PUBLIC MEETING

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

Thursday, January 26, 2017
9:30 a.m.

COMMISSIONERS PRESENT:

SARA ROSENBAUM, JD, Chair
MARSHA GOLD, ScD, Vice Chair
BRIAN BURWELL
SHARON L. CARTE, MHS
ANDREA COHEN, JD
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
CHRISTOPHER GORTON, MD, MHSA
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PENNY THOMPSON, MPA
ALAN WEIL, JD, MPP

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:30 a.m.]

CHAIR ROSENBAUM: All right. We are right at our start time. Happy January, everybody. My condolences to all of you who would like to be skiing at this point. I don't know if there's snow anywhere, but welcome to warm and sunny Washington, D.C.

So we are going to kick off our meeting. It's a jam-packed meeting. We are covering a lot of material today, and we are starting, of course, with the review of our draft March report chapters on disproportionate share hospital payments.

Take it away, Rob.

REVIEW OF DRAFT MARCH REPORT CHAPTERS ON DISPROPORTIONATE SHARE HOSPITAL PAYMENT

* MR. NELB: Great. Thanks, Sara, and good morning.

Today, I will be reviewing two draft chapters on disproportionate share hospital payments, known as DSH.

I will begin today's presentation by just reviewing the statutory requirements for MACPAC's report, and then I'll provide an update on the status of pending

DSH allotment reductions. Then I will review the findings from our two draft chapters, which build off of material that we presented at prior meetings.

I would note that although it's a bit confusing, these chapters are labeled 2 and 3 because of the fact that the CHIP recommendation, which you discussed at the last meeting, will be the first chapter of the March report.

This meeting is the Commission's last opportunity to weigh in on the contents of the March report, but there will be other opportunities to weigh in on DSH policy issues in the future, and so I will wrap up today's presentation by reviewing some next steps.

So first with statutory requirements, as you know, MACPAC is statutorily required to report annually on Medicaid DSH allotments and their relationship to the factors listed here. MACPAC's first DSH report was published in February of last year, and subsequent reports will be in our March report to Congress.

This year, we are required to project DSH allotments for fiscal year 2018, which is the first year that DSH allotment reductions are scheduled to take effect. Under current law, DSH allotments -- federal DSH allotments

are scheduled to be reduced by $2 billion in fiscal year 2018, and the amount of the reductions increases each year, up to $8 billion in 2025.

DSH allotment reductions were initially added by the Affordable Care Act, and they're premised on two assumptions: first, the assumption that ACA coverage expansions would reduce hospital uncompensated care costs; and second, the assumption that lower uncompensated care costs would reduce hospital's need for DSH payments.

In this year's DSH report, we are able to provide more data about hospital uncompensated care for 2014, the first year of the ACA coverage expansions. However, as Congress begins debating potential repeal or other changes to the ACA, it's difficult to project how hospital uncompensated care and hospital's need for DSH payments may change in the future.

Given this uncertainty, Commissioners raised concerns at our last meeting about whether pending DSH allotment reductions should take effect, as scheduled. However, at the time, it was unclear whether or not Congress was already planning to delay or repeal DSH allotment reductions as part of larger changes to the ACA.

We do know that prior proposals to repeal the ACA have included repeal of Medicaid DSH allotment reductions, but now, just as in December, it is still not known which proposal, if any, will ultimately be adopted. It's also not clear when these actions will be taken.

And so, one month later, the Commission is in a similar place that it was in December. We still have some information about the effects of DSH cuts under current law, but we don't know how that current law might change. And so because of that uncertainty, these draft chapters that we have prepared just assume current law and report the facts that we do know, without speculating on what might change. However, we do welcome your feedback today on any additional context that we should add to reflect the current policy environment and also your feedback on any policy statements the Commission might want to make about DSH allotment reductions at this time.

All right. So, with that background, let me dive into the first of our two chapters, which analyzes current and future DSH allotments and compares them to the data that Congress asked us to consider.

First, we find that the number of uninsured

continued to fall in 2015. According to the current population survey, 29 million individuals in the U.S. were uninsured in 2015, which is 4 million less than in 2014 and 12.8 million less than in 2013.

Second, we find that overall hospital uncompensated care fell by about $4.6 billion between 2013 and 2014. These estimates are based on two components: first, bad debt and charity care, which is provided to the uninsured; and second, Medicaid shortfall, which is the difference between Medicaid payments and hospital's cost of care for Medicaid patients.

Between 2013 and 2014, bad debt and charity care decreased by $5.5 billion overall, while Medicaid shortfall increased slightly by $.9 billion because of increased Medicaid enrollment.

Although uncompensated care fell overall, the decline in uncompensated care was much larger in states that had expanded Medicaid than those that had not.

And lastly, although hospital margins improved for all hospital types deemed DSH hospitals, those that are statutorily required to receive DSH payments because they serve a high share of Medicaid and low-income patients,

continue to report negative operating margins before DSH payments, about negative 3.9 percent in 2014.

This figure shows the very wide variation in changes in hospital uncompensated care by state between 2013 and 2014. In general, as I said, hospitals and states that expanded Medicaid reported larger declines than hospitals and states that did not, but there are some exceptions. For example, hospitals in Connecticut actually reported a small increase in uncompensated care cost between 2013 and 2014, which may be due to the fact that Connecticut actually expanded Medicaid early in 2010, so they may not see the same change between 2013 and 2014.

Also, I want to point out that the decline in uncompensated care that we see in each state is not directly correlated to the change in the number of uninsured in each state. So, for example, in both California and Connecticut, the uninsured rate fell by about one-quarter between 2013 and 2014, but during this period, uncompensated care fell by more than half in California and was relatively unchanged in Connecticut.

In addition to reporting on the elements that Congress requested, we're also required to project future

DSH allotments. As I mentioned earlier, our projections in this chapter are based on current law, which assumes a $2 billion reduction in federal DSH funds. To estimate how these reductions would be distributed among states, we modeled a methodology that CMS had initially proposed in 2013, which is based on the factors listed here. However, it's important to note that if DSH allotment reductions do take effect, CMS will need to issue regulations to update this methodology, which may change the specific state-by-state effects that we model.

This map shows our projections for the percent decrease in state DSH allotments in fiscal year 2018. As you can see, the size of DSH allotment reductions varies widely by state from 1.2 percent in Arkansas to 33.5 percent in Connecticut.

Because of this wide variation in state DSH allotments, as well as the variation that we saw before in the effects of the ACA on hospital uncompensated care, the states that have the largest projected declines in DSH allotments are not necessarily those that have the largest declines in hospital uncompensated care. So, in fact, we found that in 2018, 20 states are projected to have

declines in their DSH allotments that are greater than the decline in hospital uncompensated care that was reported between 2013 and 2014.

Regardless of whether or not pending DSH allotment reductions take effect, there are also questions to consider about how states distribute DSH funds that they're allotted. The Commission's first DSH report found wide variation in the share of hospitals that receive DSH payments by state, and so the Commission concluded that DSH payments should be better targeted to states and hospitals that both serve a disproportionate share of Medicaid and low-income patients and have high levels of uncompensated care.

Over the past year, we've been exploring a variety of approaches to improve the targeting of DSH payments to providers, which are discussed in this chapter.

Under current law, states are permitted to make DSH payments to any hospital that has a Medicaid utilization rate of 1 percent, which is a standard that virtually all hospitals meet. In this chapter, we analyze the effects of raising that minimum federal eligibility standard to a higher threshold.

We looked at seven different standards, which are the same that we discussed with you in December. We looked at three absolute standards, which would apply equally across states, three relative thresholds, which would differ by state based on the average Medicaid or low-income utilization rate in that state, and we also looked at the deemed DSH standard, which identifies the hospitals that are statutorily required to receive DSH payments.

In general, we did find that most DSH hospitals would meet the higher eligibility thresholds that we analyzed, and that hospitals with higher Medicaid and low-income utilization rates had more higher levels of uncompensated care. However, we also found that some of the DSH hospitals with lower utilization rates that didn't meet the higher standards appeared to face other financial challenges and relied on DSH payments to offset operating losses.

In addition, a large share of the DSH hospitals that we identified with low Medicaid utilization rates were critical access hospitals, which are small rural hospitals that receive special payments from Medicare because they're often the only hospital in their region.

The fact that so many of these hospitals did not meet the higher eligibility threshold may be due to limitations in our data since critical access hospitals are more likely to care for dual-eligible Medicare enrollees, which are not included in our utilization measures.

However, Commissioners also noted that critical access hospitals operate in different circumstances than other types of hospitals and suggested that in future reports, we consider different standards for different types of hospitals.

In this chapter, we also discuss other potential approaches to improve the targeting of DSH payments to providers. One approach that we've discussed is changing the DSH definition of uncompensated care, which would change the maximum amount of DSH funding that a hospital could receive. This definition could be narrowed to exclude DSH payments for Medicaid shortfall or for bad debt, or it could be expanded to include payments for uncompensated care costs incurred by hospitals outside of the hospital setting.

In this chapter, we look at the number of DSH hospitals that would be affected by the various definitions

of uncompensated care, but our analysis is limited to 2012, the latest year the DSH audit data are available. As a result, we don't know how the ACA coverage expansions might affect these estimates.

A second approach that we discuss in this chapter is moving away from cost-based reimbursement for DSH and moving towards more value-based payment approaches. Specifically, we highlight the example of California, which recently received approval from CMS to convert its DSH funding into a global payment that provides incentives for hospitals to deliver more outpatient and preventive care to the uninsured.

Although it's too early to evaluate the success of this initiative, we do share some preliminary feedback from Santa Clara Valley Medical Center, which is one of the hospitals that we profiled.

And finally, we discuss approaches to federalized DSH payments, including two proposals introduced by Members of Congress to combine Medicaid and Medicare DSH funding. If Medicaid DSH funding were federalized, it would likely remove the requirement for states to provide matching funds in order to draw down DSH payments. However, it would

likely limit the ability of states to target DSH funding based on their local needs.

So that concludes my review of the draft DSH chapters for the Commission's March report. I look forward to your comments and suggestions and will work to incorporate your feedback into the final draft.

I also look forward to any feedback about any policy statements you might want to make, but I do want to point out that the Commission will have future opportunities to weigh in on DSH policy, particularly if CMS does release a regulation to update its DSH allotment reduction methodology.

Thanks.

CHAIR ROSENBAUM: Thank you very much, Rob.

So questions? Andy, Alan, Marsha.

COMMISSIONER COHEN: Rob, terrific work, really two incredibly well-done, clear chapters on a topic that is really important and murky and patched together on so many levels, so a couple of points.

I think, first of all, with respect to kind of a policy statement about DSH or DSH cuts in general, I do think DSH is a terribly contextual program, like it is

designed to help address gaps in other forms of Medicaid and health policy and to ensure access sort of above all, and so I do think that some statement of caution about really substantial cuts in a context of really significant financing uncertainty for Medicaid and other kinds of health care providers is appropriate at this time, and that the issue of DSH cuts really has to be considered in the context of what else is happening in the policy environment. And it's really essential for it not to be on sort of an automatic pilot while other things are changing around it, so that's one thing.

With respect to the analysis, mostly focused on what's in Chapter 3 -- so this is the sort of ongoing question about whether DSH, as it stands, could be better targeted to providers that see a higher number of Medicaid and low income, more uninsured patients.

Your analysis shows that there are lots of challenges, especially data challenges, like there is a limit to what we know from the federal level to help us understand exactly what the impact would be of any targeting, any sort of targeting policy, but I will say I still think your data is compelling. While the majority of

funding is going to hospitals that see a lot of Medicaid and uninsured payments, a meaningful amount is still going to hospitals that are not seeing a relatively high number of Medicaid or uninsured patients. And I do think that is a real problem. It does not comport with the purpose of DSH, which, on its face, it is disproportionate share payments. So I would be in favor of us pursuing knowing a little bit more and then really wrestling with some policy decisions around targeting in the future.

I am a little bit concerned about the way in the chapter the issue of financial challenge comes up for hospitals, because I think hospitals can be financially challenged for lots of reasons that have little to do with their payer mix or their uninsured and Medicaid status, and I think the fact that a targeting policy might leave out some hospitals that are in financial distress is not a reason not to do a targeting, not to do a targeting exercise. We could make some recommendations to Congress about really being a little bit more true to the purpose of DSH and not having it be sort of a catch-all for any problems in a health care market, and financial distress is not always a reflection of a problem in a health care

market either. So I just want to be careful about how we use that as a criteria in our thinking and be careful about it.

And then my last point, I really like the way that the sort of alternatives to how DSH can be earned or how you'd be eligible for DSH is laid out in the chapter. I think this is a really important area for MACPAC to look at. So many things about DSH are old and not current in today's policy environment. The cost-based sort of tap, I think, can be really problematic, and I think the notion of trying to add some more value-based payment policies into there is really important, and I'd like to explore that much further, again, not with the notion that it will have no impact on anyone, but with the notion that policy should set incentives as well as just distributing funds.

So thanks so much for great work.

CHAIR ROSENBAUM: Thank you.

Alan.

COMMISSIONER WEIL: So I'm going to echo Andy's comment on the quality of work, but I will diverge fairly significantly from the conclusions I draw from it.

I think at this point, having these data is

critical, and I want to commend the quality of the work, the analysis, the challenges associated with it, the importance of it at this time.

I have slightly different concerns, although I do share Andy's comment about the margin as a tough proxy.

I don't even quite know how to express this, but when I look at the three alternate approaches, which you are at the end of Chapter 3, one of these is not like the other, and I guess I want to spend a moment just because I think further exploration is always warranted, but they feel a little more ripe than they are. And I want us to not be weighing in.

So the first of the three to me is very much like the utilization threshold. It's sort of changing basic quantitative criteria, and it's just a different way of doing it, but the other two are to me far more complex. I love the notion of exploring a value-based payment model, but the issues in doing that are profound, and having comments from one hospital system, health system in California, although it's what we have, I think dramatically understates the complexity of are you rewarding level, are you rewarding improvement. In

California, you have a very tight ecosystem of which hospitals are getting funds, and therefore, this is really a question of replacement. That's very different if you go to a broader model.

Similarly, the federalizing, I agree with your point that it eliminates the local targeting, but it also seems to me that the issue that I didn't see notes is that it could substantially decrease the level of DSH funding. I mean, after all, DSH payments are matched, and although, according to the quantitative analysis, the amount of state share going into DSH is smaller than it is in non-DSH, it's still far from zero, and again, those are national averages. So there are a lot of places where if you federalize DSH, even if the federal outlays remain the same, the total funds flowing would be much lower, and that just seems to me to be a first-order issue above the allocation.

So I guess this is one of these sort of cautions to staff is that I think people could over-interpret our interests in these three before we're really at a place where we can weigh in on their implications, and I would want us to be quite cautious.

With respect to what we say about policy, I guess I am more -- although I share substantively the concern about pulling DSH out in these uncertain times and the like, I am very hesitant to get us in a situation where we say, "Given that the future of coverage is uncertain, this provision should remain." I think if the future is uncertain, a lot of things -- there's a lot we have to say about what should remain, what shouldn't be touched, what should change.

To me, sort of an "if then" statement, "If coverage is going to decline, we don't know how, but we know that we don't want DSH to be touched because the premise of the cuts" -- it starts -- I get very nervous about the message there, why DSH, why not other things.

So I am confident that I substantively align myself with Andy's concerns, but from a MACPAC policy statement perspective, I would be very hesitant to have us weigh in on DSH separately based on very uncertain direction of policy. I realize things could move quickly in a way that we wouldn't have an opportunity to weigh in. I guess that's a risk that we take on the whole structure, but those are the two areas I wanted to comment on.

VICE CHAIR GOLD: Yeah, hi. Nice job. I thought the write-up was really good. I provided some written comments, and I wanted to summarize the sort of three key themes there so it's on the record and also so Commissioners have a chance to react, because I did not bother sending all that paper to you.

Basically, my comments have to do with packaging around what's there rather than the good work that's there.

The first is that I thought we did a great job in last year's DSH report in having a context and describing it, and especially with policy issues, people are going to be coming to this who may not know it's there. So I thought it was important at the beginning to flag to people that there was that chapter in last year's report, maybe with a link so they can find it, and even maybe putting a box, if there are certain points that are critical from there so that people coming into this from the start get the benefit of that and don't just think we provide a lot of numbers.

In terms of the numbers, I also think it would be user friendly to have a table that showed what was in last year's report as numbers on Chapter 2 and what is this year

-- that is, which ones got updated, which are the same, which are new, just some way so people who are trying to use this don't have to go back and flip between the two to figure out what this is saying.

I do think -- and this other people have talked to here -- that we do probably need to get into some context. I agree that it's premature for recommendations. It's also just too uncertain a time to know exactly what to recommend. But I think as written they sort of just stand there without any thought, and people have already said things.

I took my shot at points, and I'm not sure these are the points, but I'll lay them out. One, DSH allocations remain controversial across states, and also the allocation within hospitals given diversity in states and the different way it's used; but that DSH has been really important to safety net hospitals, and despite the challenges -- despite the ACA improvements, those hospitals maintained a challenge. I think that's a conclusion that comes out of your findings that needs to be there.

I think we could say that we're concerned that the DSH cutbacks could exacerbate problems at times when

policy is in flux and tie that to a general statement of concern for the safety net in general as ACA and repeal requirements may increase the number of uninsured. And maybe sort of then tip to the fact that unique features of DSH are also relevant to block grant considerations. Some proposals include DSH, some don't. I don't think we have to make a statement, but I think we need to say that, you know, this is -- it's important to think about this because it could reinforce existing inequities or problems.

So that was just my way of saying it. There may be other ways, but I think we need something that's kind of thoughtful along those orders.

The third comment I had -- and I don't have too much substantively to say here. I thought Chapter 3 just sort of hung there, and Andy has made some comments and there have been other comments made about what we do, and I think Sheldon provided you some comments as well. He can't be here today. But I think we need to say a little bit, even though we're not making any recommendations, and I think we may even -- you know, we've gotten a lot of letters from safety net hospitals, essential hospitals, and others, and we could incorporate some of the feedback that

we've gotten as we talk about that, as well as a conclusion on sort of what does it mean that our findings showed that if you made all these changes, the money wasn't that affected but certain hospitals were. So just summing it up so it doesn't just hang there.

COMMISSIONER GORTON: So two thoughts. One, I would largely associate myself with what Marsha and Alan were saying. I do think that it is reasonable from a contextual point of view to say, look, DSH fundamentally is designed to fill a gap in the safety net. If the whole framework is going to change, then where the gaps and the safety net may fall and how big they are, we don't know. And I think what your work in both chapters demonstrates -- and this might go in that umbrella piece that you talked about tying them together -- is this serves an important role in today's financing ecosystem. And whatever comes in the future either needs to take up that role or needs to -- I hate to use the "R" word. It's a hole that's going to have to be filled one way or another. If it doesn't, these critical access hospitals and others are going to struggle even more than they already do. And across the country, we do see -- and I don't know if this is a factoid worth

pulling out, but we do see steady erosion in the survival that with respect to the smaller community hospitals. So that's one piece.

The conclusion that I took away from Chapter 3 -- and you said it in your presentation, Rob. The Commission concluded that there must be opportunities to better target DSH money. And I think you're right. I think we did conclude that.

I think what Chapter 3 demonstrates fairly effectively is, in fact, that conclusion was wrong. You've disproved the hypothesis, because the states, while they're doing a variety of different things to distribute DSH -- I mean, nothing jumps out of your data that says, oh, well, this one's fundamentally wrong or this one's fundamentally wrong, or, you know, we found a better cut point that we could do this better. You know, there's nothing that rises out of those data that says here's the better way. States have each done things in their context. Alan talked about what California is doing, which is an interesting innovation, experiment. Right? That comes back to the whole idea of states as laboratories. Do you want to do that across the country before we figure out what happens

in California? Maybe not.

