as contraception only, because their hospitalizations and emergency room visits would not have been covered.

So starting with PPRs, potentially preventable hospital readmissions. These are readmissions that have been judged by experts to be potentially unnecessary because they could have resulted from poor quality care received during the initial admission, or inadequate discharge planning or post-discharge follow-up, or poor care coordination among providers -- in short, things that happened that reflected poor care that resulted in a readmission that should not have happened.

So to compute this measure, all admissions were classified by their admission type, if they were an only admission or readmission or a transfer admission, and then chains were created of related readmissions. And there's more about this in your methods section. There's a big matrix, but basically we computed -- the contractors computed; I didn't compute anything -- readmission chains.

The readmission chains were then sort of classified as to whether they had a potentially preventable

readmission in them, and then rates of readmission chains over total candidate admissions were created.

For potentially -- oops, sorry.

Potentially preventable readmissions, as well as potentially preventable emergency department visits, which I'll talk about in a minute, are determined primarily based on the presence of ambulatory sensitive conditions that could have been prevented with better ambulatory care. So what was done was we used claims data prior to the admission to classify the enrollees into a health status, and then when they have a hospital admission, that admission is classified based on its DRG as to whether it could be considered preventable or not. So these admissions are largely determined based on the diagnosis that are associated with the admission, based on expert input and sort of whether they were considered to be an ambulatory sensitive condition or not. And there's a big methodology that, again, I can't go into now.

For emergency department visits, similarly, these are visits that experts believe could have been prevented if there had been better ambulatory care. Again, the patients are classified into groups based on their past

use, and again, it's the diagnoses associated with the visit that determines whether it was preventable or not, within these groups that are created.

So for -- in -- basically, there's something, based on these outpatient groups. So in about 36 of all of the 553 possible groups, called EAPGs, all of the visits would have been considered preventable. So, for example, all asthma visits might be considered potentially preventable, even if they're not. In most of the groups, none of the groups were considered potentially preventable, and in 188 of the groups, the ED visit may or may not have been classified as preventable, based on the primary diagnosis of that particular visit, within that particular group. So again, the preventableness is determined largely by the diagnoses.

So for potentially preventable hospital readmissions, first of all, for children, the rates didn't differ much when comparing Medicaid and privately insured enrollees. For adults, Medicaid had higher rates, but this seemed to be driven largely among adults who qualified for Medicaid on the basis of a disability. About 13 percent of disabled adults, or those who qualified on the basis of a

disability, had a potentially preventable hospital readmission, compared to only 4 percent of those who qualified through some other pathway. Also among adults on Medicaid, younger beneficiaries had lower rates than the older ones, but this difference was much smaller among the privately insured group.

The 3M software, as I said, also allows us to group PPRs based on the major reasons that caused the readmission, again, based on expert judgment of the clinical relationship between the initial admission and the readmission. Adults with Medicaid coverage are more likely to have readmissions associated with the condition -- associated with their first admission than are privately insured adults. So it's sort of -- think about it as it's more the condition that they had. On the other hand, privately insured adults are more likely to have had readmissions associated with the care provided during their initial hospitalization, such as a surgical complication.

Medicaid enrollees were also more likely to have had a readmission associated with diagnosis of ambulatory-sensitive conditions in their initial admission, and with behavioral health problems than were privately insured

adults. So I said that quickly but I hope it was understandable.

Moving to potentially preventable hospital admissions. So this is people who are admitted to the hospital where the condition might have been better treated before they would have had their admission. Potentially preventable -- well, okay. I just said that. About one-third of these admissions, for children, both for those with Medicaid and private coverage, were considered preventable. Children who qualified on the basis of a disability had similar rates as to those who didn't, but among adults those who qualified on the basis of a disability had higher disability rates.

People with significant health conditions can also be expected to have higher health care use, and people with complex chronic conditions may require hospitalization more than healthier individuals, which may be associated with more preventable admissions. In addition, the privately insured and Medicaid populations may have different underlying health status, as we know from other sources, which can affect their hospital use. So we attempted to control for underlying health status, using

the enrollees' past utilization and diagnosis history, as I discussed earlier.

Among children, the preventable hospitalization rates don't vary much based on health status, with the exception of children who have dominant chronic conditions in three or more organ systems, that is, children with very complex medical conditions. Among adults, the reverse is true, with more potentially preventable hospitalizations among less-healthy enrollees. Privately insured enrollees have more potentially preventable admissions in the healthier groups, while Medicaid enrollees have more potentially preventable admissions in the less-healthy groups.

We also looked at the major diagnoses associated with potentially preventable admissions. The PPA diagnosis for adults with Medicaid coverage were higher for chronic obstructive pulmonary disease, or COPD, and diabetes, compared to privately insured adults. PPA rates were also higher for sickle cell anemia crisis for adults with Medicaid. Asthma is the top diagnosis associated with PPAs for both Medicaid and privately insured children, although Medicaid-enrolled children had a greater percentage of

their visits for this diagnosis.

Moving to potentially preventable -- I'm starting to trip on this -- PPVs. Moving to emergency department visits. I'm not going to say potentially preventable every time.

So as we've seen in other studies, including a Commission panel in 2014, Medicaid enrollees have higher emergency department visit rates, in general. Medicaid enrollees have higher rates than privately insured enrollees, and we see this for potentially preventable ED visits as well. For both children and adults, most emergency room visits are considered preventable, and rates are higher for Medicaid populations than for privately insured individuals, and the rates do not vary much by age or disability status.

Medicaid enrollees also have higher potentially preventable emergency department visit rates, as I said, for health status, and Medicaid enrollees classified as healthy have the same visit rates as those with serious health conditions. The most common emergency department rates among both privately insured and Medicaid-covered children were upper respiratory infections, but Medicaid

rates were higher than for privately insured children. Medicaid-covered children were also more likely to have ED visits for upper respiratory infections than those with private coverage. They were also slightly more likely to have a visit for non-bacterial gastroenteritis, nausea, and vomiting. Privately insured children were more likely to have visits for musculoskeletal conditions and split strapping or a cast removal.

Among adults, respiratory infections comprised the largest share of potentially preventable emergency department visits, for the Medicaid population. For privately insured adults, the most common diagnosis was abdominal pain. The percentages of visits for other diagnoses were similar between the insurance groups. It's just that the Medicaid population had more of them.

Although they aren't perfect measures of either access or quality, the methodology and measures used in this analysis rely on accessible administrative data that can be used to provide a general picture of how Medicaid and privately insured populations compare for these three measures. As I said before, states are increasingly using this methodology to look at their populations, and MACPAC

will continue to sort of watch what states are doing.

As Medicaid data become more complete, as T-MSIS comes in, as encounter data are better, we also might be able to sort of replicate this analysis using more complete samples or more recent data.

And with that I will end, and I'm happy to take any of your questions.

VICE CHAIR GOLD: Thanks, Amy. Very interesting analysis.

Who wants to go. Toby, is that you? And Sheldon. You can duke it out.

COMMISSIONER DOUGLAS: Yeah, really --

VICE CHAIR GOLD: Kit.

COMMISSIONER DOUGLAS: -- interesting analysis.

My first question, Amy, to make sure, I just want to know if I got -- summarized it right. For both the PPRs and the PPAs, is it fair to say, in general, for kids, it's very similar, Medicaid and commercial. For adults, it's really disability that drives it, and a lot seems to be around, you know, the complex chronic conditions. And then for emergency departments there is a difference for both.

So the one question is, you know, what

intervention -- just going to the next step besides the analysis and models -- it goes to me to questions about kind of what interventions are needed for the Medicaid population in those two areas. Like disability, it seems to be more around care management, and not necessarily that they're inappropriately going in or there's inappropriate readmissions, but just the complexity of the population. And then on the emergency department, are there analyses we could look at the access points near emergency -- is the reason there's higher rates is because of lack of access to -- whether it's to urgent clinic or to other access points?

So -- I'm not being clear. One is just I think that we need to acknowledge kind of policy interventions that might be needed to reduce rates on both fronts for the Medicaid population, and they're different, one being more types of complex care management, on the other is analyzing and then determining if there were better access points would that reduce emergency room admissions.

So I'll be quiet.

VICE CHAIR GOLD: Amy, do you have -- you wanted to say anything in relation to that?

DR. BERNSTEIN: No, I agree with your summary.

We've looked at emergency department use a lot, and I think, basically, our brief that's on the Web and other literature has showed that Medicaid rates are higher, in part, at least, because of lack of ambulatory and lack of access to care that would have kept them out of the emergency department. I mean, that -- we had a panel on it and we've had other research summarize that says that. What you do about that, you know, that, I think, is where we identify the problem and the states and Medicaid programs and others have to come up with some way to get access to those services.

So I'm not sure -- I mean, if you have suggestions for what we could do on that, that would be helpful.

VICE CHAIR GOLD: And I think part of what Toby was suggesting, I think, Amy, is when we write it up, think ahead as to sort of the bottom line of what we think it says and what it might mean, and, you know, just that these related to the implications a little. Right? Is that -- do I have you right?

COMMISSIONER DOUGLAS: Yeah, and then I guess it does get to what are the right roles, both from CMS as well

as the state, to incentive the right access points, and are there levers that need policy levers to really change that behavior. I think -- yeah, I don't have the answer off the top of my head, other than it continues to be a -- ways that both -- and some of this is both, you know, on the incentives in some states, to say that emergency room is a place -- the hospital is doing this, rather, not the state, so, you know, it's just a lot of different factors, and I'll be quiet, because I don't have any easy answer for it, but it's a problem.

VICE CHAIR GOLD: And you may be able to relate it back to some ongoing initiatives that states have underway. I think some of the medical home activity and other care management stuff is -- ideally would improve some of these rates. So there may be some things going on or not.

I think --

COMMISSIONER RETCHIN: Yeah, it's a very interesting effort, Amy. So some of it to me is very salient. I will say getting to some of the comparisons, it was almost like when you're comparing the Medicaid population to the privately insured population for some of

these measures, I worry it's like apples and bowling balls. They're not even both food. So I just --

CHAIR ROSENBAUM: Wait a minute [off microphone].

COMMISSIONER RETCHIN: Well, they're very different populations. So I was --

CHAIR ROSENBAUM: [off microphone] Blazing Saddles.

COMMISSIONER RETCHIN: So I was looking at -- it would be interesting to look at readmission rates as the value-based purchasing program unfolds in Medicare and whether there's a collateral effect. Those rates are incredibly low. Again, that's sort of because you're diluting it with patients who are coming largely obstetrical, so readmissions are -- I mean, we see readmission rates at 13, 14 percent just in general. So that's a very small readmission rate.

I have one question and another comment. One is on, I guess, Slide 14. The finding or conclusion that healthier privately insured adults had more preventable hospital admissions than did adults with Medicaid coverage. What is that? How is that -- am I just misreading that? And those are adults who are also healthy with Medicaid

coverage or --

DR. BERNSTEIN: Okay. Healthy is based on their past use.

COMMISSIONER RETCHIN: Sure. But privately insured adults had more preventable admissions than did I assume the same group of adults with Medicaid coverage?

DR. BERNSTEIN: Yeah, the same group. Like healthy versus --

COMMISSIONER RETCHIN: Healthy versus healthy just -- it's an odd finding.

CHAIR ROSENBAUM: Between healthy, privately insured people have more preventable --

COMMISSIONER RETCHIN: Yeah, it just seems odd to me. And maybe, just maybe it's an indication in Medicaid you have a population that, whatever we want to say, that is largely in managed care are assigned primary care physicians. I think that's a problem because of the access, but maybe it's just working -- I mean, I don't know how else to --

CHAIR ROSENBAUM: What's the year of the data?

DR. BERNSTEIN: 2011.

CHAIR ROSENBAUM: So these are not --

DR. BERNSTEIN: You are talking about hospital admissions? I mean, but it's a small number.

COMMISSIONER RETCHIN: I know.

DR. BERNSTEIN: So it's the distribution --

COMMISSIONER RETCHIN: Good point. Good point.

DR. BERNSTEIN: It's not --

CHAIR ROSENBAUM: There's nobody there [off microphone].

COMMISSIONER RETCHIN: There's nobody there, okay.

DR. BERNSTEIN: Yeah, it's a pretty small --

COMMISSIONER RETCHIN: It's not even bowling balls. Okay. So go to -- I have one other comment, and that is, in the second bullet on Slide 15, emergency room visits, which like Toby I'm not sure what the answer is, but I find this extraordinary -- not so much that 74 percent of the ED visits for Medicaid are considered preventable, but that 63 percent and 67 percent of privately insured are preventable. And it rings true for me as a provider that it's -- it is a rampant problem. I don't understand why people would want to stay -- go to an emergency room and wait six hours for the same care that

they could get by appointment. And you don't see the following when you travel in Europe: I don't think you see freestanding emergency rooms in Europe, and those are proliferating. They are for-profit companies. So I do think that that's a problem not just in the Medicaid population.

So it does get to one thing that we could start to narrow down there, and those are in -- it's not -- there is a problem with access for primary care physicians. There's also a problem for incentives. And I know that that's behind some of the co-pay efforts for emergency rooms, but there may be other ways, vouchers or actually cash incentives for beneficiaries to see primary care physicians.

COMMISSIONER GORTON: So I think it's important work, but it's hard and there's some more to do. It would be interesting to me if it were possible to see some sort of cross-tab kind of analysis with the Dartmouth Atlas stuff and Wennberg's work and colleagues and lots of other people write, this is my one paper, which we wrote about pneumonia admissions for children in Pennsylvania, and, in fact, there's huge small area variation. So from one town

to the next, the admission rates for pneumonia in Pennsylvania varied significantly. The same is true for virtually any type of service that you look at, and that's what the Dartmouth Atlas data underscore. They put it out every year. It's updated. It might be interesting for you to cross-tab this with geographic hot spots and geographic cold spots and see whether or not that's what we're seeing, it clusters geographically. So that was just one thought.

The second thing is I do think you're going to have to talk to the states, similar to the non-emergency transportation piece, about how they're coding for stuff and how they're handling things. For example, Virginia has actively taken this on, and they have an active program. It's driven by regulation. They down-code emergency visits that are viewed by their criteria as being avoidable. They down-code them to triage visits. There's a standard triage rate. That's all they pay. And if all you're looking for is emergency-level visits, you won't see those because, as a matter of payment policy, they're not paying them that way. Many of the plans do that as well.

For the admissions, if you get into encounter data at some point, the plans are pretty regularly

mirroring what CMS does on the Medicare side, which is readmissions -- same condition readmissions within a defined period of time, you don't pay for the second admission. Well, a denied service doesn't make it in the encounter data, so there's no way to -- there's no way for you after the fact to see it. So I think you need to be careful about those things because they will drive -- they could skew your data.

And then the last piece of this, which I mentioned earlier but I just want to underscore, these data, even if you got more sophisticated in terms of risk adjustment, we don't currently capture in any regular disciplined way the social determinant data that you would need to say whether somebody needed this admission or not, right? So a preventable admission, the algorithm says that a diabetic with a toe ulcer that leads to amputation is a preventable admission. If that diabetic is homeless, has a substance abuse problem, by the time he came in the toe was gone, and so you weren't going to prevent that, you couldn't not deliver that care.

And so I think until we begin to build social determinants into the risk adjustment methodologies, which

we're at the very beginnings of, it's going to be difficult to compare across these populations. So when you start comparing employer-sponsored insurance versus government-funded insurance, I think that becomes difficult because social determinants is the major dividing point between the populations.

COMMISSIONER SZILAGYI: Yeah, actually I was going to start with -- first of all, nice, this is really good work. I was going to actually start with Kit's last point. Most of my comments have to do with context and interpretation, especially as this becomes a chapter. So I think it's really important up front to describe that. Even though you mentioned unnecessary care only one time today, potentially preventable admissions or ED visits is not synonymous with unnecessary care, because with exactly the same points that Kit is making, what it means is that in the ideal world you may be able to prevent a proportion of them.

The second point was actually also what Kit was saying. Let me just give you an example of how these aren't apples and bowling balls but they're apples and oranges to some extent. The prevalence, not the visit rate

but the prevalence of asthma is two to three times higher among the poor than among the non-poor. So, of course, they should have more ED visits or admissions, because there's just more asthma among the poor. There's a higher prev -- and the severity of asthma among the poor is higher than among the non-poor. They're more severe asthma. So CRGs don't capture all that. They also don't capture the social risks.

So I actually interpret a lot of these data in a very positive way, particularly for children. I mean, first of all, if we had looked at the -- if we could have looked at this 20 years ago, or if we would have made hypotheses before you ran these data, I think we would have said that 20 years ago or before you see the data, there would be huge differences in child hospitalizations between kids on Medicaid versus the private sector or admissions. But we don't see that. So this to me is a reflection of a very strong safety net system and a very strong system that is at risk potentially in the future. But it's actually functioning very well. It seems to be functioning also better for children than for adults because there are greater differences that we see in the adult world between

Medicaid and commercial than we are seeing in the child world, although that may be due to sort of more medical and social risks. So I do think we should put a lot more into the context and interpretation.

And one last point. The conclusions aren't really conclusions of findings. It's basically saying we need more data or, you know -- so the whole -- in the chapter, the conclusions part, I would suggest to put some conclusions --

DR. BERNSTEIN: There are no find -- I did not give you findings. I mean, I didn't give you conclusions of the findings because I didn't want to interpret them for you.

VICE CHAIR GOLD: Except I think the way Toby was talking -- and maybe this is what Peter means -- you can summarize what you think the findings say. You don't have to say what they mean in terms of what should be done. But, you know, looking across all these numbers, the general pattern is X.

DR. BERNSTEIN: And now, because now you've said it, and it's on the record.

[Laughter.]

EXECUTIVE DIRECTOR SCHWARTZ: That's the difference between an initial presentation by staff and what you all think it means, which we then can put into words.

VICE CHAIR GOLD: Okay.

COMMISSIONER MARTINEZ ROGERS: Obviously, I'm ready.

[Laughter.]

COMMISSIONER MARTINEZ ROGERS: I just wanted to make a comment based on I think it was either Chuck or Peter. These are just two examples of what happened. I have two friends. One of them has private insurance. She had a back injury. She went three times to be seen at the doctor's office because she was in so much pain. The third time she went, she said, "Can you go with me?" I went with her, and basically the PA told her, "Look, we know your back X-ray is normal. You really need an MRI." So they tried to get an MRI through the insurance company. The insurance company didn't approve it.

So he comes back and he tells her, he said, "I just spoke to the doctor, and the doctor said if you really want an MRI, what you really, really need, you have to go

to the ER, and you have to go to an ER that's attached to a hospital." And that's exactly what she did. So that's an example of using an ER for whatever.

The second one, she is being seen by a -- she's on Medicare but being seen by the doctors at, unfortunately, my school, UT Health Science Center, in their clinic, and they only work 8:00 to 5:00. And so if she was sick and she called and says, "I'm sick," "Well, we can't fit you in. Do you want to be seen?" She hadn't been able to swallow for two days. So they said to her, "If you want to be able to be seen, you have to go to the county hospital, go to the ER." She goes to the ER. I drop her off at 9:15. She's seen the next day at 6:30 in the morning.

These are kind of like the examples of could you have prevented that? Sure. But how do you handle it? Because one thing is -- and I do agree with you, Kit, that until people start realizing the social determinants of health have to be looked at and recognized on everything that we do in terms of providing health care, we're going to continue to have these types of problems.

COMMISSIONER MILLIGAN: A lot of good comments I

think have captured what I was -- part of what I was going to say. You know, I do think that there's more complexity underneath this, obviously. Some of the ED visits that are preventable are after hours. Some of that is social determinants. Some of that is, you know, hourly work and babysitters and transportation. But I also think, to Peter's point, that sometimes the ED visits are a reflection of access, I mean, in a manner of speaking.

One question and I guess one other comment that I haven't heard yet. The question is when we look at the preventable admissions, how are we accounting for the change in hospital practice to treat a lot more -- to move a lot of what used to be admissions into observation status? How are we -- because that's a very big moving part that's in the midst of the preventable admissions piece of all of this.