And so, you know, to me, what Chapter 3 reinforced was DSH is an important tool for the states and the states' responsible use of it. There's issues in how the entire Medicaid program is constructed and operated on a day-to-day basis. Nothing's perfect. But, you know, DSH is pretty much working the way it's supposed to work, and, you know, you might make value judgments about the decisions people made, the peanut butter approach versus the very targeted approach. But at the end of the day, DSH is doing pretty much what it set out to do, and the states seem to have appropriately taken advantage of the flexibility available to them to construct how they run the programs.

COMMISSIONER DOUGLAS: Well, I'll just associate myself with Kit's comments. First, a great analysis. But, you know, what it leads me to conclude is, one, to hit these redactions, it's very difficult based on all these different methodologies and standards. But any of them, when you look at it, and you look at the hospitals that are impacted, from a state perspective these are important and critical hospitals. And so it really does get to the

third, that it's very -- I get back to where Kit is, that our recommendation last time around, while right without the data, the data now leads to this is really a state-by-state, need to figure out how to execute and implement in today's world. And as we get to a future state, if we do, then it's different. But state flexibility on how to target these DSH -- the way to use DSH within the broader world of all the different other payments that they're using, whether it's supplemental payments or others, is essential. It's very difficult to come up with a formula that works across all our different states since they're doing it so differently.

COMMISSIONER LAMPKIN: I have a couple broader points here and some minor comments that I'll send via email, Rob, but it's very -- it's really a ton of information. It's almost so much that it's hard to come up above it and think about where -- what the main takeaways are.

I want to say I think it would be helpful to put this in the context of the current uncertainty in some respect, in some way, and talk about, you know, it's not clear whether it will continue to be a separate funding

stream or not potentially. If there's some way to frame it there at the beginning so that it doesn't look like we're in another -- off in a different world.

The second thing is -- and I think that may have some implications for -- if it remains a separate funding stream, federal dollars with a stated purpose, there are some signals in these chapters that things have gotten a little weird, and, in particular, that Table A.6 that starts to pull the state allocations into some comparative metrics that are really quite startling, and it's a function of history, and it's a function of the very complex hospital payment context that Andy alluded to. But it keeps us in a world where hospital financing is just very -- lacks transparency, and that's tough to make and maintain and evaluate policy in that context.

And so there's some of these thoughts that we need to use to put some context around this wonderful package of information, I think.

COMMISSIONER WEIL: I'm just going to add a sentence, which is I don't think the fact that none of the federal formula changes that were modeled meet some abstract test of being the right way to better target DSH

funds disproves our conclusion that DSH funds should be better targeted.

CHAIR ROSENBAUM: You know, as I'm listening to everybody and thinking about the great information in this chapter, I also reflect on the fact that we have been struggling with what ought to be safety net policy in this country for -- well, at least 50 years when the federal government really began its first very deliberate investments in anchoring entities in very poor communities. They weren't hospitals at that point. They were clinics. But -- and DSH, of course, represents another chapter in that. We've had other programs along the way that anchor entities in communities, and we've used payment add-ons, we've used payment rates, we've used grants. And we've used them at the federal level, states have used mechanisms, localities, of course, do through special purpose financing. And in some ways, the story of DSH and the consequences of DSH are part of this long-lasting story.

And I think to me the most remarkable thing that the chapter reflects is that even when you look at the Medicaid expansion states where the situation is, of

course, much better for hospitals, that a discussion of insurance is both enormous but pointed, and it's like a Venn diagram. It's only a partial discussion of these institutions. And so I think it would be nice in our material, especially because we are at, you know, potentially a big transitional time in American health policy, if we can capture a little bit the fact that DSH questions are part of a huge constellation of questions about whether the nation needs a health care safety net, what functions it serves, how do we recognize them. The IOM, of course, did a seminal study on this 20 years ago. And much has changed in 20 years, so we can't relitigate the whole issue of, you know, what is a safety net, who should it be, how do we fund it, what should the ground rules be.

But I would say that much more than Medicare, even though Medicare DSH is obviously essential, Medicaid has been the program that has had to grapple with this. And if anything -- and this is where I think this work ties together with our access work so well. If anything, the situation has become more pronounced in terms of the relationship between infrastructure and health care

transformation, which is where Medicaid wants to go.

So it's a long way of saying that bringing a little bit of that color commentary into the opening to these chapters has less to do with just Medicaid itself and has more to do with the historic concerns around the safety net might be a good idea at this point. And I think it is notable that in an expansion state, these hospitals are considerably better off, but they are -- the deemed DSH hospitals are in, you know, tough shape, and there's so much more to safety net policy than this, although it's the single biggest factor, probably.

COMMISSIONER BURWELL: So I disagree with Sara that I really feel that in my kind of trying to get up to speed on these things, that the big picture of safety net hospitals and where they fit into our health care system isn't part of our discussion, I just -- and so kind of I feel I'm dealing with very incomplete information. But I also want to commend you on the quality of this work. I just thought it was exceptional.

I have one clarifying question. So we have data on which hospitals get DSH allotments and the characteristics of those hospitals. But we do not have

data on actually how much each hospital gets in regard to DSH payments. Is that correct?

MR. NELB: No, we do -- we have data from 2012, is the latest, about the DSH payments to particular hospitals. Yeah, so we do have some of that --

COMMISSIONER BURWELL: And we are dependent upon CMS for getting more recent data?

MR. NELB: It's from these DSH audits, and so there's a process. They have up to three years to make the DSH payments, and then it gets audited. So it is about, you know, five years later that we do get the data.

COMMISSIONER BURWELL: My understanding is that CMS was making an effort outside of the audit process to collect information around the distribution of DSH payments and supplemental payments.

MR. NELB: Yeah, so the Commission has made a recommendation for CMS to collect more hospital-specific data and make it available on a more timely basis. But as of yet, we don't have that data.

COMMISSIONER BURWELL: And it hasn't been promised?

MR. NELB: No. But we would appreciate it any

time it comes.

COMMISSIONER COHEN: I just want -- I very much agree with Sara's point that everything is sort of a vague proxy to everything else, but the big picture we're really talking about our safety net policy here. I wondered -- we have so many limitations in our data, and we are numerous steps removed from where the rubber hits the road in communities. But might it be complementary in further analysis to just do a little bit of market analysis, even if it's just in a few markets? Or, otherwise, are safety net hospitals closing? Are they changing their access policies? Are they changing their charity care policies?

Our access work is very far away and very far removed from changes in, say, DSH policy or other -- and insurance policy, really, but sort of an intervening sort of set of data might just be some market analysis about what is happening to safety net hospitals and what are some trends that we can look at. I think it would really round out much more than margin, just looking at margins, what's really happening and what's at risk.

COMMISSIONER BURWELL: I'll add to that, in addition to market analysis, I feel like we have no data on

what we're buying with DSH funding. So we have no data on costs and quality in safety net hospitals versus non-safety net hospitals.

VICE CHAIR GOLD: Well, actually, there was a report that I've shared with staff, that it wasn't targeted at that issue but it's relevant to this. It was done by ASPE and it's on socioeconomic status and quality indicators, and it looks at various payment policies like the readmission penalties and the others, and it does show some of the difficulties of -- it shows a relationship between socioeconomic status on some measures and quality, but also the difficulty of attributing that necessarily to the facility or the provider versus the patient and some other things. You might want to look at that, Brian. I can send you the report -- it's up on the ASPE website -- and staff may want to make that connection here. It's very messy, complicated, but there were some fairly clear patterns on some things.

CHAIR ROSENBAUM: Yeah, well, and it does -- we have time to wax a little more poetic in our commentary here. It does also, you know, get you to this next question of, when you have a country like ours, where the

economic lines around communities are very stark, often, and you also have a policy necessary in health care, which is so local, that anchors institutions in the very community, you know, deliberately through all cultures, payment levers, and revenue levers, anchors institutions in communities that are extremely resource-deprived in any number of ways, I think the deeper question, and some of this research now coming out around the penalty, imposition of penalties, I think, begins to shed light on it, what do you have to do in the way of policy to -- you know, what should your expectations be, and then, what do you have to do in the way of resource policy to position facilities to be able to improve their performance?

And I continue to think that the CMS DSRIP initiatives were very much on the right path, because they recognize the importance of place-based policy and they were quite targeted in thinking through, you know, what do we have to do in the long term, what kinds of advance investments do we need to get there, with DSH playing a part but by no means the only part, and I think things like the Santa Clara County experiment become extremely important in terms of also thinking about how you are able

to use the capital investments that are made.

So it's a big issue for MACPAC because, in the end, the safety net is so important to Medicaid policy, and figuring out what you do with the mountain of quality information, financing information, residential pattern information, you know, how Medicaid can be used to advance a policy of access and quality, I think this is very important.

EXECUTIVE DIRECTOR SCHWARTZ: And just to that point, we have another project underway on DSRIP to help us find out, you know, now that those efforts are maturing, that involves interviews and analysis, and I think we're still doing the interviews right now, right? So we'll have information for you probably later in the spring.

CHAIR ROSENBAUM: Any other -- oh, Stacey.

COMMISSIONER LAMPKIN: As long as we have time, as we're thinking about DSH next steps, I have some questions for Rob.

Assuming we're continuing to evaluate DSH as a separate funding stream, we talked a little bit -- I mean, you've acknowledged the treatment of bad debt in the role in DSH and monitoring of the uncompensated care. How much

do we know, or can we tell, about the bad debt piece for commercially insured individuals, in the data, especially now as we roll into 2014-2015, where we know we've got more folks in higher deductible plans, and so forth? Are we able to parse that out and understand how much of the uncompensated care is associated with commercially insured individuals?

MR. NELB: Sure. So most of our data on bad debt comes from Medicaid cost reports. They distinguish, for charity care, between uninsured and people with insurance, but for bad debt it's just a single number. But we can look if there's other sources out there. We have been looking at community benefit reports, which are only available for nonprofit hospitals. But again, I think they provide more data on the charity care, how that splits out, but not as much on how bad debt splits out between insured and uninsured.

COMMISSIONER LAMPKIN: So I would just suggest that that maybe a fruitful area for us to dig into, is to understand the implication on the hospitals, and particularly the hospitals we're most concerned about, the safety net hospitals and the deemed DSH hospitals, about

whether that transition is part of the dynamic.

COMMISSIONER GORTON: So I was -- you made the point in the Santa Clara description, and one other place, I think, about how DSH is pointed at hospitals but hospitals -- the role of hospitals, since the creation of the DSH program, has migrated substantially. So now the hospitals may employ the physician-based. The hospitals may own satellite practices. The hospitals may have other things that they do, and this gets a little bit to Brian's question, DSH is categorical funding and it doesn't come attached -- you know, it's not a fee-for-service program.

And so I think important to acknowledge that -- and particularly in these rural communities where the hospital may be the remaining large employer. Even though there are only 12 beds and it only employs 150 people, that's a big deal in some of these towns. And the doctors can stay in the towns because there's a hospital, and, and, and. Right?

So I do think, to the extent that there's an opportunity linking this to the potential access chapter, to talk about how the role -- the role that DSH going to safety net hospitals and health systems, it plays in either

maintaining access or promoting access or, you know, we probably don't have the granularity of the data but you might be able to do some qualitative work, or ask questions of the folks you've already talked to. It sounded to me like the Santa Clara people were saying, "If we didn't have this DSH money then we couldn't do these clinics." Right? And I think that's worth shining a light on.

CHAIR ROSENBAUM: So, seeing no other Commissioner commentary, we do have time for public comment at this point. We've made time right after this presentation. Do we have public comment?

PUBLIC COMMENT

* [No response.]

CHAIR ROSENBAUM: No? All right. Then we are ready to move on to the next section, which focuses on our draft March report chapter on accessing monitoring.

REVIEW OF DRAFT MARCH REPORT CHAPTER ON ACCESS MONITORING

* DR. BERNSTEIN: I kind of liked it the other way.

Good morning. At the December 2016, Commission meeting that we just had there were several presentations on access to care in the Medicaid program. One of them,

that Martha presented, was a survey of states and how they're currently monitoring access in their fee-for-service populations. Based on your discussion at the meeting on the results of that survey and on subsequent discussion on the importance of monitoring access, in general, to all Medicaid beneficiaries, we put together a chapter, very quickly, that's in your materials, in Tab 3.

As Anne mentioned, it's largely descriptive and it's based on the results of recent literature, the Access Monitoring Survey, a review of the Access Monitoring Plan, submitted by states to CMS, and a summary of what little we know about how states monitor access in their managed care plans.

Today we'd very much like your reaction to the chapter draft and, in particular, your input, as Anne again said, about whether you'd like to include any more normative statements about how access should be monitored going forward. I should note this is not a treatise on access in the Medicaid program. It really is focused on how states are monitoring access.

So, that said, the chapter overview is on the monitor. It has five major sections. We first very

briefly defined access, and then also very briefly sort of present high-level conclusions about what we know about how Medicaid enrollees access health services. Because different regulations apply to fee-for-service and managed care populations, and because the locus of control in sort of who gets what and who can monitor what is different, we have separate sections for these two populations.

Finally, we raised some issues that emerged from the fee-for-service access survey and from your discussion last month, but again, we'd like your opinion on if there are other issues that might be included in the chapter.

States have both a regulatory need to monitor access in their fee-for-service and managed populations that Martha will present on in a minute, but we also should note it's necessary for states and providers to know what they're paying for, and if their enrolled populations are able to get the services they need in order to know how their funds are being spent.

And just as a matter of sort of context for when we're talking about monitoring access, we think it's important to point out that it's not a simple thing, to either define or to measure. Access incorporates the need

for care, the ability to obtain that care, and the value for services received or not received, and all of these components, need and ability to obtain care and value, are not simple in and of themselves to define or to measure.

Need, for example, could be what a person thinks they need or it could be what a clinician thinks they need. Access barriers can differ by geographic area, by the health care infrastructure, and medical practice patterns as well as by, again, the individual's perceived and clinical need for services.

It also differs by service. For example, distance traveled is often used as a measure of access for physician visits and it's clearly important for emergency care, but it's not as relevant for services that are provided in the home, where a more important access measure might be whether a person received a service at the scheduled time. And what constitutes a barrier also is not necessarily a simple thing, and different metrics are used, or benchmarks. For example, how far is too far to travel? I mean, it depends where you are and sometimes it's hard to set a standard benchmark.

That said, there are validated measures of access

that are commonly used in national surveys and in administrative data sets that are used by states and programs. A recently released survey -- not survey; CMS report, I'm sorry -- it was a technical assistance report that just came out a couple of weeks ago, outlines many of the validated measures that are also currently in use and some recommendations for additions to national data sets, although it does not propose benchmarks.

And now I'm going to give you, I would say, 10,000 -- I'd say 100,000-foot view of access in Medicaid. So I know there's much more and it's -- anyhow.

In the past year, we, MACPAC, have actually published seven data briefs on access to care in Medicaid and how they compared to privately insured and uninsured populations. Four of them were for children and four of them were for non-elderly adults. And we also include many access measures in MACStats, in many different tables. Again, there's a lot of published literature comparing the percentage of people with Medicaid and private insurance, and those who are uninsured on access measures, primarily from national surveys but also some from administrative data sets, when you can compare Medicaid and administrative

data sets, but there aren't very many of these studies that actually compare Medicaid to low-income, privately insured persons. So it sometimes is not as fair to compare Medicaid to privately insured people overall, because privately insured people overall, on average, have higher incomes.

So we sort of summarized the results from those seven data briefs, and from MACStats and other high-level studies. Again, we also did a multivariate analysis several years ago that is in our chapters, that compared low-income and privately insured populations and controlled for many variables. We call them sort of like people. That's a somewhat more comparison than is sometimes seen in the national studies.

Based on these comparisons, as well as on the multivariate analyses, we find that Medicaid beneficiaries have much better access to care and higher health care utilization than those without insurance. That's pretty much consistent across all of the published literature.

Compared to those with private insurance, and particularly, as I mentioned, low-income people with private insurance, Medicaid beneficiaries are about as

likely, or more likely, in some cases, to have a usual source of care. They have similar rates of physician visits but lower rates of dental visits, and on most measures I think it's fair to say they report more problems obtaining routine and specialty care.

There's a lot more detail on these findings in the data briefs and in MACStats, and in other places, but I think that gives a context for sort of the high level of what we know. And now I am going to turn it over to Martha, who is going to talk about monitoring.

* MS. HEBERLEIN: Thank you. So a lot of this, as Amy said, was talked about at the December meeting, but I'm going to rehash, so, sorry.

As you all know, the Social Security Act requires that Medicaid payment levels be sufficient to enlist enough providers so that care and services available are comparable to the general population, and these requirements are commonly referred to as the Equal Access Provision. And although fee-for-service enrollees may see any participating provider, payment rates that are too low may discourage providers from participating in Medicaid, and, therefore, impede access. So much of the focus in

fee-for-service has primarily been on how changes in payment rates may affect provider participation, and therefore maybe limit enrollee access.

However, the absence of federal guidance has really led to substantial variation in the process of standards that states have used to monitor access, and the adequacy of payment rates has often been determined by either lawsuits filed by providers or beneficiaries.

However, in a March 2015 ruling, the U.S. Supreme Court ended the private right of action to providers to enforce the state compliance with the Equal Access Provision, and this placed greater importance on the role of CMS to enforce the rules.

So in November of 2015, in part, in response to this ruling, CMS issued a final rule that described how states should monitor and report on access to care under their fee-for-service Medicaid programs. So the goal of the final rule is really to provide a more transparent process for monitoring access to services paid under fee-for-service arrangements, and allow CMS to make more informed and data-driven decisions, when considering both payment rate reductions or other program changes that may

impact access.

So the final rule requires states to submit an access monitoring review plan to CMS by October 1, 2016. The plan needed to be developed with Medical Care Advisory Committee as well as provider and beneficiary input, and made available for at least a 30-day comment period. These plans are now all available on CMS, and we have reviewed all of them, and I'll go into a little bit more detail about that in a minute.

So under this plan the state must conduct an analysis, at least once every three years, for primary care, specialty care, behavioral health, prenatal and postpartum services, and home health services. They must also examine access for any services for which the state or CMS has received a significantly higher than usual call volume of complaints, and any services for which the state has restructured or reduced payment.

The rule also includes some additional parameters for plans. For example, they have to include the measures that they're using and the data sources, and when access issues are identified they have to submit within 90 days a corrective action plan on how they will address that.

So as I said, we reviewed the plans, and I presented a little bit of this in December, so I'm going to move pretty quickly.

But just to recap, most states included baseline data as required of the five service areas that I just mentioned, and some states included additional areas where access barriers had been identified, such as dental and transportation services.

States varied as to whether these data came from claims or self-reported access measures from beneficiary surveys or provider enrollment data, but for the most part, they included baseline information.

A majority of states did make comparisons to Medicare or other payment rates, typically Medicaid rates from other neighboring states in order to assess whether their payment rates were adequate.

Overall, only a handful of states really included explicit standards or benchmarks to which they could compare the data. As Amy mentioned before, benchmarks are a little hard to come by.

For example, a few states set a standard provider-to-enrollee ratio. Others used ratios in their

managed care contracts' network adequacy requirements, or the standards by the National Committee for Quality Assurance.

Most states reported very little in terms of the concrete steps they would take to address any access issues, although they did note that when any issues were found, they would work with CMS to address them within the time frame. But they didn't have any specific steps.

As Amy said, we also did a survey last fall, which I reported on in December -- or last summer, I should say, to look at what states were doing to monitor access in their fee-for-service programs. We contracted with RTI International to field this survey. It looked at how states were monitoring access as of May 1, 2016, and focused on three aspects of beneficiary access that you can see on the screen there: so beneficiary experience, beneficiary utilization, and provider supply. They were asked to report on the populations and services and providers for which the data were collected as well as the specific data sources and what they did with those data.