So does that -- Amy, do you think that that dynamic in the data affects any of the trends?

DR. BERNSTEIN: Well, we don't have trends, so it probably will eventually, I guess. Then the question is, if the point -- one of the points of this analysis was to compare Medicaid with private pay, so they would have to be

doing that at different rates in order for it to affect the comparison. Right?

COMMISSIONER MILLIGAN: Correct, yeah, I mean, if they're moving in the same direction at the same pace, presumably it's a wash. But I do think that it's something worth just kind of taking in, thinking about, because I'm not sure if they're moving at different rates. It changes a lot of other dynamics sort of with approvals from insurance companies with out-of-pocket costs in the commercial and Medicare world, more so the Medicaid, to go to observation status. I think there are some variations that might affect admission dynamics over time. Maybe I should just leave it there.

I guess the comment I want to leave -- and it's sort of to Kit's point about the Dartmouth Atlas -- if you look at just ED visits per thousand -- never mind preventable, just ED visits per thousand -- there's tremendous variation. And so having a high rate of preventable ED visits in a community that has a very low rate of ED visits per thousand, the "n" might be quite a bit different than in a market where it's a low rate of preventable ED admissions but a high percent of admission -

- a high percent of ED visits itself. In other words, we're looking at one factor, which is kind of the percent of a denominator of ED visits and how many were preventable. But that denominator varies a lot regionally and in terms of Dartmouth Atlas.

Let me be more specific. In New Mexico, there's a lot of data that ED visits per thousand across all populations, all payers, is very low relative to national averages. So a high percent of preventable ED visits, which I don't know if that's the case, may still be a lower number per thousand than a lot of ED utilization. So I just think looking at the preventable part in isolation without looking at the prevalence of ED visits per thousand could distort some of the data.

COMMISSIONER MILLIGAN: I'm not sure if this is making sense.

VICE CHAIR GOLD: Okay. Good. No, that's a good point.

COMMISSIONER MILLIGAN: Okay.

DR. BERNSTEIN: No. And it is, and that's why we put in a number of candidate admissions in the text.

The other thing I should point out is we do have

state data in the appendixes, and they do vary a lot, as you suggest.

I guess one thing that struck me was when you average all of these differences, as Peter said, for children the rates were still pretty much the same. So it gives you sort of just the high-level comparison, and anything that would go into sort of the reasons for the differences would have to be done at a much more granular level than we're capable of doing with the claims data. But, obviously, everything you've said is -- everyone has said is correct.

VICE CHAIR GOLD: Yeah. Well, good points. Then I hope as you refine the write-up and do this, it will help you.

I think Sheldon had a point, and then is there anyone else who had a point? Because then I'm going to turn it back over to Sara.

Okay. So Sheldon, then Peter.

COMMISSIONER RETCHIN: One element that has come up is the after-hours stuff, but I've looked at it as provider before. It is remarkable that the emergency room visits do not seem to peak after hours. It's actually

agnostic to the hours, as much as we would like to think that.

The other thing I was wondering, as I've seen this over and over again, is beneficiaries often never establish a relationship with a primary care physician, never do, so that they have, through generations, gone through the ERs, especially in the inner city areas. And to really redirect that behavior sometimes takes two years of managed care.

I know you probably can't do this, but it would be interesting to look at those who have actually had a visit to a primary care physician in terms of preventable emergency room visits.

VICE CHAIR GOLD: That was my first paper, I think, in 1972 was around that.

COMMISSIONER RETCHIN: It took me 40 years.

VICE CHAIR GOLD: This emergency room visit has been on forever.

Peter, last thing on this topic.

COMMISSIONER SZILAGYI: Just a tiny point. You may want to add a paragraph on what the literature showed in the older days with ASCs, with ambulatory sensitive

conditions, because there it did show very large differences between Medicaid -- or between at least the poor and the non-poor, and I actually think also between Medicaid or Medicaid and uninsured and the non-poor. Those differences for children have really narrowed a lot.

VICE CHAIR GOLD: Yeah. Peter is a good source. I know the Access Report that the IOM did summarized a lot of the literature. I don't know if you have a few other references, so Amy doesn't have to go back and look over all their literature. Any good summaries of that?

COMMISSIONER SZILAGYI: No. I just think you'd serve for ASCs, which you've already done probably.

VICE CHAIR GOLD: Yeah.

CHAIR ROSENBAUM: All right. Well, thank you. This has been a really great afternoon discussion, and now we have time for public comment. Is there anybody who would like to make a public comment? Is there any public?

[Laughter.]

CHAIR ROSENBAUM: Hello? Hello? Any public comment at all?

PUBLIC COMMENT

* [No response.]

CHAIR ROSENBAUM: Well, if not, we are adjourned.

[Whereupon, at 4:30 p.m., the meeting was adjourned, to reconvene at 10:00 a.m., Friday, December 16, 2016.]

PUBLIC MEETING

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

Friday, December 16, 2016
10:03 a.m.

COMMISSIONERS PRESENT:

SARA ROSENBAUM, JD, Chair
MARSHA GOLD, ScD, Vice Chair
BRIAN BURWELL
SHARON L. CARTE, MHS
GUSTAVO CRUZ, DMD, MPH
TOBY DOUGLAS, MPP, MPH
HERMAN GRAY, MD, MBA
LEANNA GEORGE
CHRISTOPHER GORTON, MD, MHSA
STACEY LAMPKIN, FSA, MAAA, MPA
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
PETER SZILAGYI, MD, MPH
PENNY THOMPSON, MPA
ALAN WEIL, JD, MPP

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

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P R O C E E D I N G S

[10:03 a.m.]

CHAIR ROSENBAUM: Well, everybody, Happy Friday. We have much ground to cover this morning, so why don't we begin with a presentation on the proposed and final rules related to notices, appeals, and other Medicaid and CHIP eligibility provisions.

Take it away, Martha.

REVIEW OF PROPOSED MEDICAID AND CHIP ELIGIBILITY RULE

* MS. HEBERLEIN: Thank you, Sara. There's nothing like starting on Friday talking about complex regulations, so here we go.

On November 30th, 2016, CMS released a final rule, published, that implemented a number of provisions of the ACA concerning eligibility notices, fair hearings and appeals processes, and other provisions that related to eligibility and enrollment.

This final rule addresses most of the remaining pieces of a rule that was proposed back in January of 2013. Most of this rule was finalized already in July of 2013, so this is sort of the residual.

CMS also published a companion Notice of Proposed Rulemaking on appeals and fair hearing and is seeking comments by January 23rd, 2017. Note that the Commission can but it not require to comment on proposed rules. So, at the end of this, if you are interested in commenting, please let me know.

So the rule adds requirements for states in terms of the content of notices, coordination across insurance programs, and the processes for appeals and fair hearings. Similar to other provisions of the ACA, the purpose is really to simplify the procedures for applicants and beneficiaries as well as for states, and to make procedures a little bit more consistent across the states. However, in doing so, it also limits the flexibility that states have in designing and implementing their programs.

Further, given the change in administration and the uncertainty of the changes as well as the ACA as a whole, it is not clear what the disposition of this final rule will be.

So I will go through each of these in a little bit more detail, but to provide a quick overview, the provisions of the final rule modernizes the notices and

appeals processes and establish guidelines to coordinate across insurance affordability programs, and this includes Medicaid, CHIP, and the exchanges.

The rule also finalizes provisions related to eligibility pathways, the financial methodologies for determining eligibility for some groups, verification of citizenship and immigration status, and a number of other sort of miscellaneous provisions. And unless noted, the provisions of the final rule are effective January 20th, 2017.

So, beginning with notices, effective notices must be clear and understandable and provide comprehensive eligibility information so that an individual can understand the action that is being taken, the reason for that action, any follow-up that is required of them, and the process for appeals.

The final rule specifies the minimum content that the notices should include in order to meet the standard as well as the requirement for combined notices and coordinated information with other insurance affordability programs.

So, specifically, notices must be written in

plain language and accessible to individuals who are limited English proficient as well as individuals with disabilities.

The approval notices must include the basis of an effective date of eligibility, the benefits and services that are available to individuals, any premium and cost-sharing obligations that they must pay, procedures for reporting changes as well as their appeal rights.

Denial or termination notices must include a clear explanation of the reason for ineligibility and information regarding eligibility through other Medicaid pathways. So if the individual is denied eligibility for a pathway that was based on modified adjusted gross income, the notice should include information on non-MAGI pathways.

And to the maximum extent feasible, eligibility notices should be combined across programs, so, again, Medicaid, CHIP, and the exchange. However, in the case of individuals who do not receive a combined notice, for example, because they are waiting a final eligibility determination, the notice must include what they are calling coordinated content, and that would include information relating to the fact that their account was

transferred to the exchange for a determination or to Medicaid for a final determination.

Note that the provision related to coordinated notices and content have a delayed implementation date of six months after notice of its effectiveness is published in the Federal Register. So we don't know when that will be in effect.

Moving on to appeals and fair hearings, the final rule takes a number of steps to modernize and coordinate eligibility appeals across programs. It also establishes an expedited fair hearing process for eligibility and fee-for-service-related appeals. Many of these provisions also have a delayed implementation date.

The final rule requires that applicants and beneficiaries be able to request a Medicaid fair hearing at the same time that they file an exchange-related appeal in instances when individuals receive that combined eligibility notice.

States must also establish coordination agreements and a secure electronic interface with the exchange or exchange appeals entity so that information can be exchanged across programs.

Individuals must be able to submit a request for a fair hearing and withdraw the fair hearing request through mail, in person, online, or over the phone, and these are the same modes that states are required to provide for application and renewals.

Note that these three provisions all have the same sort of delay as the coordinated notices I just talked about, and CMS also noted in the final rule that they expect to issue additional guidance on coordinated appeals as state systems improve.

Finally, the rule also clarifies when a fair hearing can be requested, including in cases of eligibility, the amount of premiums and cost sharing required, or change in amount or type of benefits.

The rule also requires states to establish an expedited appeals process related to eligibility and benefits in fee-for-service programs. These are just for individuals who have urgent health needs, and this process is similar to that which is already required for individuals who receive services through managed care arrangements as well as for those who are applying for coverage on the exchanges.

So the rule aligns the timelines for the denial of service appeals, so both for fee-for-service and managed care, it's three days for the agency to take a final action. It also requires a seven-day timeline for expedited eligibility appeals. But these timelines are revisited in the proposed rule, which I will discuss in a few minutes.

So based, in part, on changes in the ACA as well as the Children's Health Insurance Program Reauthorization Act, CHIPRA, and some other legislation, the final rule codifies a number of statutorily established pathways and also streamlines and updates others.

So, for example, it codifies the eligibility pathway, which allows states to offer individuals who are diagnosed with breast or cervical cancer access to Medicaid services, and this was approved, a pathway added by Congress in 2000, so it's really cleaning up the regs in terms of eligibility.

It also clarifies provisions related to income counting rules for the medically needy populations, those receiving family planning services, as well as those in need of long-term services and supports. Most of these

provisions are very technical in nature, but a few changes that are worth noting, given your prior interest.

Under the ACA, the states are required to offer Medicaid to former foster youth that have aged out of the program in their state up to age 26, and this was designed to mirror the provision for adults in their parents' plan.

In the proposed rule, CMS gave states the option to cover former foster youth who have aged out from other states. In a review of the statute, they determined that they do not have the legal authority to authorize this and so did not finalize that in the final rule. However, at the same time, they issued guidance that allows states to cover these children or youth from other states under a Section 1115 waiver. So the 14 states that are currently covering former foster youth who have aged out from other states will need to convert that coverage to an 1115 waiver. I note this because we had a June 2014 chapter that talks about the intersection between Medicaid and child welfare.

The other point I want to make is that the final rule also codifies the state option to provide 12-month continuous eligibility for children in Medicaid and in

separate CHIP program. In the March 2013 report, the Commission had recommended that the statute be changed to provide 12-month continuous eligibility for children in CHIP, noting that this option already existed in Medicaid.

So CHIPRA made a number of changes to the verification of citizenship and satisfactory immigration status, including the option to use Social Security Administration data and the requirement to provide a reasonable opportunity period during which documentation can be provided. The ACA also required the use of electronic data to verify eligibility to the maximum extent possible. And the final rule codifies these provisions.

So the regulation codified changes made to CHIPRA, including extending the application of the citizenship and documentation requirements to children in CHIP and exempting deemed newborns from the requirement. Similar to the approach that's used to verify other eligibility criteria, states must rely on electronic verification from the Social Security Administration for citizenship and the Department of Homeland Security for immigration status. States have the option of either making this connection themselves or through the federal

data hub.

The final rule also simplifies the paper documentation requirement if states are unable to verify these data electronically. So, for example, original documentation will no longer be required.

The rule also provides a reasonable opportunity period of 90 days (before the timeline was not specified), during which time individuals were otherwise determined eligible for Medicaid, but have not yet had their citizenship or immigration status verified, can receive benefits. And states have the option of extending this time frame for individuals who are making good-faith efforts to verify their immigration status but not their citizenship status.

So some of the miscellaneous provisions that are in there that might be of interest to you, the rule extends protections for individuals who are limited English proficient and individuals with disabilities. It means that they require the fair hearing process and related information to be accessible to them.

States must also ensure that individuals who are limited English proficient have access to language services

at no cost.

The rule also directs states to use an automated format for the submission of state plan amendments. This replaces sort of the paper-based amendment from the process. It allows for a transition period to enter the new system and talks about technical assistance that CMS will be providing during this time frame.

The final rule also gives states the option to accept self-attestation of all eligibility criteria except citizenship and immigration status in certain special circumstances; for example, if there is a natural disaster or for individuals who are homeless or survivors of domestic violence who can't produce the documents.

So, as I mentioned, they also released a proposed rule at the same time that seeks to further align the appeals timelines across the programs. The current rules require that Medicaid establish an appeals period that's not to exceed 90 days, although most states currently only permit a 30-day time period. Exchange entities, on the other hand, are required to allow a full 90 days. So the proposed rule would standardize the Medicaid and CHIP time frames to file an appeal so that it's no less than 30 days

and no more than 90 days, and it also would require that the Medicaid or CHIP agency accept an appeal if it is filed with the exchange within the exchange time frame.

The proposed rule also proposes to reduce the amount of time that the agency has to adjudicate an expedited fair hearing on eligibility matters that I discussed a few minutes ago. So it proposes the options to align from seven working days for the eligibility appeals to five in order to make it closer to the service-related appeals, but it also proposes other options, either going all the way to three, so that it would be fully aligned across all expedited appeals, or leaving the current seven-day time frame in effect.

The NPRM would also require states to establish timeliness and performance standards for final actions in fair hearings across all types, and it would still retain sort of the outer limits of 90 days for most appeals, but shorter for the expedited appeals.

So that concludes my quick overview of the final and proposed regs. So I look forward to your comments and questions, and if you would like to comment on the NPRM, please let me know.

CHAIR ROSENBAUM: Martha, can we go back to the former foster care children?

MS. HEBERLEIN: Yes.

CHAIR ROSENBAUM: So do you know off the top of your head -- I certainly don't. The out-of-state placement is very common in foster care. I remember from my work at the Children's Defense Fund, the issue of children having to be placed in other states. That's an enormous one, just because the lack of foster care capacity in a state. Here in D.C., I think it's a very big issue, or at least it used to be.

So I'm quite concerned, actually. I mean, it's finalized now, but I'm quite concerned about the CMS decision that it does not have the legal authority to allow a state, if the child ultimately returns to the state, to recognize the child is a former foster care child, and that's important because if it's a state that has not expanded Medicaid to cover all low-income adults -- most of these children obviously are adolescents at this point, would be quite low income, but this might be the only category in which they could establish health insurance coverage, coming back as former foster children.

Did CMS elaborate any more on why it concluded that it lacked the legal authority to recognize children who had been in out-of-state placements and then came home?

MS. HEBERLEIN: So the statute says that the state must cover former foster youth who have aged out in the state, so didn't say "a state" or "any state." It said "the state." And so CMS in the proposed rule thought that they might be able to expand that to include the option for states to pick up coverage for a foster youth from any state, and they determined that they do not have that authority to do so.

CHAIR ROSENBAUM: Yeah. I mean, obviously, aged out in "the state," meaning that even if the state -- you know, it's a little murky to me because of the state, in fact, used an out-of-state placement, it's still aging out under the state's own policies.

MS. HEBERLEIN: Right. And that I think because they would be aged with the -- that state be paying for their foster care, even if the child was placed out of state.

CHAIR ROSENBAUM: Exactly. The state pays.

MS. HEBERLEIN: I believe that they would be -- I

believe that they would be considered covered in Medicaid and in foster care in that state. So if they moved from New York to New Hampshire and then came back to New York and New York was paying for that, I believe that the provision would still apply, but that's something worth thinking on.

CHAIR ROSENBAUM: Yeah. I mean, I think this is, to me, a place where we might want to think about a recommendation to Congress that it clarify, and it could be done with a relatively brief letter that this is an issue. To the extent that CMS has felt the states don't have the flexibility do to this, I mean, I realize you could file for an 1115 demonstration just around this issue, but that seems a little excessive to me, and I would imagine that the cost would be pretty negligible.

But there's such an interest among a number of congressional lawmakers around this issue, and out-of-state foster care placements are so common. And there should be some quite getable data on this.

And, again, most of the time, if, in fact, the final rule allows the state making the payment to classify the child as in state, then that cuts down on 99 percent of

the problem, and it would be very easy for us to recommend the final closing of the loophole.

Yeah. Chuck.

COMMISSIONER MILLIGAN: You know, Sara, just to pick up on that comment about the former foster care, just a little bit of a framework, and then I think my comment, more than a question, Martha -- because the state is the custodial parent -- and I think your interpretation is the correct one; that is, the State of New York in your example, Martha, is the custodial parent. Even if the child is placed in New Hampshire, the custodial parent is the same. This will become, I think, an important issue as the ACA repeal-and-replace kind of conversation progresses because the pathway to coverage for these kids is as being able to be covered up to age 26 through a parent, in this case, the state. It's the pathway to coverage isn't the Medicaid expansion.

So if the element in the ACA allowing kids to remain on their parents' policy to age 26 remains, no matter what might play out over the next few months and years, presumably that protection for children ought to apply to these former foster care youth, regardless,

because their parent in that case is the state, and that is their pathway to coverage. So I think that's one of the elements that needs to be developed here because it's not the Medicaid expansion pathway for those kids in the ACA.

CHAIR ROSENBAUM: Any other comments or questions about a the rules, either proposed or final? The question of whether we comment on the proposed rule, are there things, Martha, that struck you went through the rule as areas where comments might be particularly important?

MS. HEBERLEIN: I think the areas for comment were pretty narrow. It seemed that they finalized most of the rules and what they asked for comments on were things that they got comments on in the January rule and hadn't really addressed, and so wanted to raise them again for public comment. And there wasn't really anything -- you know, I raised the three things that jumped out at me, but none of them -- I mean, it seems more further alignment than is already in the final rule. So if it's important that it's three days across the board, or five days, or seven days, I mean, if you guys have an opinion on that we're happy to comment. But it seemed more around the edges.

CHAIR ROSENBAUM: All right. Thank you.

[Pause.]

PROFILES OF DISPROPORTIONATE SHARE HOSPITALS

* MR. NELB: All right. Good morning. So today we're going to have two different DSH presentations, and Kacey and I are going to start it off first by presenting some profiles that we did of disproportionate share hospitals.

Before I begin this first presentation, I just want to acknowledge the contribution of our colleagues at the Urban Institute, Terry Coughlin and Christal Ramos, who helped interview the hospitals and compile all these profiles.

So for this first presentation I'll begin by just reviewing the purpose of the project and the methodology, and then turn it over to Kacey to walk through some of the key themes that emerged from these profiles, some of which are listed here. And finally I'll conclude by discussing some next steps about what we learned from these profiles and how it might -- the implications it might have for Commission's consideration of policies to better improve the targeting of DSH payments.

So first, the goal of this project was really to help complement all the data that we've been providing on DSH, to give you some more of the stories about -- that provide a more nuanced picture of the role of DSH funding at different types of hospitals, the relationship between DSH and other sources of hospital funding, and really the role of DSH hospitals in their markets and communities.