It was fielded in August and September of 2016, and we had a response rate that was very pleasing to us of

37 states. And they were an array of both fee-for-service and managed care states, but this specifically focused on their fee-for-service practices.

So the high-level findings which you guys saw in December, of the three general types of access measures, 29 reported collecting data for one or more of the measures related to beneficiary experience, and that included 26 states that collected data related to beneficiary receipt of care; 20 collected data on the timely receipt of care, so whether -- you know, ability to find a provider that accepted Medicaid was one of those questions. Nineteen collected data on the specific barriers to receiving covered services, such as a lack of transportation or other barrier.

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

In most areas of measurement, there was very little difference or variation in the number of states collecting data for particular populations. But in terms

of service and providers, most states focused their efforts on primary and specialty care, behavioral health, and dental health.

To assess their adequacy, states most often used claim data, beneficiary surveys, complaint hotline, stakeholder meetings, and provider enrollment data. And they usually -- they typically compared these data to prior years or national averages. Sometimes they reported these data publicly while other states reported that they used this to provide provider feedback or guide corrective action or to guide their state policies at increasing provider supply.

So moving on to managed care, as you know, managed care is a different payment and delivery system, and so the mechanisms to monitor managed care and access in managed care differ from those in fee-for-service. So managed care plans contract directly with providers and, therefore, they may have more influence over what they can require them to do in the way of reporting access as well as making sure that they have enough providers to serve enrollees.

We don't, however, have as many good studies on

the effectiveness of managed care and ensuring access in Medicaid as the data that Amy presented up front are not typically consistently available across managed care plans.

As we've discussed in the past, encounter data have limitations, and much of the plan-level data, especially in terms of payment rates, are considered proprietary. And the studies we do have tend to be either state or plan specific and, therefore, may not be generalizable.

So with that being said, we still need to monitor. So managed care organizations, or MCOs, must provide the state and the Secretary of HHS with assurances that they have the capacity to serve the expected enrollment, including that the plan offers an appropriate range of services, access to preventive and primary care, and maintains a sufficient number, mix, and geographic distribution of providers.

The statute also requires that MCOs have procedures in place for monitoring and evaluating the quality and appropriateness of care, of services for beneficiaries.

MCOs also need to document the standards for

access to care so that covered services are available within a reasonable time frame.

In May of 2016, CMS issued a final rule that amended previous provisions governing network adequacy and access monitoring in MCOs, and we brought you a review of this rule at past meetings.

Specifically, the final Medicaid managed care rule includes provisions regarding network adequacy standards for both the states and MCOs, and under the final rule, states are required to develop and make publicly available time and distance standards for adult, pediatric, primary, and specialty care, OB/GYN, behavioral health, hospital, pharmacy, and pediatric dental providers, as well as for additional providers that CMS may identify.

The Medicaid managed care rule also lists the factors that states are to consider in setting their standards, including whether providers can communicate with limited-English-proficient enrollees. States must also development standards for all the geographic areas of their state, but may allow plans to meet different standards in different parts of the state. And there's also requirements for more specific standards for certain

services such as family planning and services from out-of-network providers.

It's important to note that the new network adequacy standards will apply for plan years beginning on or after July 1, 2018, so this rule is not yet in effect. But looking at how states and MCOs currently are monitoring access, prior to the effectiveness of the rule, as with everything, states vary considerably in what they're doing, and both in what they require in their MCO contracts and how they monitor access once those contracts are in place.

For example, some states have a standard for the maximum distance for travel time allowed to travel to a primary care provider, but fewer specify these parameters for specialty care. Additionally, standards are not often specific to certain areas of the state.

States also have different strategies to assess compliance with access standards, but a recent OIG report found that they don't typically use what are called direct tests, such as making calls to providers to be sure that they're in network.

Further, states have not found very many

violations in their access standards over a five-year period, they found very little, and most of the violations were those that were found in states that actually conducted these direct tests. And among those states that identified violations, most relied on corrective action plans to address violations while just six imposed its sanctions.

So, with that, I will turn it back to Amy to talk about some of the data issues.

DR. BERNSTEIN: So based on your discussion last month and other things that arose when looking at the results of the surveys and at the state plans, in particular the fee-for-service monitoring plans, we identified several areas that we thought might warrant further discussion, and they are on this slide, and I'll talk about them. Oh. I'm sorry. I'll talk about them on this slide.

[Laughter.]

DR. BERNSTEIN: I thought I had a slide for each of them, but I guess I don't.

Okay. So the first one is data limitations. As noted, there are considerable problems -- or not problems

but limitations in the data that are available, particularly on the managed care side. And supply data, too, are scarce, especially for providers other than physicians, and we saw that in the surveys and also in the state monitoring plans.

When we look at the survey data, national household surveys in particular have limited sample sizes, and most of them can't be used at the state level. Administrative data are difficult when trying to compare Medicaid and privately insured or Medicare or anything, and they also don't contain a lot of the contextual data that are necessary when making comparisons. Probably the biggest challenge of administrative data is you don't know who did not receive care, so if they are not in the data set, you don't know it because they're not in the data set.

Moving to benchmarks, there's also a lack of benchmarks, as I indicated earlier. These can be subjective. They differ by area, and many states use Medicare and Medicaid rates, but these are different populations. So it's not clear which rate is more appropriate or correct.

Comparing Medicare or Medicaid and private

insurance may be different when the plans have different actuarial values, so, in particular, as private insurance, I believe Commissioner Milligan pointed out at our last meeting, if they have different actuarial values, then they're moving to lower actuarial value plans, and Medicaid plans tend to have higher actuarial values, then perhaps that's not a totally fair comparison.

Even when measures do exist, they're not used consistently across states and programs or plans, so, again, comparison of access measures is difficult. There are no current federal standards for access measures on either side, fee-for-service or managed care. The final access rule was accompanied by a request for information about what access measures and standards could or should be used, in part because it's so challenging to try to set these benchmarks and/or standards.

And, finally, we saw particularly in the fee-for-service access monitoring plans -- and as you again discussed last month -- that there are administrative capacity restraints in monitoring access in general that was on the fee-for-service side, but similar comments have been made on the managed care side. In their draft access

monitoring plans, a number of states with large managed care populations voiced their concerns regarding the burden of monitoring relatively small fee-for-service and idiosyncratic populations that continue to receive those services on the fee-for-service side. And on the managed care side, staff capacity to review contracts and ensure that measures of access are appropriate may also be an issue given competing priorities and expertise.

So that concludes our presentation. We look forward to your discussion and suggestions.

CHAIR ROSENBAUM: Thank you very much. I'll open it up for questions and discussion.

VICE CHAIR GOLD: Yeah, I was really glad to see that the staff put this chapter together, and I think it's a nice summary of the work we've done. I think it could use a little bit of context around it. And I would hope, if it's possible, that we can make those revisions and include it in the March report, because I think it's a nice complement to the work that we have on disproportionate share and some of the issues that are being discussed.

I had a couple of comments with respect to context, and I've provided some of these to staff already.

When the report talks about monitoring, it by nature talks about the sectors separately because they have different data sets and they've been done. I think ultimately -- and the Commission had some discussion about this, I think when we were talking about the managed care regs last spring. You know, it would be nice to have a way not so much for maybe monitoring but to at least compare the people in each program in each state, regardless of where they're getting care. And I thought that was a nice contribution that the report that was done for CMS by Kenney made. And I thought we might want to say more about that.

In terms of the comparison, though, I think you may have been a little harsh on managed care in terms of access. While the data sources are different, in fact, managed care has historically been a little more accountable than fee-for-service because it does have access requirements. It has had HEDIS requirements, it has had CAHPS requirements. And so it hasn't had the claims data that people use, but it has a denominator for the population. So there is some logical differences with what's available to monitor each, but I'm not sure I would want to give -- in fact, I'm sure I wouldn't want to give

the impression that we do a better job in fee-for-service than managed care because I think we've probably done better there. Where we don't do a good job is across them all and in monitoring.

And I thought one point that this is what's not in the report now but it might be useful is that, you know, a lot of this devolves to states. From an operational level, states have to manage and monitor because that's where the programs are run. But there is some value nationally in having data to compare access across states from an accountability point of view, from a fiduciary point of view for the dollars spent, et cetera.

And I don't know that we should give the impression that you always can get this from state data. For one thing, I think the report demonstrates the differences across states and what they have and their ability to get it. And so I think one thing that's happened over the last several years from ARRA to the ACA to some of the more recent legislation has been that there's been a little more effort at the national level to figure out how we can use national data sets to monitor states. And, you know, we've now -- NHIS was expanded, at

least temporarily, to get more state estimates. NAMCS has provider participation in Medicaid as a screener, or did as part of it for monitoring the HITECH Act. We had indicators developed that we've actually supported a continuation of child health indicators and adult health indicators. We have the HCUP databases.

I think those are important because, one, they're limited, but they're uniform across the states, and they also from an oversight point of view reduce some of the burden on states to the extent that national goals can be met through using national data sets.

And so I think one of the things, as we tie this back to the current policy environment, my sense is the ability -- states will continue to have to oversee what they're doing, so that's relevant. At the national level, regardless of how some of these things are funded, there's going to be a need for national oversight for accountability, for being able to compare, just because that's what a good funder and fiduciary does, and it's part of government.

And so I think it would be useful -- and I'd like to see this as part of the Commission's work plan going

forward -- to monitor what's happening to some of these national data sets, whether they're continuing to be supported to get, you know, to get state estimates and to look at what the capacity is at the federal level to monitor access nationally as it varies across the states and across the subgroups of the population. And I think that's where we can tie this back to the coming issues without much additional effort, I think.

Amy, you're probably familiar with them. There have been a number of reports that when they looked at how you monitor, the ACA looked at some of the data sets and what's been changed. So I think it would be a relatively easy expansion to put that in and would help us bring this back to the current environment.

CHAIR ROSENBAUM: Thank you.

COMMISSIONER SZILAGYI: Yeah, very nice work, and I'm very happy that we are doing a lot of reports and a lot of thinking about access to care. So a couple of thoughts -- actually, three thoughts, two about context, also about context, and one about the monitoring.

There's a lot of discussion about the word "access" lately, and I think with every report it would be

very important for us to sort of think, define, and put out there what our definition of "access" is, maybe go a little bit deeper than we have here. And just one thought about -- and especially because a lot of people are using our reports, including people who are not, you know, health care research experts.

So John Eisenberg presented a nice description of voltage drops in care -- this is many, many years ago; Alan is nodding -- where you can take populations, a first step is having access to health insurance, and another is access to other services, and a next step is actually using those services appropriately, and another step is getting the right quality of services. And it goes all the way down to health outcomes. And with each of those voltage drops, there are potential, you know, problems and opportunities for patients. And to get really good health outcomes, all of those have to happen, and access is only, you know, one component, and even within access, there are multiple subcomponents. So I think it would be really helpful to sort of put out, you know, how we're envisioning access and sort of the complexity of access, and access does not equal quality.

Related to that, the Medicaid population has greater challenges than other populations because they are poor. And whenever anybody is -- you know, whenever we're comparing access among different populations, we always have to put that out.

Just as an example, for 18 years I was very involved with helping to run a very large Medicaid managed care organization in New York, and we put out there for 15 years a direct comparison of our access measures and HEDIS and quality measures for Medicaid managed care versus commercial in the same geographic region, with the goal of trying to bring the quality of the Medicaid population -- the health care for the Medicaid population up to commercial, but we always put it in context that this is a harder population to take care of and there are greater challenges.

So I think as we are sort of making these comparisons, which I think is really important, we have to put the context out there that it's not -- you know, if some aspects of the Medicaid population does not have as good access, it's not necessarily a failure of the program. The challenges are greater.

The third point I want to make is on monitoring. Did we ask questions and do we know what states are doing in terms of monitoring the foster care population? Because that is a very specific population, and I know we have done some work on the foster care population. Most of them are in fee-for-service, although some are now going to Medicaid managed care. But it is sort of a special population that the states are responsible for.

And then the second monitoring question I had was: How much do we know about what states are doing with the data that they are actually monitoring?

MS. HEBERLEIN: So we didn't ask -- I'm sorry, we didn't ask specifically about the foster care population, and we did go back and look to see if states had the option of selecting other, and nobody reported -- pulled out foster care children specifically that they were monitoring for them, or had any initiatives that specifically targeted access for that population.

In terms of what they're doing with the data, we did ask, you know, when you collect it, how often you're collecting, what you're doing with the data, and those questions were -- for the most part, states were using it

to assess access, the adequacy of access. It depended on the measure. Some were looking at provider supply, and so seeing how many providers supply, and whether that was sort of -- are there policy initiatives that they can do that would increase provider supply? So some of the states were using it to inform policy decisions. Some of them were collecting it just to look at measuring the adequacy of access. Some of them reported it publicly just to report it publicly so people could look at the data themselves and make their own conclusions.

Yeah. And some of it were also feeding it back to providers for like quality and provider feedback.

CHAIR ROSENBAUM: Penny.

COMMISSIONER THOMPSON: So Peter gave me a great launching pad for a couple of observations as well.

I think the chapter is great. This is a very difficult issue, but I am worried that it's a little too focused on compliance, meaning -- though I understand the importance of Armstrong and I understand the importance of how CMS is trying to enforce some kind of accountability with (a)(30)(A), and I recognize that there needs to be oversight of managed care contracts and requirements, that

I'm more, I think, in the area where Peter is, which is I'm concerned that there's a lot of document production here around a lot of data points that are kind of lying around without a real nexus to what is the program trying to achieve and what are the real elements of action that derive from how we're looking at performance.

And so just a few points about that. One is that this is a highly localized question. So the question of what access looks like is really deeply connected to some of the questions that we were asking ourselves earlier about communities and what the health care delivery system looks like there. So I question how much effort should be put on a very national or even statewide set of measures that can easily mask very local conditions and local issues that need some kind of attention -- and with limited resources, whether or not more attention should be focused on sort of those kinds of measures than in trying to construct something that can have sort of have -- that can easily add up at the national level, if you will.

The second is the connection between access and health because there's a purpose to providing access, and it's not just for its own reason. So some of the things

that we talk about when we talk about measures in terms of waiting time for an appointment, well, why you need that appointment matters a lot, and what difference it makes to your health if you had that appointment today versus a week from now versus a month from now matters a lot, and so I think it's really important to try to kind of connect this taxonomy between is a provider present for you, do you know how to activate access to that provider for the reason that you're seeking that care.

And then that kind of connects me to the last point, which is I think it's really -- in this large area, with a lot of questions and a lot of things that we can look at, I think we should pick our targets. I think those areas of the Medicaid program, for which there is not an easy benchmark to commercial and where traditional measures of access aren't easily applied, like in home- and community-based services, I think that's an area where it would be useful for us to concentrate.

But I also think the question of how do beneficiaries in this program understand, navigate, and access the health care delivery system is also one that deserves our attention, and do they have the kinds of tools

available to them to know when and how to access the health care delivery system. And to the extent that we impose requirements around whether it's copayments or prior authorizations or other kinds of requirements, do they understand how to meet those requirements, this could be very important as a part of a conversation about HSAs.

I think the beneficiary side of this equation is as important, has a kind of importance to this in addition to the provider supply and benefit construction and network development part, and I think that that's an area where maybe we should pay some attention and spend some time.

DR. BERNSTEIN: Can I ask a question, just to clarify sort of what we can do between now and possibly March?

So are you suggesting that we raise them as issues in this report and sort of put them at the end and say these are things that the Commission is thinking about and we want to do more work?

COMMISSIONER THOMPSON: Yep, yep.

DR. BERNSTEIN: Okay. Thank you.

CHAIR ROSENBAUM: Kit.

COMMISSIONER GORTON: So two things building on

what others have said and particularly following on Penny, the more narrow piece -- and I thought she was going to say it and save me from having to say it -- in terms of this voltage-drop model that Peter was talking about and what are the elements of access, one of the failings of the current approach, which CMS has attempted to address in the Megarule, is this issue around provider data and provider directories. And so you can have a contracting network, but if you have no way to communicate that to people, one, with a level of granularity about the parameters that are important to them, and two, you have no way to maintain it, and three, the system that we have in place to do this is as administratively burdensome on providers as it is, then it doesn't matter how robust your network is because nobody could find their way to it.

And so I do think -- and the Megarule attempts to address this, not necessarily in what I would view as a particularly enlightened way in all cases, but I do think it's worth calling out the issues that everybody has in terms of who has access.

In Massachusetts, it's a matter of Massachusetts law that if you're licensed in Massachusetts, you have to

accept Medicaid. Does that mean that 100 percent of practice sites, provider sites in Massachusetts are, in fact, accessible to Medicaid-covered beneficiaries? Answer, no. And so there are states with these kind of rules, and they sort of say, "Well, you have to enroll." But at the end of the day, providers accepting patients is voluntary.

A quick example, our plan has a member who was admitted to the hospital in December with a medical decompensation, in the course of that developed a behavioral health decompensation, psychotic, won't take medicine, medical staff stabilized, needs to go to an inpatient psych bed to be managed. This person because of their medical illness is blind and uses a walking stick, which from an inpatient psych perspective is a weapon, and so nobody wants him.

So are there inpatient psych beds in our network? Yes, there are. Do many of them want to take care of people with complex co-occurring medical illness? No, they don't. And when you throw in these other things, what we have is a situation where this man -- I mean, it's now almost February, and despite daily calls to every facility,

despite the fact that these facilities are admitting others of our members with similar issues but who lack the cane, despite our lawyers calling them and saying, "Have you heard of the ADA?" the -- some of them apparently hadn't.

CHAIR ROSENBAUM: I was thinking the same thing.

COMMISSIONER GORTON: Yeah. The first time they told me this, I said, "It's the law. They can't" -- anyway, so much for it's the law. But my point being I do think it's worth sort of calling out all of the pieces of this, and I do think it's worth some attention on what we know about directories and their role in how people access care.

The broader point that I wanted to make in terms of the construction of the possible chapter is the way you've laid it out could be seen to imply that there's a fee-for-service approach and a managed care approach, and that there's a population served by one and a population served by the other. What that overlooks is the fact that it really depends on the type of service, right?

So in terms of home- and community-based services, you may be in a managed care plan for your acute medical services, but most of the states will have those in

fee-for-service.

The whole question of do you have access to care, right? Well, okay. So if we can provide you with access to institutional care, but we don't have enough infrastructure to do home- and community-based services, so that people are not in the least segregated setting, there are those issues as well. So I think it's important to tease out that even in a state which might be largely managed care, that for some types of service, it's still a fee-for-service environment, and our historic overly medicalized approach in some people's minds that focuses on do you have access to hospitals, do you have access to PCPs, do you have access to specialists doesn't deal with do you have access to behavioral health services, do you have access to home- and community-based services, which would alleviate your need to be institutionalized, and those other layers of access.

And I think it's worth laying out, again, sort of in the next steps, some of the things that we might look at in a double-click in a future deeper dive.

CHAIR ROSENBAUM: Thank you.

Brian.

COMMISSIONER BURWELL: I think I'm just going to build upon what Penny and Kit are both talking about. So I was thinking about these issues from the long-term services and supports perspective, and it's extremely complex.

And I notice kind of in the whole -- I mean, I just see the whole framework for this, even from CMS, is much more access to regular medical services in terms of the mandatory services, and I've kind of avoided the whole issue of long-term services and supports.

It's complex not only because of the nature of the population, but by the nature of Medicaid. So in Medicaid, you're entitled to access to certain services. You're not entitled to home- and community-based services. There are waivered services. States have waiting lists. They do have waiting lists. So it's an entirely different kind of legal framework.

There's a whole set of separate access issues. Kind of building on what Kit said, you may have an adequate number of dentists who say they collect -- who see Medicaid beneficiaries, but everybody knows, every provider of services for people with intellectual disabilities, there are very few dentists who are going to see people with

intellectual visibilities. And if you have one in your community, that person sees -- you know, it's like, "Go to this guy."