As I mentioned, we contracted with the Urban Institute to profile seven DSH hospitals, and for each hospital we talked to hospital executives, and then also looked at publicly available data from Medicare cost reports, DSH audits, and other sources.

So this analysis is qualitative, and so while it's difficult to draw strong conclusions from the experience of just seven hospitals, the hope is that these profiles help illustrate the role of DSH funding for different institutions and their different circumstances.

This table lists the hospitals that we profiled. So you can see, from the top, that we looked at three large public DSH hospitals, in both expansion and non-expansion states -- Parkland Hospital in Texas, MetroHealth in Ohio, and Santa Clara Valley Medical Center in California. All

of these hospitals serve a very high share of Medicaid and low-income patients and they meet the deemed standard of being -- and so they are required to DSH payments.

We also included two short-term, nonprofit hospitals. One of them also met the deemed DSH standard, Vident Medical Center in North Carolina, and then one of them did not meet the deemed DSH standard, Henry Ford Hospital in Michigan, but still had sort of an above average Medicaid utilization.

And finally we looked at a critical access hospital in Vermont, Northeast Regional -- Northeastern Vermont Regional Hospital -- and a children's hospital in Connecticut, Connecticut Children's Hospital.

Just as a quick reminder, critical access hospitals are small, rural hospitals that receive special payment designations from Medicare because they're often the sole provider in their communities.

I will mention that we tried to include a psychiatric hospital that's designated as an institution for mental diseases, or an IMD, but we weren't able to find an IMD that was willing to participate. As you know, IMDs do receive a large share of DSH funding and they have, you

know, unique payment issues in Medicaid, because they're not eligible for Medicaid payments for patients between age 19 and 65.

More information about our methodology is in your materials, but I will turn it over to Kacey to walk through some of our key findings.

* MS. BUDERI: Thanks, Rob. So the first thing we identified was that DSH hospitals operate in a wide variety of state and market contexts. As we know, hospitals in states that expanded Medicaid report lower levels of uncompensated care. For example, MetroHealth in Ohio and Santa Clara Valley Medical Center in California used to have high uncompensated care, and now have relatively little, whereas Parkland Hospital in Texas has one-third of operating expenses attributable to uncompensated care.

State payment policies, including those around base Medicaid payment rates also affected the level of uncompensated care. At some of our profiled hospitals Medicaid base payment covered a little bit over half of Medicaid costs while at others it covered Medicaid costs almost fully. And one hospital, Vident Medical Center in

North Carolina, actually received cost-based reimbursement.

State payment policies and uncompensated care affect hospital reliance on supplemental payments, and our profiled hospitals varied on this measure as well, with Medicaid supplemental payments as a share of total Medicaid revenue ranging from 10 percent at Connecticut Children's to 54 percent at Parkland.

Hospitals also varied in terms of the market context they operated in. The large hospitals we profiled tended to predominantly serve low-income populations in otherwise higher-income, urban communities, with several other hospitals in the market, such as Parkland in Dallas and Santa Clara in Silicon Valley.

And then in other cases, our hospitals were the sole providers in the communities and reported serving a more varied patient mix, such as Vident and Northeastern Vermont Regional, and this was also the case for Connecticut Children's, which is the sole children's hospital in the region and also has a varied patient mix. And consistent with broader trends towards hospital consolidation, many of the hospitals we profiled were part of larger health systems that provided extensive outpatient

services.

So the second theme we identified was that the variation in state and market contexts affects how hospitals used DSH funding. So DSH funds are one of many revenue sources for hospitals, and as we know are not tied to particular services. While hospital executives generally were in agreement that DSH payments are fungible and are used generally to support hospital operations, they did view the role of DSH differently, based on state and market characteristics.

So state expansion decisions affected their views on whether DSH payments support Medicaid shortfall or uninsured costs. Hospitals in non-expansion states reported using DSH funds to offset uninsured costs, while hospitals in expansion states reported using DSH to offset Medicaid shortfall. Similarly, hospitals in states with lower base Medicaid payment rates reported using DSH payments to offset Medicaid shortfall.

Additionally, hospital executives viewed the role of DSH differently based on their market characteristics. For example, executives at hospitals that were one of many in the market, like Parkland, Santa Clara, Henry Ford, and

MetroHealth, viewed the role of DSH as supporting access to care for the low-income population in their area, and reported offering many outpatient and community services directed at this population. Hospital executives at hospitals that were the sole provider in the region, like Vident and Northeastern Vermont Regional, viewed the role of DSH as supporting access to care more generally for the region as a whole.

So the third theme we identified was that DSH payment policy is dynamic and subject to change based on a variety of factors. Three of our profiled hospitals reported recent changes in state DSH policies that effectively lowered their DSH payments. So Texas changed its policy in a way that made more privately owned hospitals eligible for DSH, which reduced the amount of DSH payments going to Parkland. Vermont has a policy that targets DSH payments based on a hospital's Medicaid patient volume, rather than the share of its patient days that are attributable to Medicaid patients, which disproportionately affects small rural hospitals, like Northeastern Vermont Regional.

Ohio recently changed its methodology for

determining DSH payments from prioritizing Medicaid and low-income utilization to prioritizing uncompensated care costs, which reduced MetroHealth's DSH payments. Although MetroHealth serves a high volume of Medicaid and uninsured patients, it tends to have lower costs than other hospitals and thus has lower uncompensated care costs.

In response to cuts in DSH payments, hospitals sought other ways to make up that revenue, including by advocating for or participating in initiatives to increase their non-DSH supplemental payments or engaging in strategies to change patient and service mix, such as purchasing outpatient clinics in suburban areas with higher concentrations of commercially insured patients.

And then on the other side of that coin, Santa Clara Valley Medical Center is an example of a hospital that adjusted to changes in state policy that resulted in the opportunity to increase its DSH payments and expand the types of services it can pay for. California recently received approval for a Section 1115 demonstration to distribute DSH funds as a global payment. These payments are de-linked from hospital uncompensated care and disbursed only to California's 21 designated public

hospitals, including Santa Clara. They incentivize hospitals to invest in outpatient care that can reduce inpatient costs for the uninsured. Santa Clara reported using global payment funds to support clinic services that were previously not paid for by DSH.

So now I'm going to turn it back over to Rob and he is going to get into some of the implications of these findings for the Commission's work on DSH targeting.

MR. NELB: Thanks, Kacey.

So as the Commission continues to explore policies to improve the targeting of DSH payments, including our next presentation this morning, I just wanted to highlight a few findings from these profiles that you might want to keep in mind.

First is that DSH payment policy is dynamic, and so the way that states target DSH payments today may not be necessarily how they'll target DSH payments in the future. There's a lot of factors that lead to different changes in state policies.

And second is that I think our profiles help illustrate that there are factors other than utilization that can affect a hospital's need for DSH payments. So one

example -- so we had a -- one of our non-deemed DSH hospitals, Northeastern Vermont Regional Hospital, reported a high need for DSH payments because of its sort of unique market characteristics and because it was sort of the only provider in its community, as a critical access hospital. But then second, in terms of Medicaid payment policy, we saw one of the deemed DSH hospitals that we looked at, Vident Medical Center, which reported lower uncompensated care costs than other hospitals, in part because the state has such high regular Medicaid payments to the hospital.

And finally, just a point to keep in mind is that hospitals respond to DSH payment incentives. So whether it's some of the cuts that we saw or the new changes in California, these DSH payment policies have some larger effects on the hospitals.

So in terms of next steps from this work, we do plan to include examples from these profiles in our March report chapters on DSH, and we're also thinking about publishing these profiles as a separate Web-only report.

Kacey and I look forward to your feedback and are happy to answer any questions that you may have. Thanks.

CHAIR ROSENBAUM: Thank you. Questions?

Comments?

Okay. I have Sheldon, Brian, Alan.

COMMISSIONER RETCHIN: I'll just kick it off. I think these are such a wide range of different circumstances, I think it underscores how different in terms of DSH -- deemed DSH hospitals and then the one that's not deemed. I guess that was Henry Ford? Yeah.

I have, I guess, one comment and then a question. The one comment would be whether -- and I'll turn to Peter on this -- I think Connecticut Children's is a little bit of a different example. For one, you have to keep in mind that although it has 53 percent inpatient Medicaid utilization, and I often tell the Children's Hospital CEO in Columbus the same thing, when he says "you wouldn't want our Medicaid," but remember the rest is commercially insured, because they don't have Medicare.

And I think Connecticut Children's had a lot of controversy, and you have to wonder whether a freestanding children's hospital really can exist in a metropolitan area the size of Hartford, if everyone -- and I don't know whether they have -- the others have gotten out of pediatrics or not. But that's a different circumstance,

and I'm not sure that it's a great example of the overall DSH policies in particular.

The other thing I'll say -- and I won't get to the big systems. I'm going to let others comment and then I'll come back, but -- is the critical access hospital, and I did note that they made mention and underscored their issues with employing physicians. And the interesting thing about rural hospitals, and Leanna was bringing this up, is, yeah, they need primary care physicians, but it's interesting that if you look and ask their CEOs what they really need are specialists. But particular -- and I'll just mention one -- is a general surgeon. A general surgeon in a rural hospital is worth their weight in gold. They keep open surgery and today, still, were paid more for procedures, but also if you think of the risk in travel time for trauma and other elements, that's critical. So I noted that in their discussion about what's at risk for them.

CHAIR ROSENBAUM: Thank you. Brian.

COMMISSIONER BURWELL: I just want to say I thought these case studies were excellent and I think it just underscores the importance of doing qualitative work

in addition to quantitative work. It just really brought out a lot of issues that we don't get otherwise, and I found them extremely educational.

The other thing that I got out of these is kind of the dark side of DSH funding, how dependent these hospitals are on their DSH allocations, and what a large impact changes in DSH allocations have on their financial operations, independent of, you know, how they operate as businesses. And, you know, I just think that's something we have to keep in mind as we examine this, from a public policy perspective. The letter that we got today also underscores that. You know, we are highly dependent upon DSH funding and don't mess with it, and blah, blah, blah, you know.