You have very unusual populations. You have fire starters in the Medicaid population. Nobody wants them. So, I mean, those are small, but people with autism have very difficult -- there aren't enough providers who know these populations. So it's a very -- I mean, I don't know if we want to get into this, and it's kind of off the table, it seems to me, from this kind of whole CMS regulatory -- but I do think it's worth mentioning.

CHAIR ROSENBAUM: Well, I think it goes to Marsha's contextual point before that is -- I mean, so many people have echoed it around the table, which is to present this information, I think it would be strengthened by -- because it's a slice of a big issue, and so an introductory couple of pages that sort of explains the complexity of access and harkens to the Commission's origin -- actually, we're the Medicaid Access Commission -- and talks about the uniqueness of different populations, different services, different ways of thinking about access.

I would add in myself. I'm sitting here writing

down Handbook of Public Assistance Administration, Supplement D, which is 1965, where you see the first language, and in the beginning, it really was because they focused on payment. I mean, it really was can people use beneficial care. Are there enough providers in the program so people can use beneficial care?

We've gotten much more, as Penny pointed out, legalistic and compliant-istic. You know, are people utilizing covered services? Are the actuarial rates enough to cover the expected use of covered services? When, in fact, in the beginning, the questions that SRS was asking were very deep: Can people get beneficial care?

I think what we're saying is that question is very varied, depending on the population, the care, the setting, the organizational structure, so a couple of pages on that, and then a couple of pages at the end on these issues that Marsha and others have raised about where we think we're going.

But, yes, I mean, I think we need to clarify for Congress, and sort of in the course of it, remind ourselves that our roots are in the access questions as a Commission, and so this is just the latest iteration of a long

exploration of access.

COMMISSIONER BURWELL: I want to say one more thing about the managed care part.

CHAIR ROSENBAUM: Yeah.

COMMISSIONER BURWELL: In managed long-term services and supports, one reason states are moving to a managed care payment mechanism is specifically around access. They do not have adequate networks to serve their populations and believe that private companies with more access to capital -- I mean, they're basically saying, "We need you to expand the network."

CHAIR ROSENBAUM: Yes.

COMMISSIONER BURWELL: That's one of the major policy objectives of this shift.

CHAIR ROSENBAUM: I have Alan, Toby, Marsha.

COMMISSIONER WEIL: I was going to say something maybe a little, Sara, like you did.

When I think of how we approach issues, it feels really important to me that we begin with the empirical base, which is what we've done here. This is starting to sound like a really long chapter, and I'm not sure we benefit at this stage from a really long chapter.

So I was going to say a little bit, Sara, the framing, I think, is important, which is there is a statutory provisions of equal access. It's very hard to do equal access for services that have no access outside of Medicaid, and equal access does not have the word "quality" in it. It comes from an era when access was presumed to be high quality. So you didn't even ask the question of whether you were seeing good. It was just a question of are you getting in the door. And we're in a legal environment where there's no private right of action. So the only enforcement of this comes through HHS.

As much as I agree with the comments about access is not the entirety of quality and all of these other things, I worry that if we start sounding like because this measure doesn't capture everything that's important, let's just not -- and because collecting this information is really hard, maybe people shouldn't be so worried about this. That is not a message I want to send.

CHAIR ROSENBAUM: No, no.

I am going to put Leanna on the list because I have watched you now sort of react. So, after Marsha is done, then we are turning to you.

COMMISSIONER GEORGE: Oh, really?

CHAIR ROSENBAUM: Yes. So gather your thoughts.

[Laughter.]

CHAIR ROSENBAUM: Toby.

COMMISSIONER DOUGLAS: Well, Alan summed it up.

CHAIR ROSENBAUM: Marsha.

VICE CHAIR GOLD: Yeah. I mean, I think -- and I'll remind the Commissioners because only one of the classes, as you used the word, was here when it was done, but I was involved as a consultant working with the staff then. I mean, in one of the first years, I think, of the Commission, we did write a report on access to care. The Commission reviewed the definitions of things, made some changes that may or may not have been an improvement, but which CMS and the states have adopted. So I think some of what people are talking about in terms of context setting, if we go back and look at some of that, it's in there.

Peter, your thing about -- I think what John Eisenberg did -- and I didn't see that article. I think what he's using at the IOM framework but adding the concept of -- what is it? Volumizing? No. That's a hair term. What is it?

COMMISSIONER SZILAGYI: The voltage?

VICE CHAIR GOLD: Voltage, yeah. That's an interesting addition on top of it. It's not a new framework. He's probably working with the existing IOM frameworks, which that sounds like, and there's been other work that's been done on managed care and how you access the system and the rules. But I think that some of the beginning context, if you'd bring that in, will help.

I also want to make the case for some national monitoring. I fully recognize -- my career has been devoted to looking at how delivery differs across markets. I am really well aware that -- and I am well aware of why it's valuable to do -- and important -- that the oversight of some of these access provisions happen at the state and even within state level at the localities because of all the differences. That doesn't mean, though, that there isn't some value at a high level and being able to benchmark things. The same as the National Quality Report that AHRQ puts out has some state data, it's important on access, to have some things, particularly if we can use existing datasets. And there has been some development there, and that's where the Kenney report does.

And actually, Brian, the CAHPS work that CMS started tries to get -- and I don't know if they'll ever continue it, but state-level estimates that are managed care versus fee-for-service for the duals as well as the disabled non-duals and the regular. So it starts to get a benchmark that can even look at some of these populations.

And I think if you go back to the transcript for the last meeting, when we looked at some of the flaws of -- I call it "flaws" -- of the way the monitoring systems were being implemented by states, it was sort of like a meat ax approach where we were going to have states look at every subpopulation the same way, and it seemed complicated, not that the populations weren't important, but the ability to get data for some of these subgroups with unique characteristics were really hard. And yet it was important, but we need to think about what the best way is versus just generating paper.

So I think that I'm more optimistic that there's a way to sort of round it out without making it long and without going into a lot of stuff there because the Commission has done this before.

CHAIR ROSENBAUM: Leanna.

COMMISSIONER GEORGE: Well, just adding some clarification to what it's like as the parent of a child who had a severe intellectual developmental disability, trying to access care. Currently my daughter is in an ICF and they drive over 90 miles for dentistry. You would think that ICF would have dentistry services closer for the population that they're serving. That's kind of wild, in my opinion.

We live not too far from major cities, but we're traveling 60 miles for ophthalmology, for vision appointments for my daughter. So my son would break his glasses and it's the only place that's allowed to repair them, or the place where I got them, and the state laws require that it be associated with the ophthalmologist that issued the prescription. Once again -- yes. Well, I can go to Walmart and they will do it for free, but they just kind of do it under the table. But if I have to have a significant repair I have to drive 60 miles to take it back to his ophthalmology appointment, to get them looked at.

CHAIR ROSENBAUM: [Off microphone] I'm so glad you raised it because one of the things on my mind that, you know, we'd throw in for good measure here is that

Medicaid programs actually are so much at the mercy of underlying licensure laws, and that's an example, probably not of a payment restriction. That's an example of a state's ophthalmology board very narrowly defining who can dispense prescriptions.

COMMISSIONER GEORGE: But, I mean, just when you think about these miles, if you live in an area that doesn't have a lot of supportive transportation, you might be a family that may or may not have reliable transportation to get you to and from work, let alone 100 miles to an appointment. Trying to get on the Medicaid-supported transportation units, you have to call at least a month in advance to get a ride somewhere. We're not that rural. So I think of people that are even more rural than we are, and the distance they have to travel, it's just -- access is a critical thing, especially amongst, you know, the more medically needed populations. Like I said, IDD for one. That's my personal experience.

CHAIR ROSENBAUM: Well, I mean, and your observations really drive home the point that no matter -- you know, I mean, not in addition to, sort of at the core of capturing this phenomenon, which we, you know, have

worked on since we were established, and obviously will continue to work, is ensuring that there is a way of measuring beneficiaries' own experiences with the health care system, which is something, of course, that managed care requires. But there is nothing in the fundamental Medicaid statute that goes beyond payments, so there is nothing in the statute itself that, in the broadest sense of Medicaid, says that the Medicaid program will, you know, in its operation, take into account how patients are experiencing the health care system, whether they're in need of long-term services and supports or preventive care, or you name it.

And so it really, I think, is a crucial point to make to Congress.

Yes.

COMMISSIONER ROGERS: And I do think that Leanna brings up a very, very good point, and you do too, Sara. As I listen to this conversation -- of course, I live in the state of Texas, and access to care -- what really does it mean? Yes, you can get care, but if you live on the outskirts of the city you're still in the city. It takes three to four buses to get to a clinic, which may take you

up to 2 hours to 3 hours to get there. And then, if the bus is late and you're late for your appointment, you're out of luck.

So when you look, Medicaid is a very complex picture, as we all know, as we all discuss it over and over. I think the more we know, and I agree with Peter on so many things, and that is because it's the underserved, the poor, that it becomes even more complex, because how we determine or define access to care, quality of care, is that really the way that you define it for this population, which is really -- who, really, those of us sitting at this table, except for Leanna, can really determine what it is to walk in those shoes unless you've walked in them? So, you know, I think we should take what Peter says, having the years of experience that he has with this population, and, of course, many of us also, really to heart about how do you determine what is access?

CHAIR ROSENBAUM: Sharon.

COMMISSIONER CARTE: I think the heart of a lot of the comments of my fellow commissioners zeroes in on, or points to the need for more data and focus on specialized services for specialized populations, and going back to

some of the information that Amy and Martha gathered on managed care and the discussion on managed care, I think that there's real opportunity there for states, and I think we have been in the process of working with CMS to set state goals around quality and consumer assessment, and I think that that needs to continue and that the Commission should try to nudge things in that direction, where possible.

CHAIR ROSENBAUM: Peter.

COMMISSIONER SZILAGYI: This is probably redundant but I'm a little bit worried that we may be totally confusing Amy and Martha with all the different comments. But just to take off on multiple comments, including Alan's, I think maybe one way to bring the various thoughts together is if we present the context in more detail, that here are the different access steps, and this particular chapter is taking this very narrow slice, I think it will work that we consistently point out these are the issues of access and accessibility.

These words are going to be used a lot, I think, in the next few years. I think, you know, having something out there does not mean that a population actually is

accessible to it, and that does not mean that a population will get those, either insurance or those services, and it will not mean that the population will be better off, because there's other things.

So I think consistently putting out that, whether it's a voltage drop or however we define it, and then to point out, this chapter takes this important slice, can kind of meet both those needs.

CHAIR ROSENBAUM: Absolutely. I think we're all sort of expressing the feeling that the information is tremendously important and you need to nestle it inside our long history with this issue and the long history of the issue itself. And quite frankly, I don't think there's a more important or timely chapter that we'll be writing. So that's what I glean from everybody's observations, going around the table.

EXECUTIVE DIRECTOR SCHWARTZ: I think we can also probably use some boxes to reference things that are a little bit of a sidebar, that we want to let people know about and give a little bit of summary and then send them on to other resources. And whether that's more conceptual or, for example, our specific access briefs, to direct

people to those.

COMMISSIONER SZILAGYI: And it's particularly important because people aren't going to be reading all of our different chapters. They'll read one chapter. And so those boxes or the context, I think, will help.

DR. BERNSTEIN: Can I just summarize, just so we're clear?

CHAIR ROSENBAUM: Yup.

DR. BERNSTEIN: So you want more in the introduction about the importance of access and where this chapter fits in; the complexity of access and sort of what the different pieces are, real versus actualized, structure process outcome, back to the Ron Andersen days; and then in the conclusions and the issues, many of the specific issues that you discussed, like directories and national versus state data, and things like that.

So does that work?

CHAIR ROSENBAUM: Yes, and I think it's worth, in the opening, also, to note that this Commission's history with the issue, and the fact that we have -- this was a core part of our establishment and continues to be a core focus of our work, so the people, you know, have a flavor

that this is not our first time at the rodeo here. If you go back and read our earliest reports, they deal with these issues.

COMMISSIONER DOUGLAS: And I think you need to add in the changing legal environment, because that really has driven so much of this.

CHAIR ROSENBAUM: [Off microphone.]

COMMISSIONER DOUGLAS: [Off microphone.]

CHAIR ROSENBAUM: Right. And I think it's worth noting -- again, I'm talking about a couple of sentences here, not 12 pages. But I think because it's such a changing policy framework for the Medicaid discussion that Medicaid itself, since its origins, has been concerned with the question of access. And, you know, its legal requirements have changed over time, but this has been a long-standing issue for the federal government, for state governments, for researchers. Assume that you have an audience now of some fresh eyes.

At no additional cost, because we're running ahead of schedule, I don't know if there is any public commentary at all on access. We had public commentary scheduled, of course, for DSH, but we have some extra time,

if anybody would like to address this issue.

PUBLIC COMMENT

* [No response.]

CHAIR ROSENBAUM: Seeing none, we are adjourned until one o'clock.

* [Whereupon, at 11:28 a.m., the meeting was adjourned, to reconvene at 1:00 p.m., this same day.]

AFTERNOON SESSION

[1:02 p.m.]

CHAIR ROSENBAUM: Happy afternoon. We are just getting settled up here. We will get underway momentarily. And if you had a chance to walk around a little bit before you can feel that springtime in Washington is about to end.

All right. Let's get started. The first topic that we're going to tackle this afternoon is alternative approaches to Medicaid financing, and we have Martha back in the saddle, along with Chris. So we turn things over to you.

ALTERNATIVE APPROACHES TO MEDICAID FINANCING: BACKGROUND AND CONTEXT

* MS. HEBERLEIN: Thank you, Sara. So I am going to begin our joint presentation today with a brief update of the Commission's work to date and future plans for our analysis. I will then provide a refresher of the major alternative financing proposals and highlight key decisions and considerations for policy-makers. And I will conclude with an overview of some of the recent proposals to alter Medicaid financing before passing it off to Chris to discuss some illustrative examples.

As Congress and the new administration consider substantial changes in the Medicaid program, staff are pursuing a number of analyses that will hopefully help inform the larger debate. This work falls into three general areas: financing, state flexibility, and coverage of low-income adults.

On financing, the work Chris and I will present today builds on our prior analysis of Medicaid spending and financing reforms. A chapter in the June 2016 report presented the Commission's initial analysis of the major federal financing alternatives. As I said, today I will present a quick refresher of those, as well as some more information on some recent proposals. We will also present some initial analysis of various design considerations and how different decisions may lead to different results.

On state flexibility, in Chapter 2 of the June 2016 report, we focused on state policy levers to control Medicaid spending. It described areas where states have flexibility in design and administration of their program, such as managing enrollment and determining provider payments.

At the March meeting we plan on bringing a more

thorough review of the Medicaid program requirements as well as state options, and an initial analysis on mandatory and optional spending and enrollment.

Finally we have a companion line of work related to Medicaid's future role as an insurer of the poor, in particular, with a focus on the future coverage for the new adult group. Our prior work in this area included a March 2015 chapter on premium assistance to expand Medicaid, as well as fact sheets on the expansion waivers and a study on the use of non-emergency medical transportation that was presented in December. Today, Jane will present more detail regarding the characteristics of low-income adults, and the review of the expansion waiver provisions.

To begin with the alternative financing proposals. As I said, the June 2016 chapter discussed key approaches to limiting federal financing in Medicaid, the design considerations and the potential implications of these changes. Commissioners, the full chapter is included in your materials, and for those in the audience, it is available on our website.

The alternatives I will discuss today include block grants, capped allotments, and per capita caps.

Beginning with block grants, block grants are structured to provide lump-sum grants to states with amounts based on a predetermined formula. States would then spend the funds on a specified range of activities that could either be narrowly or broadly defined. Under a block grant approach, states typically do not need to provide matched funding, but may be subject to a maintenance of effort on their existing spending. A block grant approach would eliminate the automatic increases that are currently seen in federal funding, in response to enrollment growth and increases in per enrollee spending.

Capped allotments act as a ceiling with federal funds provided as matched payments up to that cap. Under a capped allotment approach, states are required to contribute state share to draw down federal matching funds from their state-specific allotment. They may receive less than the full amount in a given year, depending upon their level of spending, but are limited in the total amount of federal financing by the amount of the allotment. This differs from a block grant under which states would receive the full grant amount without providing state match, and as you are all well aware, the Children's Health Insurance

Program functions as a capped allotment.

A per capita cap would establish per enrollee limits on federal payments to the state with federal spending rising based on the number of enrollees but not on the cost per enrollee. States would be responsible for any spending above the fixed per capita payments. Unlike fixed block grants or capped allotments, the total amount of federal spending would vary with enrollment changes, and per capita caps could be designed on an aggregate level, or as is more commonly seen on a targeted basis for each eligibility group, as I'll talk more about later.

Chris is going to provide some illustrative examples of these different design decisions in the next presentation, but I'm going to walk through them quickly, just so we all know what we're talking about.

The first step policymakers are likely to take is to choose a base year in order to define the overall spending level. Policymakers may also want to consider whether and how to increase spending going forward and choose a growth factor that reflects their policy goals. Policymakers will also need to figure out to allocate spending across the states, and depending upon the

approach, how to establish per enrollee spending caps.

There are also some additional design considerations beyond just setting the spending limits. Given the size of state and local contributions to Medicaid, federal policymakers will need to clarify the expectations about continued state financing as the federal portion of the program is restructured. Policymakers must also weigh which aspects of the program will fall under the new approach and whether to exclude certain groups of enrollees or types of spending.

Finally, under a restructured program, policymakers may wish to provide states with greater flexibility to manage their own programs in exchange for state or federal dollars, but at the same time they will need to decide upon the appropriate level of federal oversight and accountability.

Moving on to some recent Medicaid financing proposals. While changes in the Medicaid financing could be designed so that the future level of federal spending is higher or lower, block grants and per capita caps have typically been offered in the context of achieving substantial federal savings. For example, the last three

budget resolutions passed by the House all included federal savings for Medicaid, ranging from $700 billion to $1 trillion over 10 years. Few details, however, regarding how these savings would be achieved were included in the Committee document, but it's important to note that budget resolutions are generally broad statements of policy and additional legislation that would flesh out the details was not introduced.

I'm going to discuss some of the features of the three Medicaid reform proposals introduced by the figures expected to play key roles going forward. This includes Speaker of the House Paul Ryan, Senator Cassidy, who serves on the Senate Finance Committee, and Congressman Price, nominee for the Secretary of the Department of Health and Human Services. I want to note up front that the level of specificity in these plans varies. For example, Speaker Ryan's plan discusses his vision of health care and Medicaid reform more generally, while Senator Cassidy's bill was actual legislative language. I also want to note that as CBO has not provided an official cost estimate of any of these proposals, their estimated budgetary impact is unknown, including whether they would produce federal

savings and the magnitude of those savings.

So with all those caveats --

Under Speaker Ryan's A Better Way plan, states would have a choice of either a per capita allotment or a block grant. Under the per capita allotment option, state allotments would be the product of the per capita allotment for each of the four eligibility beneficiary categories, so that includes children, individuals with disabilities, elderly individuals, and other adults. So it would be the product of the per capita amount and the number of beneficiaries in each of those categories.

2016 would serve as the base year, and the allotment would grow at a rate that is slower than current law. States would draw down their allotment based on their federal matching rate. States could opt out of the per capita approach and receive a block grant instead. Funding would be determined using a base year that assumes transition of the new adult group to other coverage sources, and states would be required to provide required services to elderly and disabled individuals who are mandatory under current law, but would have maximum flexibility to manage eligibility and benefits for non-

disabled, non-elderly adults and children.

As I mentioned earlier, this proposal from Senator Cassidy and Representative Sessions has legislative language, so the level of detail around the financing is greater. Under the World's Greatest Healthcare Plan Act, it would convert most medical expenditures and DSH payments to an adjusted aggregated beneficiary-based amount, so, essentially, a per capita cap. The per capita caps would be set for each of the four main eligibility groups, as in Speaker Ryan's plan, however, the Cassidy proposal specifies that the rates would be risk-adjusted. The bill also specifies the growth rates, and beginning in Year 4 the state per capita amounts would be compressed to the national average.

States would be required to contribute a non-federal share and the higher of 75 percent or the current FMAP would apply, and they would be prohibited from financing their share of the program cost through intergovernmental transfer or certified public expenditures. Certain services, such as pediatric vaccines, would be carved out of the per capita allotment. There is little detail on the level of state flexibility.

However, it does limit the populations for which states can receive match to those with lower incomes.

Finally, the fiscal year 2017 House budget resolution. One quick note before I go into this. This is the version that the House passed in March of 2016, and not the more recent resolution that was passed by the Senate. The Senate resolution focuses only on the ACA repeal and did not specifically discuss restructuring the Medicaid program. So this is flashback to March of 2016.

Again, as this is a budget resolution, the committees of jurisdiction would be responsible for devising the legislative language, but the resolution itself did outline a set of potential approaches to restructuring.

Similar to Speaker Ryan's plan, states would have the option between choosing a block grant and a per capita allotment system. Under the block grant structure, federal funds for Medicaid and CHIP would be combined into one lump sum and level funding would be provided for 10 years. Under the per capital allotment structure, the amount of federal funding would be determined by the estimated average cost per enrollee in each of the four main groups,

and the number of enrollees in each category. The growth rate would be indexed based on a predetermined but unspecified formula. States would have discretion over eligibility requirements, benefits and provider payment rates.

With that, I'm happy to take any questions before turning it over to Chris to give some more math examples.

CHAIR ROSENBAUM: Do we have questions now? Yes, Stacey.

COMMISSIONER LAMPKIN: Just one. Do we have much insight into the kinds of accountability? You highlighted that as a key program design element. For these various proposals, anything -- do we know what they're thinking in terms of state accountability?

MS. HEBERLEIN: Similar to state flexibility, I don't think there's a whole lot in there. There's been some talk about looking at quality measures, but there hasn't been a whole lot.

CHAIR ROSENBAUM: I have a question sort of along those lines. I notice, of course, and it reflects the language of the documents you were looking at, I'm sure,

but I noticed that in many places it says block grants, but, for example, we don't really know at this point whether it would be a block grant as you're defining it here, or along the CHIP line. So, for example, where the FY 17 budget resolution says things would be combined into a single block grant, we can't be sure at this point that it's a block grant as opposed to a capped allotment, or do we know enough?

MS. HEBERLEIN: I think sometimes those words are used interchangeably, and I don't think it's always fully specified as to what they difference is.

CHAIR ROSENBAUM: That's -- I've reached the same conclusion, and so I just wanted to flag that for people.

Any more questions now?

[No audible response.]

CHAIR ROSENBAUM: All right.

ALTERNATIVE APPROACHES TO MEDICAID FINANCING: ILLUSTRATIONS OF DESIGN ELEMENTS IN ALTERNATIVE FINANCING PROPOSALS

* MR. PARK: Okay. Thanks. As Martha mentioned earlier, there are several design options to consider under these different alternative financing proposals. My

presentation will provide data examples to illustrate the impact that certain design choices may have. We've looked at design elements from a few of the proposals that Martha just went over: Speaker Ryan's A Better Way proposal, and Cassidy and Sessions' World's Greatest Healthcare Plan Act of 2016, as well as a few reports from the GAO that looked at key policy and data considerations for a per capita cap, as well as CBO's more recent report on options for reducing the federal deficit.

Just one note. These are illustrative examples and they're not intended to endorse any specific design decision or policy proposal on how Medicaid should be financed. We just wanted to show examples of how these different design options could lead to different results.

And just quickly here are some of the data sources that we used to provide these examples. We used actual and projected spending from the CMS Office of the Actuary's most recent actuarial report. We also used Medicaid Statistical Information System for MSIS data and CMS-64 Financial Management Report data that we use in our MACStats data book, as well as other sources for different growth factors for consumer price index, gross domestic

product, and national health expenditures.

Here is a list of many of the design elements. Martha went over a bunch of these already. Today's presentation will focus on the first four, the ones that have the checkmarks beside them.

The first topic I wanted to talk about are which populations and services are included under the cap spending. A proposal could choose to include all individuals in spending under the cap, or they could choose to exclude specific populations and types of spending to remain under the existing open-ended financing structure. These decisions are important as it impacts how much spending is ultimately capped, and it can create incentives for states to try to maximize the number of individuals and spending invested outside the cap.

CHAIR ROSENBAUM: Chris, can I ask you just to stop for a minute.

MR. PARK: Sure.

CHAIR ROSENBAUM: We have people out in the hallway who can't get in. We can't bring in more chairs. There are seats to be filled in. So if people could sort of move over, fill in, so that we can get people who are

standing, and because there is a limit to what we can do here to accommodate people who want to come in.

All right. Sorry, Chris.

MR. PARK: Okay. No problem.

So this slide shows a couple of potential population exclusions that have been mentioned in different proposal or highlighted in different reports. The first is the dually eligible for Medicare and Medicaid. This population can be considered for exclusion because states are not in direct control of the spending as much of the spending is for Medicare premiums and cost-sharing. In fiscal year 2013, there were about 10.8 million dually eligible enrollees and their spending was about $143 billion. So this is about 15 percent of enrollees and over a third of spending, if you were to exclude those populations.

In fiscal year 2013, there were about 12.5 percent of full-year equivalent enrollees who received limited benefits. Here we're defined limited benefit enrollees as those who received coverage for only family planning services, assistance with Medicare premiums and cost-sharing, or emergency services. The number of limited

benefit enrollees ranges greatly from state to state. It is less than 1 percent in D.C., 0.1 percent, and goes all the way up to 27.4 percent in California. So the impact of excluding these limited benefit enrollees would greatly differ in each state.

Because they receive a limited benefit package, they are less costly than others who receive the full Medicaid benefits package and have a big impact on the calculation of a per capita cap. For example, the average benefit spending for everyone was about $7,000 per full-year equivalent, but if you excluded the limited benefits enrollees, it would be about $7,700.

On this slide are some of the services and spending exclusions that have been mentioned in recent proposals, or highlighted by the GAO and CBO reports. These services are either not in direct control of the state, such as the Vaccines for Children program that Martha mentioned earlier, or the Medicare premiums and cost-sharing, that I already mentioned, or spending is not linked to specific enrollees or services -- for example, disproportionate share hospital spending. Additionally, state program administrative spending is also not directly

tied to a particular individual or service.

And if these services are included, decisions need to be made on how to allocate that spending to a particular individual if you use the per capita cap model.

Additionally, Medicare Part D clawback spending is a piece of spending at the state level that could be considered for changes in any of these alternative financing proposals.

MR. PARK: So this chart comes from our most recent MACStats and shows the percent distribution of spending for certain services by each eligibility group.

I wanted to highlight how different that spending can be within each eligibility group. For example, if you were to consider excluding long-term services and supports from the capped spending system, that would be about 30 percent of overall spending. However, that would be over 35 percent of spending for the disabled group and about 61 percent of spending for the aging group, compared to less than 3 percent for children and less than 1 percent for adults.

This chart just shows the projected Medicaid spending for different services over the next few years

using national Health Expenditure data, and you can see how the estimated growth in spending for specific services is quite different over this time period.

We just wanted to highlight that because each eligibility group has a different service mix, and there are different rates of growth over time. It means that the enrollment mix, which I'll mention a little bit later, will be very important determining the level of future spending.

To date, all the existing proposals have chosen a historical year of spending and then applied growth factor to establish the spending cap, and so the choice of this historical year spending is important, as it establishes the baseline for the spending cap, and there can be year-to-year fluctuation in spending and in the growth of spending between years.

This graph shows three recent years of spending from fiscal year 2011 to 2013. Spending increased less than 1 percent from $407.9 billion in 2011 to $409 billion in 2012 and then increased over 5 percent to $432.7 billion in fiscal year 2013.

Generally speaking, a year with higher spending should lead to a higher cap in the future, but that is not

always the case.

And so this graph shows an example of a block grant scenario using either 2011, 2012 or 2013 as the base year and then trending that base year spending forward using the Consumer Price Index.

The dark blue line at the very top shows the actual and projected benefit spending from the CMS Office of the Actuary's report.

One thing to note here is that we have excluded spending for the newly eligible adult group from fiscal year 2014 and onward to keep the covered populations the same throughout the time frame.

Under this example, you can see that fiscal year 2012, the dotted line, would lead to the lowest cap in spending in fiscal year 2017. This is because even though actual spending was greater in fiscal year 2012 than 2011, the growth in spending between the two years was less than CPI trend.

Fiscal year 2013, the dashed line, would lead to the highest cap in spending.

This graph is similar to the graph that immediately preceded it except for it shows a per capita

cap approach. Spending for full-year equivalent for each eligibility group was calculated in each base year and trended forward at CPI. This trended amount for a full-year equivalent was then multiplied by the projected number of enrollees for each eligibility group in that particular year.

Again, this graph excludes the new adult group. One thing I wanted to point out, if you look at the actual and projected line, it is slightly different than the graph before it, and that is due to the rounding in the number of enrollees and spending per full-year equivalent amounts used.

Here, you can see that similar to the block grant approach, fiscal year 2012 leads to the lowest capped amount in 2017. However, for fiscal years 2011, the solid light blue line, and 2013, the dashed line, have changed places, and so now 2011 base year would lead to the highest capped amount, and this is because the per capita cap approach takes enrollment growth into account. So while total spending between 2011 and 2013 grew faster than CPI, the spending per full-year equivalent did not.

And so these two graphs show that a later base

year with higher spending does not always lead to a higher cap in the future, and also, the same base year may lead to different results relative to other base years, depending on whether a block grant or a per capita cap model is used.

This graph shows the percent change in annual benefit spending from 2009 to 2013 by state because the year-to-year change in spending at state level can be very different than the national trend and choice of the base year may have very different results, state by state.

The dark blue line in the middle shows the national average. The green line for State A shows large increases in spending for fiscal years 2011 and 2013 and a large decrease in spending for fiscal years 2012. State B, the light blue line, is the opposite. There is decreases in spending in 2011 and 2013 and a large increase in spending in 2012.

So from this example, you can see that if you chose a fiscal year 2012 base year, it would have very different results for State A and State B.

Once a base year is chosen, the baseline spending is trended forward to the capped spending amount by a growth factor. This factor could be linked to a variety of

measures, such as price inflation, economic growth, or health care spending.

So this chart shows the trend in spending from 2014 to 2023 using a fiscal year 2013 base year and trending it forward using either CPI, gross domestic product -- GDP -- or the national health expenditures trend.

Similar to the prior example, we excluded spending for the new adult group, and one change in this example is that we did include spending for state administration.

In this chart, you can see that the CPI trend, the light blue line, leads to the lowest amount, the lowest cap, and, thus, the greatest reduction in spending by 2023, followed by the GDP trend, which is the dashed green line.

This graph is similar to the one before it, but it shows the same information under a per capita cap scenario. Again, the new adult group was excluded, and administrative spending was allocated to each eligibility group by grossing up the benefit spending by about 5 percent to account for the level of administrative spending out of total spending.

Overall, because a per capita cap does take into account spending associated with an enrollment growth, the reduction in spending associated with a CPI or GDP trend are less than what we would have under a block grant scenario, shown on the prior slide.

The CPI trend still produces the largest reduction in spending of the three trend factors, but now the GDP trend is fairly similar to what is projected by the CMS Office of the Actuary.

This chart summarizes the various scenarios of the prior two slides, comparing the projected federal spending from the Office of the Actuary, and the cumulative reduction in federal spending of each scenario for the 10-year period. And I just want to emphasize the prior charts show total spending, and this chart shows federal spending.

Here, you can see that the CPI trend under either a block grant or a per capita cap would lead to the greatest reductions in the spending.

Excluding the new adult group reduced federal spending by about $633 billion. So, under this example, if the coverage of the new adult group is repealed and spending was trended forward from the base year at CPI,

there would be a trillion-dollar reduction in spending over this 10-year period, so the two examples at the bottom.

As mentioned earlier, differences in service use and spending by eligibility group, the mix of enrollees at both the national and state level will have an impact on what the spending caps would be and how each state can manage their spending within the caps.

A block grant proposal would lock in the enrollment mix from the base year, and if a per capita cap model is used and have caps set by eligibility group, that would allow for some changes in enrollment mix.

This is another graph that you've seen recently from our most recent MACStats, and it shows spending for a full-year equivalent by eligibility group and type of service. Here, you can see that there's a large difference in spending between the eligibility groups, particularly for the disabled and aged groups versus the child and adult eligibility groups. The average spending for disabled enrollee is about six times that of a nondisabled child and over four times that of a nondisabled adult.

Under a per capita cap scenario that sets caps by eligibility group eligibility assignment into the most

appropriate category is important. States would have an incentive to try to get an appropriate disability determination for as many individuals as possible, so that they could receive the higher cap for those disabled enrollees.

And, again, the different mix of services within each eligibility group and the projected growth of spending for those services will have a differential impact on states, depending on the starting point of each state in terms of their enrollment mix.

This graph shows the percent of enrollees in the disabled eligibility group by state for fiscal year 2013, and you can see how that varies state by state, and for states with a higher proportion of enrollees in a disabled group, growth in service and spending for services such as long-term services and supports will be particularly important.

Not only does spending vary by eligibility group, but spending can vary within an eligibility group. So a per capita cap set at the eligibility group level may still not take into account the full impact of changes in enrollment mix.

These next few slides are examples of spending variability within eligibility group.

This slide shows spending for children under the age of 21 by different age bands, and the thing I want to point out here is that the spending for the newborns were about four times that of other ages, and you can see that the difference in spending by age group is similar for children eligible on the basis of disability and those who are not eligible on the basis of disability.

This next slide shows the difference in spending for individuals who are dually eligible for Medicare and Medicaid and those not dually eligible, for the aged eligibility group and the disabled eligibility group. You can see the difference in spending, and if you were to only include the not dually eligible group and capped them out, then you can see that the per capita cap amount would decrease for the aged eligibility group but increase for the disabled eligibility group.

This slide shows benefit spending for full-year equivalent, for those enrollees who use LTSS services and those who do not, and as you can see, use of LTSS services leads to about 5 to 10 times greater spending, depending on

the eligibility group, than those who do not use LTSS services.

So these three slides just show how enrollment mix within the eligibility group can have a great impact, even if a per capita cap does set caps at the eligibility group level.

The CMS Office of the Actuary does analyze the impact of changes in enrollment mix over time, and they've done this for the next 10 years under the current law.

Through 2018, they project enrollment growth in the new adult group is expected to lower the overall average spending for full-year equivalent, and after 2018, enrollment growth in the aged eligibility group, due to aging of the baby boomer population, is expected to increase overall average spending per full-year equivalent.

So if the enrollment mix remained the same over the next 10-year period, average spending per full-year equivalent would grow at 4.5 percent instead of the projected 4.1 percent per year.

So this presentation highlights the first step in our work to analyzing the design elements of alternative financing proposals. This is just a list of the additional

design considerations that Martha had mentioned earlier and were listed on the earlier slide that we did not present on today, but we can include as part of our work on this topic for future presentations.

With that, I will turn it over for any questions.

CHAIR ROSENBAUM: Thank you very much.

Questions? Alan, do you want to start us?

COMMISSIONER WEIL: Are comments permitted?

CHAIR ROSENBAUM: You can comment. You can question. You can stare and wonder. You can do anything you want.

COMMISSIONER WEIL: Maybe I'll just stare and wonder. That's probably the safest reaction.

[Laughter.]

COMMISSIONER WEIL: As always, the analysis is extremely valuable, and I am appreciative of the effort and think it will serve us well.

My role in my comments is to try to think how to take the high-quality work here and have it make the most difference in the policy debate that we're about to engage in as a country, and I want to present a couple thoughts on what I think our unique contributions can be, mostly to

help guide the staff, assuming others agree, and if other Commissioners disagree, I'd be very happy to engage.

There is a risk, I think, here of the high-quality analysis being -- the level -- the degrees of complexity are so great. It's, I think, quite easy to get overwhelmed, and so when I think of the comparative value, given the discussion under way, I think of three things.

First of all, I think the number of technical issues that have to be addressed in making changes, just the sheer number of those issues and the importance of those issues is an important story to tell, without regard to actually analyzing the effects of every single dimension, because that does become daunting. But I think it's really important. There is this sense that block grants are simple; per capita caps are maybe a little less simple. I don't think either one is simple, and I think you show that quite well.

So, at some level, what I'm hoping we can do is not simply analyze every option but capture the level of complexity. I think that's a really important role.

The second issue is the relative importance of different items here. Again, I think we can look at all

these options, and they all have different effects.

It seems to me that there is some level of hierarchy of importance. For example, the growth rate really dominates in terms of what the long-term implications are of these changes, and what's in and out matters a lot, base year, transition, whether things are rebased. So, again, I think trying to -- instead of present these are series of lots of options, to sort of put them together and say, "These are decisions that have this scale of effect. These are decisions that have that scale of effect," I think will help us and others reflect on it.

The final area where I really see -- in not just, Chris, your presentation, but Martha's as well -- is this notion of context and scale, sort of relative to what. I guess what I'm concerned about in our communication is the notion that a block grant or per capita cap is less responsive to future changes. It's sort of obvious. Anything that is not a match is going to be less responsive. The notion that these reduce spending is not surprising. That's an objective of many of the proponents.

I think the question is relative to what. So these are percentage reductions relative to Medicaid

baseline. How do these projected levels of growth relate to what would be expected in growth of other payers? When you do it with respect to NHE, that's one relationship, but I think comparing it to expected trends in commercial insurance, expected trends in Medicare provide some context.

I was really struck in some of the materials earlier about the overall health and insurance context of low-income adults. This is not just what's happening to Medicaid, but what are the insurance options for people who might be affected by these policy changes? Maybe a little bit too long way of saying I'm finding great value in the analysis. I'm thinking to map it onto the policy discussion that there are few comparisons and ways of grouping topics that I think might help us and others figure out what to do with this information.

CHAIR ROSENBAUM: Thank you.

Oh, I'm sorry. Penny and then Stacey.

COMMISSIONER THOMPSON: Thank you. This is a great analysis. I really appreciate it.

I'm trying to absorb it. I agree a lot with what Alan just said. A few questions and then maybe comments,

and some of it arises out of this fundamental proposition, which is it seems like we're constructing under any of the scenarios that we're talking about, base year calculations that's composed of what we don't really know and accounted for by what we don't really know, and then we give that to states to do what we don't really know. And so I'm trying to figure out both sides of that equation.

Starting with the base year, we see a level of cost and we see a level of variation in those costs, and I'm wondering whether we have any way to account for any of that. How much is about -- first of all, there's one issue, which is that it's a set of decisions made under a financial agreement, that maybe I would make different decisions if I had a different kind of financial agreement to make. It may be a result of a particular situation that I find myself in, in the state. It may be a particular set of pressures. It may be something that represents a fair amount of efficiency or a fair amount of waste. We don't know.

Things vary, and we can start to really see that variation at a very early level, as you represented. We don't have to go very far before we start seeing some of

that state-to-state variation, person-to-person variation, et cetera.

So one is that I wonder what we can really say about what's in that math. Is it service-driven? Is it medical price-driven? Is it state administration-driven or delivery system-driven? What accounts for that, and what can we account for or not account for? Because, as we've discussed in other context, if you choose a base year, you're locking in all of that. For good or bad, that's -- and however you attach some kind of factor to that going forward, I mean, that's the first part of the equation.

And as we've found with 1115 waivers when we've constructed budget neutrality worksheets, it's a lot easier to produce savings if you start from a more wasteful and higher case, and so you end up in a place where you potentially benefit those states that have made certain kinds of decisions and disadvantaged states that have made other kinds of decisions, and they may not be the benefits or the disadvantages that you really want to apply.