So that's not the way businesses should operate, is kind of my bottom line.

CHAIR ROSENBAUM: Thank you. Alan.

COMMISSIONER WEIL: I just want to echo Brian's comment about the value of these and note that one of the challenges in describing what any dollar does is that money is fungible and yet marginal money is -- as a practical matter, organizations treat marginal money differently than

they treat core money. And so understanding what the implications are of changing policy is complicated by that. So I realize you can't -- part of the nature of this work is that it's case studies, but I think giving some perspective on that reality is very important, given the data limitations that make it difficult to generalize.

CHAIR ROSENBAUM: Any other comments?

[No audible response.]

CHAIR ROSENBAUM: All right. Well, then, why don't we move to the next presentation.

TARGETING DISPROPORTIONATE SHARE HOSPITAL PAYMENT: FURTHER ANALYSIS

* MR. NELB: All right. I am back for more.

VICE CHAIR GOLD: You still [off microphone].

MR. NELB: Yes. Great. So for our second DSH presentation today, I'm going to present some further analyses of policies to improve the targeting of DSH payments.

So as you'll recall, at our October meeting I presented a number of different potential policies to improve the targeting of DSH payments, including changes to which hospitals should be receiving DSH, how much DSH

funding they should receive, and how state DSH allotments should be allocated. And today I'm going to just focus in on one of those areas, which is the question of sort of which hospitals should be receiving DSH payments, and by looking specifically at policies to increase the minimum federal eligibility standards for DSH from a 1 percent Medicaid utilization rate to a higher standard.

So in this presentation, I'll be reviewing the current provider eligibility criteria, discuss seven of the different utilization-based thresholds that we looked at, and then talk about some of the hospital and state effects, and then finish with next steps for our March 2017 report.

So, again, before talking about changes to DSH policy, let me just review what the current law is. So today virtually all hospitals meet the current minimum federal eligibility standards for DSH, which is a Medicaid inpatient utilization rate of at least 1 percent.

However, on top of the minimum federal standards, states have flexibility to establish their own DSH eligibility standard based on state-defined criteria. Many states choose to target DSH payments to particular types of hospitals, such as public hospitals, teaching hospitals,

and critical access hospitals. The complete information about current state DSH targeting policies is in your materials in the back in Appendix E.

So states have flexibility to determine who receives DSH payments. However, they are required to make DSH payments to hospitals that meet what we call the "deemed DSH standards." Deemed DSH hospitals meet one of two criteria: they have a Medicaid inpatient utilization rate that's one standard deviation above the average in their state, or they have a low-income utilization rate, which is a measure of Medicaid and uninsured utilization, that is above 25 percent.

As a result of the variation in current state DSH targeting policies, there is wide variation in the share of hospitals that receive DSH payments by states. So this figure, you know, which you've seen before, shows the variation in 2012. Nine states made DSH payments to less than 20 percent of hospitals in their state; eight states made DSH payments to more than 80 percent of hospitals in their state. And, nationally, on average, about half of hospitals received Medicaid DSH payments.

So today to help inform the Commission's

consideration of various policies to raise that minimum eligibility standard, we're going to look at the seven different utilization-based thresholds listed here.

So first we're going to look at the effect of increasing the minimum standard from 1 percent to a higher absolute standard that would also apply equally across states. We are going to look at a 15 percent Medicaid utilization rate, which is similar to the standard that's used for Medicare DSH payments. And we're also going to look at two lower thresholds, 5 and 10 percent, to look at sort of more incremental changes. To put these numbers in context, the average Medicaid utilization rate for hospitals was about 19 percent in 2014.

Second, we analyzed the effects of using various relative utilization thresholds which vary by state. So within this category, we're first looking at the effect of requiring DSH hospitals to have above average Medicaid utilization in their state. And so because Medicaid eligibility levels and also incomes vary by state, the average Medicaid utilization also varies widely by state. So in 2014, it ranged from 10 percent in Nebraska and New Hampshire to 32 percent in New Mexico.

We also looked at a relative utilization standard based on the low-income utilization rate, which, as I mentioned, again, is a measure of Medicaid and uninsured utilization that's part of the deemed DSH standard. So while Medicaid utilization rate only looks at the Medicaid patients in the hospital, low-income utilization rate also looks at the uninsured which is measured in a little complicated way based on hospitals' charity care charges. In 2014, the average low-income utilization rate was 11 percent, and it also varied widely by state, from 5 percent in New Hampshire to 21 percent in D.C.

So then in addition to looking at the average low-income utilization rate, we also looked at a standard that would allow hospitals to qualify based on either above average Medicaid utilization or above average low-income utilization. And, finally, we looked at applying the deemed DSH standard, which is a combination of a relative threshold for Medicaid utilization and an absolute threshold for low-income utilization.

So now that we've laid out sort of what the options are, let me show some summary statistics of DSH hospitals that would be affected by various targeting

thresholds.

First, just a data note. To minimize the effects of missing data and allow for constant comparisons between the various thresholds, we limited this analysis to short-term and critical access hospitals that had complete Medicaid and low-income utilization data for 2014. So we're looking at about 2,000 hospitals that received about $12.6 billion in DSH payments in 2012. And we are using 2014 utilization, so this is after the effects of the ACA. So let me walk through some of the findings.

First, you can see, kind of unsurprisingly, that more DSH hospitals are affected by higher utilization thresholds. So 121 DSH hospitals are affected at a 5 percent utilization rate threshold, and 704 have utilization rates below 15 percent.

What's a little more interesting is the fact that the amount of DSH payments to hospitals with low utilization rates is relatively low. So, for example, when you move from a 10 percent to a 15 percent threshold, it affects about twice as many hospitals, but about three times as much DHS payments.

When we compare the absolute utilization standard

to the relative standard, the average Medicaid utilization rate, we do find that more DSH hospitals are affected. But this isn't too surprising since the average Medicaid utilization in most states is higher than 15 percent. So, again, this is that trend that if you have a higher standard, more hospitals fall out.

Now, when we compared to the average Medicaid utilization standard, fewer hospitals would be affected if you also allow hospitals to qualify if they have an above average low-income utilization, so if we do that either/or approach. And this is because Medicaid utilization isn't always correlated with low-income utilization. So some of the hospitals we profiled before gives some examples of that. So hospitals that primarily treat pregnant women and children, such as some of the children's hospitals, tend to have very high Medicaid utilization but don't serve as much uninsured; they don't have as much low-income utilization.

On the contrary, there are also some hospitals that primarily serve adults in states with large numbers of uninsured – such as Parkland that we profiled -- which had very high low-income utilization rates but not quite as high Medicaid utilization rates.

And, finally, as we move across the table, we can see that a large number of DSH hospitals do not meet the deemed DSH standard, so about three-quarters.

But what's important to note again is that, again, the number of hospitals affected versus the dollars don't always line up, and so although 72 percent of hospitals in our analysis had utilization rates below the deemed DSH standard, they only receive 35 percent of the DSH payments in 2012.

As we just look across the board at the share of DSH payments affected by various thresholds, I just want to point out that for most of the different thresholds we analyzed, if you use them, it would result in reductions in DSH funding that are smaller than the amount of pending DSH allotment reductions. So as you'll recall, federal DSH allotments are scheduled to be reduced by about 16 percent next year, in fiscal year 2018, and by up to 55 percent in 2025. So if those cuts do go into effect, you know, this amount of payments sort of will already be -- states will already have to figure out ways to reduce a certain amount of their DSH payments.

So for each eligibility threshold we examined, we

also looked more closely at the effects on particular types of hospitals. So, first, using a methodology that had previously been proposed by other researchers, we took a stab at identifying about 371 hospitals that were considered highly reliant on DSH funding and also in poor financial condition based on the criteria listed here. And we found that, you know, at least some of these hospitals were affected by even some of the small changes to the minimum DSH eligibility threshold.

So, for example, about 19 of these highly reliant DSH hospitals had Medicaid utilization rates below 5 percent, and 79 had below average Medicaid or low-income utilization rates.

Second, looking at the types of hospitals affected, we did find that many of the DSH hospitals with low Medicaid utilization rates ended up being critical access hospitals. Again, as you'll recall, critical access hospitals are the small rural ones that receive special payments because they're often the only provider in the area. This was a little surprising because rural hospitals in general tend to have higher Medicaid utilization rates, but for whatever reason, the critical access ones tended to

have lower ones.

And, you know, as I mentioned before, many states make exceptions for critical access hospitals when targeting DSH payments, so that may explain why there were DSH hospitals with -- why some of those had low Medicaid utilization rates, because they were held to a different standard.

And, finally, when we looked at hospital margins, we didn't see a clear relationship between Medicaid and low-income utilization rates. So, on one hand, we saw what we've reported before, that the deemed DSH hospitals generally have lower operating margins than most other DSH hospitals. However, we also found that the hospitals that have the lowest Medicaid utilization rates also reported other financial challenges. So there wasn't that clear relationship there.

In addition to looking at the effects of various thresholds on particular types of hospitals, we also looked at the characteristics of the states that had affected DSH hospitals. So, first, we found that at least one hospital in more than half the states would be affected by even small changes to the DSH eligibility threshold. So, for

example, raising the minimum threshold from 1 percent to 5 percent, there was at least one hospital in 28 states that were affected. However, I want to underscore that the amount of DSH funding in those affected states was very small and often less than the amount of pending DSH allotment reductions projected for next year.

Second, we found that hospitals in states that distribute their DSH payments more broadly were more likely to be affected by higher utilization thresholds. So this isn't surprising; if they distribute it to everyone, if you raise the standards, they're more likely to be affected.

However, we also found that, you know, as we were trying to look at some of the reasons why particular states were affected, some of the variations in state-specific DSH targeting criteria also, you know, affected the impact of higher thresholds. So if a state had exceptions for particular types of hospitals, that might explain why they were making payments to hospitals with low Medicaid or low-income utilization rates.

So I'm happy to answer any questions you have about the analysis. Before I wrap up the presentation today, I just wanted to review some of the next steps for

our March report.

As you know, this report is statutorily required to include certain data elements, including the ones listed here, and the report can also include the Commission's analyses of potential DSH targeting options, such as the one I presented today and what I presented in previous meetings.