So then on the other side of that equation, there is -- it's hard for me to separate this conversation. How will you construct that? What is that federal payment

paying for? And it seems a poor bargain to construct under some kind of elaborate framework where we recognize what kind of services can be delivered or have been delivered and the eligibility groups and then don't have any of those same kinds of constraints or requirements on the other side of the equation, and you can simply say, "Well, we've constructed this elaborate model to give you some money, but we don't have anything on the other side," that sort of, I think, to where you were going, Stacey, with your initial question about where is the state accountability. What's the expectation for -- what's produced out of that? And it seems to me that there has to be some connection between those two things. Otherwise, we could come up with a number in an easier way if we don't really know what we're buying for.

So a couple of questions. One is that the state-to-state variation piece, you showed a little bit of that, that initial slide, state variability in the annual increase. Can you just go back to that? Yeah, that one.

So can you say anything about what State A and State B were doing?

MR. PARK: Well, one of the reasons for some of

this variability is that this comes from the CMS-64 data, and that is data about when dollars were spent. And so it's not necessarily for services incurred in a particular year. So states may pay certain payments at the end of a two-year period. Rob mentioned earlier states have so many years to spend their DSH allotments, and so maybe they spent more DSH money in year two than in year one. So that might be some of the reasons for the differences in variability in spending year to year.

And then the rest, it's, you know, some of the stuff that you mentioned, like individual state decisions. Did they switch to a different delivery system? Did they make changes in their benefits and populations covered and things like that?

COMMISSIONER THOMPSON: So but we don't really -- like even though we picked a couple of states to show those variations, we don't really --

MR. PARK: I mean, we could dig down, at least look at what service lines might have been changing the greatest year to year, but, again, we don't know exactly why those particular services might have changed spending. It could have been the timing of payments, or it could have

been, you know, differences in the population or, you know, a particularly bad flu season or something like that.

COMMISSIONER THOMPSON: Okay. And did you, when you did all of the analysis -- you mentioned all of the potential population and service exclusions that could be thought about here.

MR. PARK: Yeah.

COMMISSIONER THOMPSON: Did you include all of those here?

MR. PARK: No. So we tried to -- you know, a lot of these examples we're just taking information from the Office of the Actuary, so they've included all spending for all populations. The most we were able to do is by eligibility group like the per capita cap amounts. But we didn't take into account any of the particular service or population exclusions, except for some of the early examples where I just showed benefit spending and some of the other examples I showed before plus administrative spending.

COMMISSIONER THOMPSON: So this isn't all-in --

MR. PARK: Yeah, that's all-in.

COMMISSIONER THOMPSON: And we haven't tried --

so we don't know if the variation is greater or less when we look at it like this from some of those slicing and dicing that we could do?

MR. PARK: Right. We could certainly do more slicing and dicing in terms of excluding like the dually eligible population or limited-benefits enrollees or, you know, excluding DSH and some of the other supplemental payments and things like that.

EXECUTIVE DIRECTOR SCHWARTZ: I think the problem is also in thinking about what's the combination of those things, so we could show you each of these with each of those things taken out. But then is it really of the ten things that could possibly be taken out, what combination of those? So at this initial stage we just mention those to give you a sense of the magnitude. And we know from our DSH work, for example, the variation in the DSH spending.

COMMISSIONER GORTON: So did you exclude obvious outliers?

MR. PARK: From this chart, this is just what the states reported in spending --

COMMISSIONER GORTON: So 2012 was the year of Sandy, so I'm just going to go out on a limb and say that

maybe New Jersey's costs were out of the normal range that year. And I do think that some of that work needs to be -- I think we have to be careful about eye-popping charts that haven't been given --

CHAIR ROSENBAUM: Right, but I think the point that Chris is trying to make is -- it goes to your issue, which is depending on the five years we take and depending on the states we take, we're going to get this craziness among states, and we're going to get it for a variety of reasons. But I take it you're showing us this to show that life is not a smooth path often.

MR. PARK: Yes, that's correct.

VICE CHAIR GOLD: And it could be that, depending on how anything is written, if it goes back to XYZ data, whatever that random occurrence was in X state is going to be baked into the policies and transferred on for the future. So, you know, it's not clear that some of this random variation wouldn't apply.

COMMISSIONER GORTON: Exactly right. So I do think that it's -- so the story that you're telling about the complexity here I think is an important story. And the actuarial community has ways of dealing with complexity and

black swan events. And I do think that -- and you may or may not like how some of them get done. There are selection issues. Again, you've sort of pointed to that. You know, we have the three R's, which are no longer popular, but there are program design elements that you can put -- if we think about this, as I do, as how do you manage an insurance risk pool, there are design elements that you can bake in in terms of, you know, risk adjustment and corridors and reinsurance for black swan events and those sorts of things. And I do think it's important to sort of lay those things out because it gets to Penny's point of this baking in a base year and then you live with it forever. I mean, we talked about DSH this morning. We're living with whatever the base year was for DSH.

And so I think it's important to raise the methodological questions about how you determine what the right base is and then what adjustments you're going to make year after year and then where do you need a circuit breaker. What are the events that would cause you to rebase? What are the events that would cause you to give a state a pass for any given year? You know, Hurricane Katrina hit, and Mississippi, Alabama, and Louisiana were

pretty much basket cases for a long period of time. Maybe the usual trend assumptions should be reconsidered in a construct like that.

So I think it's -- and all of that by way of saying to the extent that you can pick some of these things out of the data and illustrate the event with that -- right? So find a state that's got this, and double click on it and say, okay, well, what happened in 2012 was Sandy hit New Jersey, and so it all skyrocketed. What happened to somebody else is they saved all their DSH payments up for five years, and then they finally decided to pay them in 2011. And maybe we should control for that, or maybe we should just tell them they shouldn't do that because they get DSH for the purposes of spending it or giving it to the hospital.

So I think that to the -- I guess what I'm trying to say is -- and this is to Alan's point. Where these things have impact -- and we can sort of call them out and give a concrete example as opposed to sort of an abstract statement of eligibility mix matters. Well, okay, show us how eligibility mix -- show me an aberrant pattern that was driven by eligibility mix so that people can see the

magnitude that comes from that.

COMMISSIONER LAMPKIN: So I am going to overlap a little bit with Kit's comments, because what's striking to me looking at this and the design elements of this is how much of an analog exists with states and their actuaries as they've designed managed care programs, right? So you have many of the same issues. What populations do you include? Well, the ones where you have a realistic opportunity to manage their costs. Well, how do you group them? Well, you group them in ways where their costs are predictable, so if the populations grow at different paces, your finances adjust for that. What services to include? Do you have the right incentives? Are you making sure you're not allowing for substitution effects that produce the wrong incentives?

So many, many of the same issues, even, as Kit noted, what to do when the unexpected rare thing comes up and, yes, you've hired that managed care organization or that state to manage the risk, but you recognize it's something unusual. What other risk mechanisms can you do?

So, you know, even the variability in your underlying data, what of it is real that you need to

incorporate, what is not, and how do you slice through that. So many, many of the same issues. Is there a way that we can look to that process, and to some extent the 1115 waiver budget neutrality process as well, to glean principles and examples and real-life things that can help policymakers understand where we as an industry have maybe at least partially resolved some of these things or have some really good ideas.

COMMISSIONER BURWELL: So two things. One is just the methodological problems in establishing what states -- what Medicaid spends in a particular year. Having done these annual reports on Medicaid LTSS expenditures, I mean, the best data source is the 64, and you still deal with the issue of data payment versus data service in the 64. But even in the 64, states, you know, submit quarterly reports and get federal match on what they report. And they have a certain amount of time to make those claims.

But there's also something called "prior period adjustments," so states may not really claim all the services they paid for in a particular year. For example, in California, there's a program called the "In-Home

Supportive Services Program," and it is renowned for not claiming federal match for that program for like two years behind. So just, I mean, establishing a base year, regardless of what's included or not included, is very difficult.

I am interested in the state variation in a block grant approach or any kind of -- and there is a conundrum. I mean, I just think there's a basic conundrum. One is if you just take what states spend now, there's huge variation across states, regardless of any metric you use. You know, we've done some of the math on this. The highest-spending state spends seven-fold what the lowest-spending state spends. So there's, you know, an inequity -- there's a lot of inequity in existing Medicaid.

You'll notice in some of these proposals then they propose, well, we'll start that way, we'll start with the current inequities, and then we'll compress to the mean. What does that -- I mean, I'd like to see the math around that, because then you create huge winners and losers. New York will lose an incredible amount of money. Mississippi will gain a huge amount of money.

CHAIR ROSENBAUM: And that I think actually arose

as an issue in '95 with the block grant.

COMMISSIONER BURWELL: Yeah. This has been done before. So I think that's an important part of the analysis to get out there and just show what these different approaches -- I mean, there's no perfect solution to this issue. It's the way Medicaid is.

COMMISSIONER DOUGLAS: So I just want to touch -- others have said it indirectly, but on Slide 13, I think it's really important to break this type of slide down into the various major eligibility categories -- duals, the aged disabled, you know, parents, children -- to show the same type of trend to what the actual projected versus the CPI-U, because I think what we're going to see based on our other analyses is there's -- some of these are going to track pretty close to the CPI-U and others are going to be huge, huge variation, huge delta.

And just for us as well as for Congress to understand where the costs -- where you're going to see that delta, which is most likely aged disabled duals, and so to understand these values of flexibility, where we had cost savings, what are going to be the drivers that states have to focus on to do that.

COMMISSIONER THOMPSON: Yeah, that's a great point, Toby, and I just wanted to come back to Stacey, which I think we talked about this before, about like this is effectively a PMPM or something along those lines. But when you create something like that, you also create a contract -- I mean, you price it based on a contract, on a set of specifications for what you're expecting to buy for that purpose. And that's part of what drives you to decide what am I including and what am I not including. And so I think that's an important element to bring out here.

CHAIR ROSENBAUM: Meaning that it becomes much more complicated when you untether the expectations from the money.

COMMISSIONER THOMPSON: Yeah, when you just create a target and then you kind of don't have something on the other side of that in terms of what that's supposed to represent in terms of buying power or a purchasing--

COMMISSIONER LAMPKIN: And to me, that's why the first question is: What is the accountability on the other side?

COMMISSIONER THOMPSON: Right.

COMMISSIONER LAMPKIN: What is the state

accountable for this money?

COMMISSIONER THOMPSON: Right, and that will help you figure out what are legitimate costs, what are efficiencies that you expect, what are -- you know, et cetera.

I do want to get back to what Toby said, though, too, about -- because the other part of that is however you create the numbers and however many numbers you create, then the question is: What are the incentives that that produces on the other side? And however you specified what you're supposed to be doing. And I do think that where you get big -- and this is maybe a question for you, too, Chris. I'm trying to figure out where variability is good and where variability is bad from the standpoint of trying to drive towards that mean or drive towards that common place.

On the one hand, in a place where there isn't a lot of variability, then it doesn't seem to me that establishing some kind of mean gets you very far, because you're basically just reflecting, you know, there's a small amount of variation, pretty much everybody spending along this for these kinds of people and doing these kinds of

things, and so all you do is reflect that in a line item where there is little variability. I don't know that creating that kind of a management control accomplishes much.

On the other hand, if you're trying to drive some kind of efficiency or trying to drive some kind of thinking around how health care is delivered, and you're trying to identify those places where you think there is a lot of variability and there could be a different way of doing things that would produce more efficiency, then you create some potential risks if you have no answer for how that variability is going to get addressed. And I think if we dive into some of this and try to get underneath of this into those areas where there really is -- hey, there's a lot of variability going on here, there's a wide spectrum of costs, how can we account for that and how many of those things are movable by states on a year-over-year basis. And I think the delta between that and the numbers can produce a little bit of an understanding about how far do you have to go to meet that target if that becomes your target. And I do think given what we know about the program, we're going to find the high-cost, high-need

populations, the duals, you know, those are going to be the folks that are going to have some of that tremendous variation. And I think we just need to really put a focus on that.

EXECUTIVE DIRECTOR SCHWARTZ: I just want to add, to tag onto these two comments, both sort of the rate-setting-like feature of this and what Penny's saying, is that the variation across states both reflects a spectrum of efficiency and well-designed, well-managed delivery systems, and also quite a lot of variation in the generosity of the benefits that are being offered. And so if you were just driving toward -- if you knew what was truly efficient, what was the best model, and you were driving towards that, that is sort of a different set of consequences versus driving out generous benefits in some place for a skinnier package somewhere else, which -- and, you know, may or may not be a good thing. Certainly people losing benefits from their perspective tends to be not a good thing for them. So it's not like you can just say like driving towards the mean will result in the desired effect -- so you have a lot of these things moving at the same time, because we don't know how to value those

benefits.

CHAIR ROSENBAUM: Can I just jump in? Because it's right on this issue, because I think it's a very illustrative group, and I'm quite taken with the slide. I'm looking for the number. It's the children's slide. It's Slide 22, okay?

So Slide 22 I think is quite instructive because, of course, for children -- and, you know, nothing ever works in a unified fashion nationally, but we come as close to it for children as we do for any population in Medicaid because their entitlement is universal, it's everything that falls into the definition of medical assistance. States obviously vary some in amount, duration, and scope, but the entitlement is a uniform design. And cost sharing is virtually prohibited for children. So we have as pure an illustration in my view of how things sort of play out in this program.

So if you look -- of course, it's not a surprise -- we see that little children, you know, in their first year of life are more expensive than older children, and children with very serious disabilities are more expensive than children who don't have -- who are eligible based on

poverty. And rather than being driven by entitlement, scope, or cost sharing, it seems that more likely it's driven -- the premium payments are -- $1,500 of the $2,200 is the children's per member per month payment, and the managed care numbers from one of the other slides here.

And so the irony is that you can throttle back on the benefits, and you can vary the package based on health status, and you can introduce cost sharing, you can do all these things, and in a world right now where none of that is a feature of the program for a population that is subject to uniform rules, you can see that the spending is quite low for people who are healthy, and it's very high for people who are not healthy.

And so, I mean, I raise this just to make the observation that I absolutely appreciate all of the underlying factors for variable spending and the importance of finding an efficient way to spend this much money federally. But I also think we have to be quite realistic about the extent to which shifting away from a comprehensive coverage approach in Medicaid, shifting toward higher cost sharing in Medicaid -- I mean, in the end, the populations who consume huge resources in the

programs will consumer huge resources in the programs, and the ones who are healthy will not.

And so I think children are a tremendously important object lesson for policymakers as they think about this restructuring. It's sort of a little case study of, you know, a bigger point.

Marsha, I know you wanted to jump in.

VICE CHAIR GOLD: I have, I think, about three points. One is a technical one, and the other built on some things that were said.

First is because the big proposals involve the block grant versus the per capita, I think we need to be careful to make sure that our labeling on these tables lets us know which one is which data.

In particular, Slide 9, where you talk about the projected growth in spending, I don't know if that's per -- way back to Slide 9, yeah. Yeah, there. I don't know if that's aggregate, change in aggregate spending, or change in per capita because one will take into account enrollment mix and one won't, and so I think it's important that we say what that is, and I also think, given other issues that we -- on the bottom, as much as we can put as much on the

sources and the notes about what is or isn't excluded and how it's done so that people using this can use it.

Second point is that I think -- and this is sort of in Alan's category, big-picture things we shouldn't forget, and it fits with Sara's comment. The risk categories, if you're going to do any kind of per capita something, how you bucket it makes a big difference, and certainly, there are big differences by eligibility group, but even within eligibility group and a lot of the lessons we've learned from capitation setting in managed care apply here in terms of an equity perspective. So if you were going to do this, you'd want to worry about how that was done.

The final thing is maybe what people have said, and I'm just going to say it bluntly. Under some of these -- under all of these proposals, there's substantially less money, especially over time. The CPI-U gives the least amount. The gross domestic product also gives the least. The health expenditure target is a little closer to the current projection.

So what that means is -- maybe it's what Penny was nicely saying, the "What are you responsible for?" but

it means probably, with that much money, you either are going to assume states can be a lot more efficient, which I have a feeling, they probably can't or won't because they haven't so far, and as we said in our initial report, they have been under a fair amount of pressure, their own cost as well, so they've looked for things.

So that means that probably fewer people will be covered or there will be fewer benefits, and it gets back to Stacey's point, which is what is the requirements and what are you assuming.

If I was a state, I'd be scared to look at this, at what I'm assuming. On the other hand, if I was a beneficiary and the state had no requirements and I saw this, I'd be really scared because there would be no reason for people to cover me. I mean, people don't spend what they don't have, or at least states won't. So somehow these figures are going to have a human consequence and affect things, and I think that the data are real. And the more the proposals get specific as to what the requirements are in the state -- and I don't know if you want to say anything, Stacey. I think that's what you were getting at a little bit, but from a real-life perspective, that's what

it means. Either the state is going to take a bath, or the beneficiaries are going to take a bath if the money is a lot less.

CHAIR ROSENBAUM: Kit and Toby, unless, Stacey, you want to respond?

COMMISSIONER LAMPKIN: Well, that was part of it, and I think along those lines, the savings, as I interpret it, has got to be coming from either operational flexibility that states don't have now that they would get under this, different incentive structure, to the extent that that's meaningful to them, and then the priorities they set, given a limited set of funds. And what I don't have a sense of is really how the potential savings allocate across those three areas, and so how much of it does come down to fundamentally having to make a choice about coverage or who to cover.

CHAIR ROSENBAUM: Kit.

COMMISSIONER GORTON: So I think this latest section of the conversation misses something, which I think is important. The way you get to spending is by taking utilization, which is controlled by eligibility in the benefit package and multiplying it times unit cost, which

is controlled by the political and market power of the provider communities and to some extent to the plans.

The providers, in particular -- and I've been one -- they participated in the program on a voluntary basis, and yet the statute says thou shalt put enough money into the program so that the providers are willing to participate.

And it's interesting to have Marsha -- and I think she's absolutely right -- characterize it as either the beneficiaries are going to take a bath or the states or going to take a bath, but notice very infrequently do we arc to the place where the providers take a bath, now DSH being sort of the counter-argument to that.

So I just think it's important -- and so what I would say is that some of the variability that we see state to state is a unit cost variability. It's what the providers have been able to get.

So Massachusetts on aggregate pays its providers in Medicaid more than Medicare. There are plenty of states that are paying their providers very small shares of Medicare, and that state-to-state variation is an important factor as we think about the base year and about this

compression. I raise that point because that may be a place to legitimately address the compression is to say, "Okay. Let's get some discipline around unit cost and what's reasonable."

Now, as Alan said, there are going to be winners and losers. My friends at the Massachusetts General Hospital never liked me talking about unit cost, but this would be problematic because their business model is constructed in a unit cost, which is way above -- you know, it's 170 percent of the median in Massachusetts.

But I do think that that unit cost piece needs to sort of be illuminated here because, if we just talk about per capita again, you sort of bury that, and I think we should sort of tease out the variation.

COMMISSIONER THOMPSON: I'd just jump in to just add on to that point for one second, which is that goes back to the question I was asking about. How can we account for this initial variation? Is it price? Is it health status? Is there a different risk profile for beneficiaries in certain states versus other states? Is there a different kind of provider mix and health delivery system? Is there a different kind of reimbursement

strategy, et cetera, et cetera? And I think if we can pull that apart, that might begin to help us understand how we ought to think about accounting for that.

VICE CHAIR GOLD: The one caveat there -- and I know it's Toby's turn, so I'll be quick. Medicare has looked at this. The Institute of Medicine has looked at small area variations and stuff. It's been looked at by Wennberg. One of the things you find is that some of it isn't accountable. There's unique crazy things that happen, and so while I don't object to looking at it, we shouldn't expect that we're going to be able to take it away.

COMMISSIONER THOMPSON: That's why the question is "How much can we account?"

VICE CHAIR GOLD: And the policy.

Sorry, Toby.

COMMISSIONER DOUGLAS: No, that's okay. That's okay.

I just want to be -- I think we need to be very careful to jumping to conclusions on what the data means yet until we do some more of this drilldown because it all depends for -- all these assumptions can change, but it

does raise the questions of, okay, Where do you see the differences? What are the drivers? Is it, as you say, the state beneficiaries, or is it that we need to look at some of these big cost drivers, whether looking under the hood on physician and clinical, how the states have control over -- or is there something we need to look at, at hospital unit cost differently or delivery system differently? But the answer isn't just, I think, at this point that we know yet that nothing works when we don't drill down by different groupings and where the cost drivers -- and when we allow for policymakers to think through what are the different trends, not to say any of them. Maybe at the end of the day, none of it, but I just want to be careful on jumping too soon to that.

CHAIR ROSENBAUM: Well, this has been an unbelievably rich discussion, and what I take away from this is that we've spent the past 90 minutes focusing on, first of all, the possible implications of a major shift in federal policy regarding how much of the cost of low-income and vulnerable populations the federal government bears, however it articulates that, and we've also focused on just how complicated it is to build a structure that could

adequately support such a shift in policy, even right out of the box. I mean, never mind seven years from now when we have more of Chris' crazy triangle picture and are wondering why and the stop-losses that point to that will kick in and we have to revisit. So, I mean, just even starting down this pathway is extraordinarily complicated, and these complexities are really there, putting aside the issue of a flat limit on federal growth, however it's expressed. I mean, these are the questions that we have to be asking about Medicaid all the time, but once you introduce a flat limit on federal growth tied to some external factor or factors, rather than simplifying matters, it sets off -- it's like one of those great Fourth of July fireworks, where you shoot it up in the air and then it has those buildings sparks that add more and more complexity to the picture.

So, I mean, this is the first of what I'm sure is going to be a lengthy exploration by the staff and under the guidance of the Commissioners about the ramifications of a policy change toward control federal growth in the program, so thank you.

We are going to move right into a presentation

now on the low-income population in Medicaid with Jane Horvath, who will take the stage, and this is a focus on coverage for low-income adults, both their characteristics and state approaches.

MEDICAID COVERAGE FOR LOW-INCOME ADULTS: INDIVIDUAL CHARACTERISTICS AND STATE APPROACHES

* MS. HORVATH: Thank you, and I guarantee this section of the agenda today is not going to make your head hurt like the last section. It's far more straightforward and less complex.

So this conversation was started by the Commission last summer, and the policy environment has gotten a lot more complex since that time, but it was our thinking that the questions that the Commission wanted to consider have potential relevancy going into the future as well.

The question was Medicaid's future serving the low-income working-age adults, and the original question was framed around the new adult group that became eligible as a result of the ACA. So that's folks who are not otherwise eligible for the program in a categorical sense, with income at or below 138 percent of poverty.

So the question was: what are the needs of the group, and is the program, Medicaid, as we know it, structured to meet the needs of this group? And then how have 1115 waivers been used or sought to be used for this new adult group?

In terms of thinking about the social and health characteristics of the population and the waivers, we will look at the way that states are thinking about and have sought to provide innovative or reform coverage approaches for the group. Some of the trends that we have seen in the waivers, to think through as we go through the demographics, there's been a desire on the part of some states to link Medicaid coverage to work or job search activities or community service activities.

There's been an emphasis, sort of a trending emphasis, in the waivers around personal responsibility--increasing or emphasizing personal responsibility for health outcomes and for resource use. Then, and this is not the best wording on the slide about "eliminating benefits not found in commercial coverage", I think a better way to think of it in terms of a policy goal was aligning Medicaid benefits to commercial benefits, given

issues of churn in this population, and then adding coverage of services that were not otherwise eligible currently under federal match to serve the needs of the population.

So just turning to the first part here, the social and health characteristics of adults with low incomes, we looked at this without regard to any source of coverage--Medicaid, uninsured, insured, commercially insured. We were just looking at low-income adults and their demographics. And this is all population-level information. So we're going to look first at social characteristics briefly and then health characteristics, and then this other issue that seems to be growing in import with respect to the literature: justice involvement among low-income populations.

So I think it's fair to characterize, as you have probably seen in your books, that there's not a lot of surprising information that comes out from a demographic look at folks with low income.

In terms of educational attainment, we find that almost 30 percent of people who live in deep poverty, which is defined as below 50 percent of the federal poverty

level, do not have a high school degree. And that's just about the same number for folks between 50 and 138 percent of poverty as well. And the trend, the educational attainment, starts improving as income improves. When you get to folks with incomes over 250 percent FPL, only 8 percent of them lack a high school degree, so that the trend is pretty steep and pretty significant.

And the reason to look at this is, potentially, literacy translates into health literacy, and educational attainment may have the potential to affect enrollees' ability to understand really complex insurance and benefit designs.

The next section that we looked at briefly is work and inability to work. The data show that 40 percent of people in deep poverty actually work, and 50 percent of them work full-time. Just slightly over half of people with incomes below 138 percent of poverty work, and 60 percent of these people work full-time.

For folks who aren't working, there's a substantial portion of the population that cannot work because of disability, and so the data that we've found demonstrates that roughly one in five people with income

below 100 percent of poverty can't work because of a disability, and about one in four people in deep poverty can't work because of a disability.

In terms of the state trends of wanting to connect eligibility to work requirements and other things, these data may have some relevance to that kind of benefit design.

In terms of health status, clearly, there's nothing particularly new on this slide, and I think the first statistic about prevalence of chronic conditions is less significant than the second bullet, just because of the prevalence of chronic conditions writ large in the U.S. population.

But the second bullet really speaks to the potential the severity of chronic conditions. I would point here that almost a quarter of the folks with incomes below 138 percent of poverty self-report being at fair to poor health status as compared to only 4 percent of people with incomes over 400 percent of poverty.

Obviously, the worse health you're in, the more chronic conditions you have. The potential is there for a lot more service use and potentially more out-of-pocket

cost, depending on the benefit design.

Serious psychological distress. We saw this and just thought it was interesting. This is from the National Health Interview Survey, and this metric of serious psychological distress is not one question on the survey. It's how the researchers look at a series of -- I believe it's five questions, and the answers to those five questions produced this particular metric.

So for people reporting serious psychological distress in the 30 days prior to the date of the interview, for the general population, for the sum total of the population, the rate was 3.4 percent. It's 1.2 percent of people reporting serious distress with incomes above 400 percent which contrasts rather significantly to the 9.1 percent of people living below the poverty level. Again, this speaks to a potential nexus between the Medicaid eligibility and program design features.

And this is the issue of involvement in the criminal justice system. We raised this because there's, again, a growing body of literature around this issue -- criminal justice and poverty -- in the U.S., and it's becoming a larger issue of research and policy focus

because there's a lot of change going on at local and state levels in the criminal justice system, a lot of changes that are starting to have an impact. There is potentially a nexus between the new adult group population on Medicaid and the folks who are justice involved. So that's why we brought this up.

The data is not great, and it's not recent, but in 2011, researchers had found or estimated that almost 40 percent of the local jail population had incomes at or below 80 percent of poverty, and that, increasingly, the criminal justice system is creating financial burdens for people. Jails and prisons in 41 states now charge room and board and processing fees and other fees related to court.

There's sort of more literature now too around the fact of requiring financial bail for people in jail for bad car registrations and unpaid parking fees; they can't make bail, and at the same time, they're incurring room and board charges.

There was a recent estimate, about 80, 85 percent of people who leave the system leave with debts stemming from the system. Failure to pay those debts can wind you back up in jail.

And so the point is as Medicaid increasingly looks to increase personal responsibility, depending on the state and locality where that's happening, there are potentially these other sets of issues that create difficulties or complications for people's ability to be compliant.

So now, looking at the 1115 waivers, there are seven states that have waivers that are specifically targeted at innovative ways of providing coverage for the new adult group in specific. There are other 1115 waivers that are not on this list where states are pursuing different service options -- services not otherwise matchable -- to deal with the needs that they're seeing in the new adult population. But they're not reforming how the coverage actually happens.

Just to reprise, the trend that we're seeing in a number of the waivers that have been submitted, ones that have been approved, ones that are still pending, and ones that have been rejected are: states' desire to adopt a more commercial insurance benefit design for this new adult group population; and provide support and encouragement for moving people into the workforce, again, in this new adult

group; and creating greater accountability and responsibility for resource use and their health outcomes.

And we're going to look briefly at three main areas of the waivers. There's lots that can be said about these waivers, the submissions, what states have sought, what has been approved. We just chose to focus on three big buckets of eligibility, service/coverage issues, and cost sharing. And what we present here is not exhaustive by any means, but represent trends.

So for eligibility requests, what states have requested -- and this list is things that have been approved in at least one state for their 1115 new adult group. What we're seeing is a desire to condition eligibility on monthly financial contributions -- in some states, they're called "premium payments" -- with some sort of penalty for failure to pay. And in one case -- Indiana, I believe it is -- there's actually a six-month lockout. It's more significant than a disenrollment. It's a lockout for six months.

Sum total of policies in a state also produce waiting periods for coverage. Now that has been approved

by CMS. And a number of states have requested eliminating the three-month retroactive coverage that is part of standard Medicaid, again, align it with commercial coverage.

What states have requested and what has been rejected, though, is conditioning eligibility on work or job search or community service. Time limits on eligibility, the specific proposal before CMS was five years. Requiring additional proof of citizenship and imposing resource requirements on the MAGI group -- the income-only group, the change that ACA made -- a state had submitted a waiver to undo that. That was rejected.

In terms of service coverage requests that states have submitted, what has been approved in at least one state is waiver of non-emergency medical transportation, and the Commissioners heard about this recently at a prior Commission meeting. Changes in pharmacy benefit rules, and then requiring healthy behavior activities with rewards and penalties associate with that, financial rewards, other rewards, and penalties. And then providing adult institutional psychiatric or substance abuse treatment (basically getting coverage of IMD services for adults).

That was approved in one state recently.

What CMS has heretofore rejected is waiving EPSDT. States have sought to waive EPSDT for older youth/young adults who come in via the new adult group. Eliminating wraparound coverage so extra Medicaid benefits that don't appear in commercial coverage when states leverage employer-sponsored insurance or qualified health plans inside the exchanges. And also rejected -- and some are still pending -- is coverage of housing or rental costs, particularly dealing with the new adult group and homelessness, severe mental illness, things like that, trying to wrap housing services around it. There are some housing services that can be provided, housing support services, without a waiver, but these requests go further.

And then cost-sharing requests that states have made. So what CMS has approved to date is higher co-payments at lower-income levels than otherwise allowed under current law. Allowing third parties to pay for beneficiary financial obligations, particularly when a state benefit design is tied to disenrollment for failure to adhere to financial requirements.

Allowing higher co-payments for inappropriate use

of services. Basically this is the emergency room co-pay that a number of states have instituted. And beneficiary management of medical spending or savings accounts. They're not true health savings accounts.

And the interesting thing about this, I will just say -- it's not on the slide, but these medical spending accounts are prefunded using FFP. They're funded anywhere from $1,200; one state prefunds them up to $4,000. There's FFP available. They are used on a first-dollar basis generally. And some of the program designs allow people to take that money that accrues in that account, (if they keep their resource use low) and if they leave the program for employment or some other source of non-Medicaid insurance, they can take that with them, and that has been approved.

What has been rejected by CMS thus far are mandatory premiums, or the monthly contributions for people below 100 percent of FPL. States have it but it's voluntary at that income level. Allowing enrollee financial exposure to exceed 5 percent of family income. A state wanted to have 10 percent of family income for folks who were enrolled in employer-sponsored coverage, and that was nixed. Charging interest on late contributions or

service co-payments or charging fees for missed appointments, those were all rejected.

Again, there's so much more that can be said about these waivers and what states have sought and CMS' response and what's still pending that hasn't been adjudicated at all. There is a lot of material there.

But in general, we can see that people with low incomes face challenges that people of higher financial means do not necessarily face. And the question is if, and how, policy should address or accommodate those challenges. And, we look forward obviously to your feedback and your comments and suggestions for further analysis. And Anne had highlighted this earlier I believe, that one of the things we will do, pending feedback from you, is looking at gap analysis of 1115 waivers. The research plans of these waivers and if the research plans are well suited, to studying the questions that arise from the benefit design itself. And then potentially a little later on doing a lot more in-depth work with one or two of the older, if you will, older new adult group waivers to see where the rubber meets the road, how they're operating more of a field

exercise.

With that, thank you.

CHAIR ROSENBAUM: Can I ask one question? Isn't it the case that in Indiana everybody has to pay something, and if they don't pay, they -- if you're below poverty and you don't pay, you get a more limited -- you lose your dental benefits. If you're above poverty, you actually can be locked out of the program. But I thought in Indiana at least they have allowed a mandatory contribution requirement.

MS. HORVATH: It's tricky, so you've got to read it a bunch of times. So how it works, as I understand it -- and Martha and Kacey can dispute it if I'm wrong. So Indiana enrolls everyone in the Basic Plus, which is the program with the extra benefits and then no co-pays either, and you make your premium payments on a monthly basis, and then you don't pay a per unit or point-of-service fee. People below 100 percent of poverty, if they don't pay that in 60 days (they have 60 days to make that payment) they are then dropped down to basic. So it's a voluntary premium payment for people below 100 percent of poverty. And then they're in this basic program -- forgetting about

the dental, but what they do have is point-of-service cost sharing at that point. But that's the waiting period --

CHAIR ROSENBAUM: They do get -- I mean, it's one of these things where we sit here and agonize, of course, over every term. So, in fact, they are enrolled in the program without regard to payment. But if they do not make this post enrollment payment, then they lose certain benefits.

MS. HORVATH: So basically you're not enrolled -- I believe that this is Indiana. You're not enrolled until you make that payment.

CHAIR ROSENBAUM: That's what I thought [off microphone].

MS. HORVATH: So it becomes effectively a waiting period. But Indiana does -- I mean, just to be totally fair about this, if you have urgent need for medical services, there's a way around all that. But on its face, it is a waiting period for benefits for lower-income people.

CHAIR ROSENBAUM: Yeah, I mean [off microphone] sort of dissecting these things. But one of the things I have noticed about these demonstrations is that the terms

of art varied tremendously, and often the terms of art are, in fact, different from the terms of art as they're used in federal Medicaid statutory policy. And so as we can see from this struggle to how to characterize Indiana, you know, understanding what would or would not be permitted under current law, where the 1115 demonstration authority becomes crucial then, you know, is it a premium -- is it the bar against premiums that's been waived? Is it a cost-sharing bar that's been waived? I mean, so, anyway, I open it up to everyone.

COMMISSIONER DOUGLAS: I mean, I just -- it's technical on this, that, you know, in -- really the waiving under 100 percent really -- the cost sharing, it's still voluntary. The way I would view Indiana is they have a minimum benefit package for the Medicaid expansion, and for those above, they've given, you know, a supplement that you can pay a premium. And the way they characterize it is the opposite from a -- you know, if you don't pay this. But there's still the basis of the Medicaid program, and it's not something that can be waived under 1115. We've talked about this before, Penny, because we tried to in California. It's congressionally so tight that 1115 waiver

wouldn't even allow it on mandatory co-pays, that it would take statutory changes.

CHAIR ROSENBAUM: Because on co-pay, absolutely, because it's outside the scope of 1115.

COMMISSIONER DOUGLAS: It's outside, and there's an evaluation process --

CHAIR ROSENBAUM: Yeah, yeah.

COMMISSIONER DOUGLAS: -- that is so detailed --

CHAIR ROSENBAUM: Governed by its own statute.

COMMISSIONER DOUGLAS: It's governed by its own statute around it, that co-pays and premiums for under 100 percent would have to take statutory change.

CHAIR ROSENBAUM: Well, yeah. The premium rules are lumped with the cost-sharing rules, and so you have this added layer of statutory complexity. And so your point being that what you're really paying for is the benefit package that includes dental in Indiana.

COMMISSIONER DOUGLAS: Yeah, I mean, Penny would probably part -- but that would be the way, I think, that it would have been gotten through all the processes to do that, a minimum benchmark plan that the Medicaid expansion can have with supplemental.

COMMISSIONER THOMPSON: Can I go to a different subject? Not that I don't love talking about Indiana.

[Laughter.]

COMMISSIONER THOMPSON: Two questions. One is you talked about education and justice involvement. The one issue that I didn't see is housing and what we know about low-income adults and their housing situation.

MS. HORVATH: So that's not in here because it could get to be really long, and it's also -- the housing waivers are not these 1115 system reform waivers. They're looking for FFP for services not otherwise matchable, and if my memory serves me, it's Oregon and Washington, and potentially Maine has an 1115, because they are finding that this new adult group has, a high degree of homelessness that affects health outcomes and CMS has put out notices -- so I'm sure you are probably more aware than anybody -- about how Medicaid can actually finance housing support services, I think even basic small appliances and things like that. What these waivers have requested is being able to pay the first 30 or 60 days of rent or coming in and paying rent in crisis when something is falling through the floor.

COMMISSIONER THOMPSON: Because I think that's another one of those issues -- I mean, I think the other thing in addition to some of the justice issues that you've been -- that you've highlighted that we're all learning a little bit more about, we're also learning a little bit more about housing uncertainty and eviction and some of the other issues that plague this population in terms of -- you know, when you're living on the edge and when there are various kinds of rental agreements with landlords in which there can be fairly precipitous eviction notices issued without a lot of other options and without having access to first month's rent and deposit and your bank account and so forth that it can be very difficult to maintain safe and affordable housing. So I just wanted to suggest that maybe that might be just another area to point out as a particular challenge for this population.

And then related a little bit to our earlier conversation, which is do -- and I don't know how we would get this, but it would be useful to figure out for at least waivers that have been granted what the impact of those granted waivers are on costs. So forget whether or not they are -- you know, in the larger 1115 evaluations,

there's more than that, right? Which is what impact did those have on people and, for example, if you waived NEMT, you know, did people still have access to health care? Could they get to their appointments and so forth and so on?

But it would be useful to see, if you just accumulated any or all of approved waivers for this group, what attribution of cost savings are associated with that. So that, again, kind of going back to earlier conversation about do we have a pathway to efficiency, do we have a pathway to sort of our common goals here for some of these populations, it would be useful to kind of put up -- irrespective of other impacts that those policies might have, just to know do they affect costs in one direction or another?

MS. HORVATH: Right. There's probably several ways to do that, one just using administrative data for trends and stuff that we can talk to Chris.

CHAIR ROSENBAUM: Okay.

COMMISSIONER BURWELL: So in regard to the first set of analysis about the characteristics of low-income populations, low-income adults, I'm a little frustrated by

the fact that we did these analyses without regard to health insurance status.

MS. HORVATH: Okay.

COMMISSIONER BURWELL: So I'm very interested in the characteristics of the expansion population covered under Medicaid, but in order to do that, I would think that I would have to know, you know, the differences between those who are currently receiving Medicaid and those who are not or, you know, those who have employer-sponsored insurance.

MS. HORVATH: Okay. We can do that.

CHAIR ROSENBAUM: You mean you want to know -- I wasn't following what additional --

COMMISSIONER BURWELL: When I started reading this chapter, I thought it was, you know, what are the characteristics of the expansion population? But these data are without regard to health insurance status, so I would want to see the data presented differently for those who are already receiving Medicaid.

For example, the data around disability status, well, some of those people may be categorically eligible for Medicaid on the basis of disability, that kind of

thing.

MS. HORVATH: So that is what you mean, Brian --

CHAIR ROSENBAUM: And the data [off microphone].

COMMISSIONER BURWELL: Right.

CHAIR ROSENBAUM: The data were from what year, the data that are the characteristics data?

MS. HORVATH: 2015.

CHAIR ROSENBAUM: So it is current.

MS. HORVATH: Yeah. A lot of it is the National Health Interview Survey.