So I look forward to your feedback on what we should include in the report and also your feedback on next steps for our DSH targeting work. Thanks.

CHAIR ROSENBAUM: Thanks, Rob.

COMMISSIONER BURWELL: So I have a question. If the Commission was going to make recommendations on changing the targeting of DSH funds, what would be the most appropriate timing of that?

EXECUTIVE DIRECTOR SCHWARTZ: We would discuss it today if you had an idea for what that recommendation would be, and we could come back in January and have a vote on it. We're a little bit over time in terms of notification of the Conflict of Interest Committee, but we could notify the Conflict of Interest Committee immediately. So I think if you think there's a recommendation to be had here, I

would be as specific as you can about what that might be so we can preview what that discussion would look like, and then depending upon the sense of the room we --

COMMISSIONER BURWELL: Include it in the March report?

EXECUTIVE DIRECTOR SCHWARTZ: We could include it in the March report. You could vote on it in January and include it in the March report. So it's not too late.

COMMISSIONER MILLIGAN: So, Rob, there's one just presentation comment I have and then one question/comment I have.

So on Slide 6 -- so this slide, actually. Sorry. I would find it easier to follow personally if that top row listed the hospitals that survived instead of the hospitals that fell out. So knowing that the "n" is the 2,278, I just think it's cleaner to have it be the hospitals that still meet the requirement instead of the hospitals that lose their eligibility under that criteria, just for presentation.

My question/comment -- I think it's kind of both -- is Slide 15, the state-by-state effects. So if -- the dilemma of a lot of really good use of PowerPoint. If any

of those criteria were used, it remains an open question as to whether it's redistributed within a state versus across states. So let me just -- I want to frame it and then ask you whether I'm sort of tracking this correctly.

If a certain number of hospitals fell out of eligibility because of the application of any of these criteria, either could be true: the state allocation could stay the same and it would result in redistribution to the eligible hospitals within the state; or it could be true that the redistribution would be across states provided the state came up with its respective match. Is that a fair statement?

MR. NELB: Yeah, so this analysis, just looking at the redistribution within states, so we -- there's the second questions about state allotments, which would change the amount of funding between states. And you might want to tie, you know, one to the other. But this is just --

COMMISSIONER MILLIGAN: Okay. So just -- that's helpful. So if in a given state a higher number fell out, maybe because of, you know, Medicaid expansion or maybe whatever, the economy, all of that, this doesn't necessarily result in any bias toward sort of a

redistribution across states. This is really resulting in a greater distribution within a state of its share toward the hospitals that would meet whatever criteria might be applied. Is that fair?

Okay.

CHAIR ROSENBAUM: Penny.

COMMISSIONER THOMPSON: I know we talked about this before, but are any of these methodologies more sensitive to problems in the underlying data? So beyond the policy question about what is more just or more appropriate in support of that and in terms of administering these methodologies, are there some that are more problematic in terms of the consistency and availability of timely data?

MR. NELB: Yes. Medicaid utilization is used in a number of different things, including Medicare DSH policies, so that's more available and more reliable for most hospitals.

There's some questions about whether you decide to include the duals or not, but they are available for more hospitals.

The low-income utilization rate, which is this

measure to try to capture the uninsured, does have more issues with it in that it's actually a measure not of like the number of people that go to the hospital, but it's a financial measure. So it's a measure of Medicaid revenue divided by total revenue and then charity care charges divided by total charges.

So the Commission has raised before that we don't have complete data on all the Medicaid revenue that hospitals get. It does create some issues with the measure, but we compared it to the DSH audits. I think the average that we present here gives you a good sense of what it will be, but in terms of the two measures, the low-income utilization rate has potentially more -- is more difficult to calculate without complete Medicaid data.

COMMISSIONER THOMPSON: And so what does that mean for us? Does that mean -- given what you've said, is your conclusion we can trust the impact analysis at a certain level, but maybe we get a little bit more worried about it at a state-by-state level, or we can trust the impact analysis overall, but in terms of actually then operationalizing some of this, there's going to be a need to audit some additional financial statements, or there's

going to be a need to improve certain kinds of reporting to really be able to administer that?

MR. NELB: Yeah. So it's something you may want to think about, whether there should be some data strategy or something, if you use the low-income utilization rate.

It is something states are required to calculate, low-income utilization, for the different hospitals in order to determine whether they're deemed or not. So, presumably, the states have this data, but it's not available nationally in some of these sources that we have access to.

CHAIR ROSENBAUM: Sheldon.

COMMISSIONER RETCHIN: I guess where I stand on this is -- and I want to turn to you, Rob, turn it back to you -- that I also feel like, I mean, the game has changed tremendously, and I guess my only fear would be that despite the declarations that some of the DSH cuts will be reversed given all the uncertainties, my fear would be somewhat that we might go ahead with DSH cuts and then some of the other areas, like expansion, and we just won't be able to resolve all that.

If you were to ask me for a recommendation, I

would say we really should recommend delaying DSH cuts further. That would be the one recommendation I would say, given all the uncertainty.

That said, I guess I would ask you -- and I do want to -- let me just peel off critical access hospitals first, because it's evident to me -- and I don't really understand why the Medicaid utilization is so low in critical access hospitals. I could hypothesize. But I do feel like the supplemental payments are paying for stand-by capacity in critical access hospitals. It's a very different issue. It's an issue of really just volume and the market. Those require a whole set of different policy issues.

That said, I guess I would ask you, if you had to -- and so the cuts that are due, the first round is about $1.6 billion? Is that it? How much is the first round?

MR. NELB: $2 billion in federal.

COMMISSIONER RETCHIN: $2 billion.

So none of these really will reach that, or will it? No, actually, it will. Yeah. The deemed, if you used the deemed status, you'd more than reach the $2 billion in the first round.

MR. NELB: Correct. Yes.

COMMISSIONER RETCHIN: So, if you had to refine that to better targeting -- and there was a proposal for that -- what would you do?

[Laughter.]

MR. NELB: I've got to play the role of a Commissioner.

EXECUTIVE DIRECTOR SCHWARTZ: He gets to put in all the things that I took out of the paper.

MR. NELB: Yeah.

[Laughter.]

MR. NELB: So it's up to you all, but --

COMMISSIONER RETCHIN: But you're closer --

MR. NELB: Yes.

COMMISSIONER RETCHIN: But you're closer to this than anyone.

MR. NELB: Yes. Oh, sure. Yeah.

So I think -- let's see. In terms of this targeting stuff --

COMMISSIONER RETCHIN: That question has never been asked for anyone.

MR. NELB: For a group like this Commission, you

may want to say something like pick one of these things, like above average, Medicaid or low-income utilization, but then provide an option for exceptions based on critical access hospitals or sort of something that's gone through a process and defined by states or CMS or something, these exceptions for our essential services or different things, to sort of lay out some of the targeting.

There actually was a commission 25 years ago. The ProPAC Commission made some recommendations around DSH targeting and sort of high level, but just to say that there should be a higher minimum standard, and that there should be different standards for different types of hospitals. So it's hard with all this data and for this Commission to probably come up with this is the exact right number, but to articulate some principles and also provide some options for state flexibility might be a way to sort of thread the needle.

COMMISSIONER RETCHIN: So I think you're correct that there is not going to be a single category. There are going to be many exceptions, and the sand is through the clock, I'm afraid, in terms of us being able to actually bring a recommendation in January. We have to face that.

Again, if there was any recommendation, I would say because of the uncertainty, we would have to delay.

MR. NELB: Maybe just one other highlight is, in terms of the DSH cuts, I think we discussed in October that potential policy to apply DSH cuts to unspent funding first, so there's about $1.3 billion in unspent DSH allotments.

COMMISSIONER RETCHIN: That's true.

MR. NELB: And so that would be a way of reducing, rather than having a $2 billion cut the first year, have a smaller cut.

COMMISSIONER RETCHIN: That's a good point.

CHAIR ROSENBAUM: I have Toby, Stacey, Brian, Marsha.

COMMISSIONER DOUGLAS: So I continue to struggle on this from the perspective of we're just looking at DSH, and there's so many other payments. So there's that lens, and there's state flexibility lens. And I just come back to do we really need to refine the policy on targeting when there's so many other payments that are going to these hospitals, and it really then becomes a state decision of how to use the various different payments to meet the local

needs. I worry that by tightening, even though in its own in a silo, it makes sense to look at DSH differently, it doesn't take into account all the other buckets.

So I'd probably go with Sheldon. I find these analyses, as great as they are -- and you've done an excellent job -- it's hard to just look, especially with the descriptive that you did, the valuable descriptive, what Urban shows. There's just other pieces, and you can't just look at it in a vacuum, so those are my --

CHAIR ROSENBAUM: Stacey.

COMMISSIONER LAMPKIN: So I have questions. When we last talked about this, I think we thought we'd be seeing a rule or a proposed rule in January. Do we still think that that's the timing?

MR. NELB: We are no longer expecting that. We'll see, but --

EXECUTIVE DIRECTOR SCHWARTZ: What we heard earlier this week was that there are not going to be any more Medicaid rules coming out before January 20th, that there are too many other things in the pipeline, government-wide, to have that, so no UPL rule and no DSH reduction allocation methodology rule.

COMMISSIONER LAMPKIN: Thank you.

And I am assuming we have no special insight on how the DSH reductions will be thought about in the context of the larger actions?

EXECUTIVE DIRECTOR SCHWARTZ: Just that several of the pieces of legislation that have been suggested in the past would restore the cuts that haven't yet happened.

COMMISSIONER LAMPKIN: So I agree with others that it seems premature to recommend at the detail level that the analysis addresses, although I think it could be helpful information for us to share with the appropriate caveats.

I continue to wonder about interaction between this and some of the other provider targeting and state targeting questions that we have and whether we would make -- whether this is the sort of thing that needs to be considered as a package, where you understand the interaction effects rather than individual pieces.

But thank you. Very helpful.

CHAIR ROSENBAUM: Brian.

COMMISSIONER BURWELL: So a question and a comment. In regard to critical access hospitals, if you're

a dual, are you included in the Medicaid utilization rate or not?

MR. NELB: You are included for Medicaid DSH purposes, but in our analysis, we only have the data for the non-duals, so that may be why some fell out.

COMMISSIONER BURWELL: That was my -- given the high rate of older people in rural areas.

And then my comment is we seem to be moving towards a consensus of not making any recommendations for the January meeting, and that's fine with me, but I just want to be clear on where we stand on that.

CHAIR ROSENBAUM: Marsha.

VICE CHAIR GOLD: Well, maybe this will push it a different way.

I guess, one, I don't have any problem with the recommendation on delaying DSH if the reason the DSH cuts are there is that it was the ACA and the ACA is up in the air. It seems like the two are linked. So I wouldn't object to doing that.

I guess I'm curious. Maybe people can just react and say why this would be a bad idea because it sounds like most people think it's a bad idea, but I was struck with

the distribution of DSH across hospitals. And everyone gets in on it, and yes, there are things it's accomplishing, and I know it's complicated. And it relates to all the other supplemental payments, and you might destabilize something or other.

But I also was struck with some of the comments from DSH hospitals that were deemed and the examples we have with people here that really have been affected. I mean, it's a distribution issue within a state as to who gets it and who doesn't, and I guess I'm -- just for reaction, what would be the reason for not going with saying we'd be consistent with Medicare and do a 15 percent standard or something? The data exists. Medicare uses it. Why wouldn't we want to do that?

CHAIR ROSENBAUM: Toby, do you want to --

COMMISSIONER DOUGLAS: It goes, again, back to, first, the state flexibility of understanding kind of all the different buckets of funding. There are other supplementals. I mean --

VICE CHAIR GOLD: It's federal money.

COMMISSIONER DOUGLAS: It's federal money, but there are many other Medicaid supplemental payments and

ways that states are -- you can't look at DSH in just isolation. I just don't believe so. In isolation, it makes sense, but there could be unintended consequences. It just seems -- unless, again, federal versus state, without understanding on a state level how they're using DSH in connection to the other funding sources, tightening the limits could have unintended consequences is my --

CHAIR ROSENBAUM: Kit and then Alan.

COMMISSIONER GORTON: And I would just add onto what Toby was saying. Why do we think the federal government is in a better position to make this allocation decision than the states? The states know the roles that the hospitals play in the various communities far better than -- I mean, the states are dealing with 100 or 200 hospitals. The federal government is dealing with 4,000. So why would we feel that we had more insight into what was going on?

Brian talked about hospitals as businesses. Yeah. But, at some level -- and I think the point Sheldon was making is, certainly, with these critical access facilities, they're utilities. They're community utilities. They have to be there whether there's a volume

demand on them or not. You don't tear down your power stations because the temperature is warmer in the summer, and so you don't need to do heating. So they have to be maintained at a certain level all the time, or else they die, as is happening as Leanna pointed out earlier.

So I think that the people who are close to that are states, and as a general rule, we let the states regulate those things which they are close to. And I'm all in favor of transparency, and I'm all in favor of accountability. But for all the reasons that Toby said -- to me, it's not -- the question, Marsha, is not why is it a bad idea to do it. To me -- I'll turn it back to you. Why is it a good idea to do it? What is the purpose of consolidating yet more power in this town?

VICE CHAIR GOLD: I didn't look at it as a way of consolidating power in this town. The issue is supposed to stand for disproportionate share hospitals, and it turns out that because of the power in some states of some hospitals that money has been disused across things. And so it's not necessarily from a federal funds accountability point of view, that it's not necessarily the case that the money is consistent with the purposes of the authority for

the money.

So I'm for state flexibility, but we have to figure out what the purpose -- within what constraints, if it's federal money. So that would be the argument I would make. It's really just how -- what's the rationale for the money, and what parameters do we place upon state flexibility when it's federal funds?

CHAIR ROSENBAUM: Alan.

COMMISSIONER WEIL: I don't know, given the last back-and-forth, if this is helpful, but I can't help myself, anyway.

My first job out of graduate school was helping administer the uncompensated care pool in Massachusetts, which we did on a Lotus 123 spreadsheet, saved most likely on floppy disks, something my children have never seen.

And even in a rate-setting state, there was always the question. Given a shortfall between the inflows into the uncompensated care pool and the level of uncompensated care provided, do you proportionately spread those dollars, or do you disproportionately allocate them to the highest -- to those hospitals that have the highest levels, leaving those that have lower levels, too, sort of

absorb that shortfall? And I would just say that, of course, then when Massachusetts many, many years later converted those dollars into coverage dollars, you then once again had the question of how did the facilities that have been relying on those dollar survive in a new world where the allocations are made through the insurance system rather than through a separate pool.

So I am not going to resolve the discussion here, but simply to say we've been having it for a really long time.

CHAIR ROSENBAUM: Chuck.

COMMISSIONER MILLIGAN: I commit to not resolving it either.

[Laughter.]

COMMISSIONER MILLIGAN: There's one contextual thing I just feel like I want to add to the discussion. I sort of support what Sheldon said, which is, in light of a lot of uncertainty maybe in January, it's worth saying let's hold off on some cuts or take the unspent or something, but

I guess I do want to draw a distinction between DSH and some of these other supplemental funds, because

there is an important distinction to be drawn, which is DSH is not tied to utilization. Every other disproportionate -- every other supplemental fund, there's a nexus to utilization directly, whether it's sort of paying up to another payment limit where you're tying it to volume and then attaching it somehow to a rate, and there's a calculation based on volume and Medicaid equivalents and so on.

DSH is really -- sort of, I think of it, or for purposes of this conversation, we think of it as a grant of sorts, matched by the state, but it's a -- it is a supplemental payment de-linked from utilization, and it is meant to be a subsidy of a provider to help them sort of retain a safety net function, but not linked to their volume, explicitly not linked to their volume.

And so it is -- I mean, Sheldon used the phrase "critical access," it's a mechanism -- or critical access is to have available capacity or surge capacity or something. DSH is not -- DSH is intended to keep providers in business that meet safety net obligations.

And so, you know, a lot of this work was started in our sort of analytic framework, mindful of the fact that

with the Affordable Care Act and coverage expansion and a conversion of a lot of previously uninsured individuals into a coverage model, do we need to have a lot of these subsidies anymore, or should it be better targeted and all of that? But given a lot of uncertainty now post-election and kind of where are things going, I do find myself support, kind of like, let's sort of wait and see, let's not take cuts kind of DSH model, and where and whether subsidies continue to be needed in a DSH type of historic framework, because of that relationship to coverage.

So I'll just stop there.

CHAIR ROSENBAUM: Alan.

COMMISSIONER WEIL: Chuck, can I offer a friendly amendment? If I heard you right, I don't think it's accurate to say that in all instances DSH is not tied to volume. I would say it's not tied to a specific transaction or to a specific service delivered at a specific point in time. It's not tied to a claim. But I think there are many instances where the level of payment is actually tied to volume.

COMMISSIONER MILLIGAN: No, I --

COMMISSIONER WEIL: I just want to make sure I'm

hearing you right or viewing it -- get your reaction.

COMMISSIONER MILLIGAN: I agree with the friendly amendment, Alan. I think -- so by -- I mean, it's -- as Rob noted, I mean, there's deemed and all -- there's a lot of criteria that are underneath, based on distribution of payer mix and uncompensated care and so on. So it is, in that sense, tied to volume. But a DSH allocation to a hospital is without regard to Medicaid claims or Medicaid specific utilization. You don't need to tie it back, in the way that you said.

CHAIR ROSENBAUM: Let me raise one issue. It could be that by the time we meet again the House will have taken action on a successor bill to the one that was vetoed, which will contain, as it did last time, a reversal of the DSH cuts. If the House, for some reason, has not taken action, we could decide that we want to send a recommendation on this. I mean, if the issue is moving through Congress anyway, that's one thing. If nothing has happened yet, we may want to act.

And Anne and I were just conversing about sort of a prudential step in the event we want to make a recommendation in January, which would be to convene the

conflicts of interest committee as soon as possible, so that we can go through the conflict process that we need to go through, so that in the event that we do need to have a vote, or want to have a vote on a delay in the DSH reductions, we will be set to do that. And that way we can decide, you know, before we meet, that we will need a vote, and we will be all set to vote.

So if people are comfortable with that, then we will, as fast as our little legs can carry us, get the conflict of interest committee together to go through the process and be prepared.

Yeah? Okay.

COMMISSIONER CARTE: I was just wondering if there's -- in the past hasn't the Commission also focused on transparency, and is there anything further in that area that we would want to consider?

EXECUTIVE DIRECTOR SCHWARTZ: The DSH audit data. We have a lot of data. It's old because it's got to be audited data. It's hard to sort of speed that up. But I think this is one area where we actually have a lot of information.

CHAIR ROSENBAUM: All right. I think we are done

for now. Thank you, Robert.

And now we have time for public comment from the public.

PUBLIC COMMENT

* MS. GONTSCHAROW: Hi. Good morning. Zina Gontscharow with America's Essential Hospitals.

I'd just like to thank the Commission for this opportunity to comment and for your continued work on this important issue, particularly given the period of uncertainty that our hospitals are facing now, which we were not expecting. We fully support any recommendations from the Commission to further delay the Medicaid DSH cuts, particularly if the House and Senate do not move as fast as they are intending to.

It goes without saying that Medicaid DSH funding for our members is absolutely vital. Without this funding, they would not be able to provide care to the most vulnerable, train the next generation of health care leaders, provide comprehensive coordinated care, and the specialized life-saving services to their community, and especially the most vulnerable.

So we look forward to the March report and we

look forward to continued opportunities to work with the Commission.

Thank you.

CHAIR ROSENBAUM: Thank you.

MR. PUGH: Good morning. Greg Pugh here on behalf of Doctors Hospital at Renaissance, a deemed DSH hospital in the Rio Grande Valley in South Texas.

We just want to thank the Commission and the staff, especially Mr. Nelb, for their hard work on this, and we have written comments to submit as well, into the record, and I'll do that, however is most easy for you guys.

Thank you very much for your work.

CHAIR ROSENBAUM: Thank you.

All right. We are adjourned.

* [Whereupon, at 11:28 a.m., the meeting was adjourned.]