CHAIR ROSENBAUM: Uh-huh, so you would know that.

COMMISSIONER BURWELL: So it would be very interesting, for example, for those who are not on the disability program but are low-income, what percent report a disability?

MS. HORVATH: Okay.

COMMISSIONER BURWELL: In any case.

MS. HORVATH: Okay.

COMMISSIONER MARTÍNEZ ROGERS: I just have a comment, and that is that it would be interesting, I think -- one is that if we're going to give a waiver for housing, at some point we have to have something about education, to

teach people a skill, to be able to even maintain that house so that they're not evicted, so that we don't continue with this cycle. Because I think that one of the things that we have discussed, Leanna and I have, is the lack of education of a skill to see if you can move beyond where you are, from Point A to Point B. It's just a comment. That, you know, as we look at -- and I've done studies with substance abuse, and I look at working with women, because my population is primarily women -- that it cycles. And we all know that. It's a cycle. And at some point, when do we stop that cycle? Or how can we help in stopping that cycle? And, you know, for those that aren't disabled but are just poor and have no education -- you know, we have in San Antonio a place called "Haven for Hope," which is for the homeless. They go in and they live in Haven for Hope. They can stay there for six to nine months. While they're there, they're being taught a skill. Before they leave, they're moved from there to rent some kind of an apartment or a housing facility, where they are taught how to be responsible for a house, because they haven't learned that. And when are we going to start thinking about what is it that we can do -- because we talk

about cost of Medicaid. It's a tremendous cost. And it is a tremendous burden on states. But we just can't take it away if we don't have something to give in return.

Just a comment.

CHAIR ROSENBAUM: Thank you, Norma.

COMMISSIONER GORTON: So just a minor addition to what Penny was talking about with respect to the housing piece, and she said to me before she started, "You know, it's really expensive to be poor," and it's important to keep that front of mind.

There are data out there -- I can't cite them -- but there are data out there that talk about the high percentage of low-income people who are unbanked, and so this idea of paying a premium -- if you get paid in a cash economy, and you know, your discretionary income is not very much to start with, these people, not only do they have involvement with the criminal justice system, they have high levels of victimization, so people are taking their money. And then if they're relying on payday lenders or other people like that, you know, there's a huge sort of tax that they have in order to have liquidity.

And so I do think if we're going to talk about

these ideas where they have more financial accountability and the ever-popular skin in the game, we need to think about, do they have the financial utilities available to them to actually participate in the way that the rest of us do.

And then to Norma's point, even if they have those, do they know how to use them? Right? So these transitional housing programs often teach people how to balance a bank account, and how to keep track of your money, and how to do a simple budget. And so I think it's a more complex that's worth sort of capturing.

I'm not philosophically biased against the idea that people should be able to participate in buying their own health care. I do think that we need to recognize that the playing field is not level. They don't start with the same skill sets, they don't start with the same tools, and simply layering a requirement on top of them, you know, that may be a very high bar indeed.

CHAIR ROSENBAUM: Thank you. Marsha.

VICE CHAIR GOLD: Yeah. I think I want to go back to -- it relates to the point Brian raised, but it's broader. It's with the first half of the stuff. As I

understand it, some of the proposals, at least, that would deal with the ACA, might be to handle the new eligible adult group, through some private means other than Medicaid, or some means -- and I could be wrong. I'm not that in detail familiar with them.

And what I think would be useful, that isn't quite here, is to look at -- sort of understand better the adults that were eligible for Medicaid before the expansion, and their characteristics, the new adults who are eligible for Medicaid, and anyone else you think we need as the residual. But the reason being it's sort of how well that matches.

So the question, which I think is behind some of what you're asking, and it relates to Kit's point, is how well can people negotiate the system in commercial insurance. Do they need the more social type benefits that Medicaid provides versus others? And I don't understand, by income or by other characteristics, just really who those new expansion people are and how they would be affected.

The other part to just think through is I'm not sure -- and I don't know the statistics well enough -- the

issue is what's an able-bodied working person versus who a disabled person is, and whether you have the drug abusers and the homeless, and how that all cuts. And if you had a work requirement, how that relates to who the people are and how realistic or not it is. It's a good idea if people can work, I assume, sometimes to create options for them, but we've heard a lot of stories about some of the people who might be coming on with the new adult group that are really difficult to manage. People have life circumstances that are very chaotic. And I don't get a feel here, and I don't know if it's here and I didn't see it, or we can do anything more there.

MS. HORVATH: I'm sure there's more to do and I've just taken a note. Just to put a word in. So folks on Medicaid, you're categorically eligible via disability, you have to be determined to have disability by Social Security. Social Security disability, confers Medicaid eligibility in most states, with a couple of exceptions, but in most states.

And then for the new adult group, there is also this other sort of provision that is --

CHAIR ROSENBAUM: The medically frail.

MS. HORVATH: -- yeah, the medically frail, and it's carried through to all the waivers. So people who are medically frail, who have not gone through an SSI, or Social Security disability determination, either they are not that disabled or they've just never done it, but they're medically frail in some way. They're typically exempted from these systems, or booted out quickly and reverted to full Medicaid with the long-term services and supports, as soon as they've blown through their pre-funded health savings account.

VICE CHAIR GOLD: And do we know much about how those are defined by states, and how large a number that is?

CHAIR ROSENBAUM: This is an issue that's come up for MACPAC, and the suggestion of looking at medical frailty and how states have dealt with the definition of medical frailty in the context of the expansion population, I think arose before, and I think now it becomes particularly timely that we do the analysis of medical frailty. I know that Arkansas, of course, has been a particularly strong user of the medical frailty exemption and it's one of the things that helped in two ways. One

was that it helped, of course, identify people who were going to be higher-need, higher-cost users, and the other was that it meant that the people who went into the alternative coverage arrangement, through the marketplace, were younger, healthier workers who really helped the risk pool.

MS. HORVATH: Right.

CHAIR ROSENBAUM: So it had a double benefit.

MS. HORVATH: Right.

CHAIR ROSENBAUM: Just a couple of other things. There is a considerable literature on access to employee benefits, and insurance in particular as a work incentive, and I think we might want to take a look at that, of course, from all of the welfare reform efforts that have been undertaken, and we may want to -- you know, not spend a lot of time, but it's relevant literature for this particular question.

And the other thing, which, of course, runs through your slides and your excellent presentation, is this sort of underlying literature on what does affordability mean and what does it mean in the context of a very poor population. And those are the kinds of pieces

that maybe might make good topical briefs for MACPAC, as Congress considers whether to broaden conditions of eligibility for coverage.

All right. We have time for an open mic, if there are public comments, and then we will take a break and resume in about 15 minutes. But do we have public comments?

PUBLIC COMMENT

* [No response.]

CHAIR ROSENBAUM: A lot of public; no comments.

Okay. So we'll see everybody back about 3:15.

[Recess.]

CHAIR ROSENBAUM: Okay. Here we are. Coming down the home stretch. Take it away.

PROGRAM INTEGRITY IN MEDICAID MANAGED CARE

* MS. FORBES: Thanks. Good afternoon, everyone.

So this session continues the Commission's work in program integrity. Since the initial chapter on program integrity and accountability in the June 2011 managed care focus report, the Commission hasn't conducted a focused look at the unique issues relating to program integrity in a capitated, contracted delivery system. This is largely

because we were waiting for CMS to issue its updated Medicaid managed care rule, which was finalized last spring.

Now that the updated regulatory framework has been established and the federal expectations are more clear, we thought it was time to follow your directive to examine the issue in more depth. Specifically, we conducted both internal and external research to identify the strengths and weakness of existing federal and state program integrity oversight efforts, review the final rule provisions and determine how well they strengthen state and federal oversight, and evaluate whether there are additional or alternative steps the federal government can take to prevent fraud, waste, and abuse.

As we've mentioned in prior meetings, our work has consisted of a comprehensive literature review, interviews with states, managed care organizations, and federal agencies, and we also had the expert panel at the December meeting.

So in this presentation we will provide a brief overview -- sorry; I had a slide -- we will provide a brief overview of some of the program integrity concerns around

Medicaid managed care and share findings from our research.

So first some brief context, of course, on why program integrity in managed care is an important topic. As we've noted many times -- I think Martha even said this this morning -- managed care is a major delivery system within Medicaid, accounting for almost half of spending. More than half of beneficiaries are now enrolled in comprehensive health plans, MCOs.

In managed care, as well as fee-for-service, federal and state governments have a statutory obligation to know whether they are paying appropriately for quality care, and whether enrollees have adequate access to necessary care. Program integrity activities are meant to ensure that federal and state taxpayer dollars are spent appropriately and to prevent fraud, waste, and abuse. However, the shift to managed care in Medicaid requires some differences in the way states conduct program integrity compared to their traditional fee-for-service approaches.

Some of the primary differences between the fee-for-service and managed care delivery systems -- primarily how they pay and how they contract -- create a potential

for new or different kinds of program integrity risks that require appropriate safeguards, as summarized in this table. I'll just give a few examples.

In managed care, the state delegates provider contracting, utilization management, and claims processing to the MCO, which means that the MCO, not the state, is primarily responsible for making sure that provider payments are accurate and that sufficient service-level data is collected for oversight. MCOs are also allowed to subcontract and they can pay providers or subcontractors on a basis other than fee-for-service, which makes MCOs also responsible for contract oversight, making sure that payments are appropriate, and collecting encounter data.

Because the state contracts with the MCO, the state has to provide oversight of the plan and of payments to the MCOs. For example, the state has to make sure that the capitation payments are appropriate, that the encounter data they receive from the plans are valid, and that the MCO enrollment rosters are accurate.

MCOs carry the financial risk associated with capitated payment arrangements. Therefore, the traditional assumption has been that they have an incentive to monitor

for fraudulent provider activity in order to reduce improper payments. States have maintained a focus on fee-for-service provider payments and MCO contract oversight, broadly speaking, and delegated to MCOs the responsibility to oversee provider-level program integrity for network providers.

As the proportion of Medicaid spending that flows through managed care contracts has grown, states, and increasingly the federal government, have formalized the requirements for MCOs to ensure that they're conducting a full range of provider oversight activities, and increased state oversight of managed care plan. As our panelist, James Golden, of CMCS, pointed out in December, the new rule includes several specific program integrity provisions. CMS has also strengthened many other parts of the rule in ways that support program integrity, such as provisions on improving the reporting and quality of encounter data, setting a standardized medical loss ratio, establishing MCO reporting requirements, requiring MCO contract provisions to flow down to their subcontractors, and so on.

So the next two slides show how many regulatory

requirements now apply to state Medicaid managed care programs and to Medicaid managed care plans to address some of the risks identified on Slide 4.

Federal rules include a number of specific program integrity requirements that states must include in all Medicaid managed care contracts. Importantly, each Medicaid MCO must now have a formal compliance program that includes specific elements intended to address potential vulnerabilities. For example, all MCOs must periodically verify whether billed services were received by enrollees, which can help detect fraudulent claims.

MCO contracts must require them to promptly refer any potential fraud, waste, or abuse to the state Medicaid program integrity unit or the state fraud control unit. MCOs must also notify the state if they receive any information about changes that could affect enrollee or provider eligibility. MCOs must provide audited financial reports, complete and accurate encounter data for services provided to enrolled members, and documentation to demonstrate compliance with network access and adequacy requirements.

And I do want to mention that MCOs, of course,

engage in a variety of program integrity activities, in addition to those required by the federal rule or that may be required by their state contracts. MCOs typically implement additional pre-payment and post-payment reviews of provider claims to detect patterns of fraud. They may conduct data matches with other insurers to identify third-party liability, and so on.

In addition to federal rules requiring states to include specific program integrity requirements in MCO contracts, they also require direct oversight of MCOs. For example, states must periodically conduct an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by each MCO. In addition, to reduce the risk of provider fraud, beginning in July of 2018, states will be required to directly enroll all MCO network providers in the state system and to conduct all of the required screening and disclosure reviews and database checks.

As I mentioned earlier, many parts of the rule support overall program integrity. For example, states must develop mechanisms to ensure that payments are appropriate, that the capitation rates are correct and

actuarially sound, also that MCOs are not paid for non-enrolled individuals, and that the fee-for-service program doesn't pay claims for services that are the responsibility of the MCOs.

They must also ensure that MCOs deliver quality, necessary care. For example, the states must validate that MCOs have adequate provider networks and review encounter data to determine that there is not underutilization. Finally, states must provide oversight of MCO administrative requirements, such as marketing and enrollment rules.

Here we shift a little to talk about how all of these program integrity entities are organized and coordinate among themselves. Both the federal and state agencies that oversee Medicaid are responsible for ensuring that mechanisms are in place to assure appropriate use of services and to detect and deter fraud, waste, and abuse, as mentioned earlier. This applies to managed care as well as fee-for-service program integrity. In a state with managed care, the MCOs also have responsibility for program integrity.

This is a chart from a GAO report that shows all

of the federal and state entities with Medicaid program integrity oversight responsibilities, as well as, on the bottom, MCOs are also on this chart.

So this Commission has previously identified challenges associated with insufficient collaboration and information-sharing among federal agencies and states, and diffusion of authority among multiple federal and state agencies. So these challenges still exist. You can see from the chart that there are many agencies and many layers at the state and federal levels, and managed care, of course, adds another layer of complexity. Adding to the collaboration challenge is that MCO contracts are with the states, so federal oversight agencies don't have direct contact with the MCOs.

And with that sort of background, I'll turn it over to Jessica to talk about our study and our findings.

* MS. MORRIS: Thanks, Moira.

Commissioners, as Moira pointed out, and you may recall from the October and the December meetings, my reference to a MACPAC study that was looking at existing federal and state managed care program integrity efforts, and their strengths and challenges in the context of the

final managed care rule.

We recently completed our work and the contract with Booz Allen Hamilton. In addition to an environmental scan of existing state and federal program integrity practices, the study included an interview with ten state Medicaid agencies, five MFCUs, three managed care organizations, and multiple federal agencies, including CMCS, the Center for Medicare, the Center for Program Integrity, and OIG -- two offices of the OIG. And we also held a panel in December that included federal, state, and managed care organization program integrity experts.

For this study, we sought to answer the following questions. What are the current managed care program practices of MCOs, states, and federal oversight agencies? What practices are effective in reducing fraud, waste, and abuse? Are the elements incorporated in the final rule sufficient to ensure robust oversight? Are there still areas where more could be done, or where things could be done differently in order to be more effective?

And given how many entities are involved in program integrity, managed care organizations add another layer of coordination, and because the managed care

contract requires some MCOs to tackle some of the traditional program integrity responsibilities away from the state, such as provider screening and enrollment, claim fraud protection, it also creates some new responsibilities, such as ensuring the accuracy of capitated payments and tracking enrollment.

So, ultimately, we were interested in learning what is being done now, what works, what are the challenges, and are there any further changes necessary, and what would be helpful?

Our study findings have shown that managed care oversight lags fee-for-service oversight as an area of state and federal focus. For example, there is less guidance in managed care than fee-for-service or Medicare managed care oversight, which have required compliance plans, periodic audits, et cetera. And managed care encounter data has been poor -- historically incomplete, inconsistent, and untimely, which we've talked about today.

State oversight of managed care organization program integrity activity, and managed care program activity -- managed care program integrity activities vary -- such as what is required of the plans and how detailed

those requirements are in each contract. What kind of information is reported, both on an ongoing basis, as partners in PI, and periodically, so that the state can evaluate how well the managed care organization is performing on program integrity? And then, lastly, how the state and the managed care organizations work together, and what their oversight entities, such as MFCUs, such as how frequently and how closely they work.

Additionally, we found that there aren't very good measures of the effectiveness of program integrity interventions, such as to identify or predict which practices are best at effectively fighting fraud waste, and abuse. Therefore, it's difficult to measure the return on investment or to quantify what works and what doesn't. Also, because of variation among states, it's difficult to identify best practices, in terms of specific PI approaches.

However, there are some effective practices we heard during our research. Clear and enforceable contract language requirements can be effective. States seek models from other states in this regard. Both specific contract provisions and reporting requirements are important. The

communication and the collaboration across all of these partners that we talked about, and shown on the slide before, is helpful across all entities, all program integrity partners. Frequent and direct communication between state and managed care companies. Additionally, many states said that they meet monthly with the managed care program integrity staff and some include meetings with their MFCU as well.

Guidance and training can also be helpful, according to what we heard from states. Training for state staff at the Medicaid Integrity Institute, also known as the MII. In fact, states would like to be able to extend the reach of the MII such as to have remote access to their training or to have more localized training where the MII comes to them. Also to include managed care organization staff in the training, especially those responsible for program integrity.

We found that states, federal entities, and managed care organizations generally agreed that the final rule strengthens managed care program integrity. It addresses many of the recommendations made by federal oversight agencies, such as OIG and GAO, and often adapts

existing practices of leading states. States are preparing to implement the rule. Many states are already in compliance with various provisions. For example, many states have an MLR in place, and some states may require significant changes, such as provider screening and enrollment.

CMS is developed detailed guidance on many aspects of the rules, which states are saying they're waiting for. For example, how they can use the EQRO to assist in oversight of managed care organization program integrity activities; provider screening and enrollment, such as current databases used in fee-for-service don't align well, and now many more entities will need to use them. The 21st Century Cures Act actually addresses this and was passed after our interviews, which requires CMS to establish a uniform terminology and to collect data on terminating providers.

Some states mentioned the need for more guidance as to how states and managed care organization program integrity operations should be organized and staffed, although federal rules often don't get into this level of detail.

We also heard of areas that either were not addressed in the final rule or where program integrity experts anticipate that additional guidance or support is needed. They include payments and incentives, encounter data, coordination, and greater clarity of the rules among the various program integrity entities.

Regarding payment and incentives, ideally the requirements for managed care organizations would align with what they're paid to do, but that's not always how it works. We heard in our interviews and on the panel that the rules about how managed care plans are paid complicates incentives to invest in program integrity. For example, managed care organizations are at risk for total costs of care for enrollees, and they have a built-in incentive to manage spending wisely, which includes being vigilant about monitoring for improper payments. On the other hand, in the MLR formula, program integrity counts as an administrative expense, so investments to strengthen the PI may come at the expense of other administrative expenses.

The final rule clarified that state contracts with MCOs must have to address how to handle the treatment of recoveries. States have the option to require managed

care organizations to return recoveries to the state or to retain them. Regardless, the MCOs must report their recoveries. And yet we heard a lack of consensus on whether MCOs should return overpayment recoveries to the state or retain them. CMS and actuaries can disagree about what was an overpayment and yet managed care encounter data is the data used for rate-setting. Therefore, the decision states make about how to handle overpayment recoveries can affect the rate-setting process.

We know that accurate and complete data are needed to support program integrity, as well as other program management and oversight functions. Timely and accurate encounter data can be used to support state program integrity activities, including collaborations across MCOs, for data analytics, and potential fraud investigations. Of course, it also helps with state oversight including looking for overutilization and underutilization, and to establish accurate rate-setting.

States and federal entities both cite challenges in obtaining accurate, complete, and timely encounter data from their managed care organizations. The new rule strengthens reporting requirements, but states expressed a

need for guidance and best practices for how to improve their encounter data.

Additionally, states can defer payments to managed care organizations for encounter data but not for other compliance issues. However, CMS lacks the authority to defer payments for a portion of managed care contracts that are out of compliance, as discussed in the panel in December.

The Center for Medicare, on the other hand, issues a report card as feedback for MCOs on their data quality. Center for Medicare's report cards are not public, but they can provide the MCOs with the data quality benchmarks and some actionable information on how to improve their encounter data.

The final Medicaid managed care Rule requires managed care entities to submit complete, timely, and accurate encounter data to the state in the level of detail and the format required by CMS. CMS must periodically conduct or obtain a contractor to conduct an independent audit of the accuracy of the data, as Moira pointed out earlier, and the completeness of the managed care encounter data. Eight out of the ten states we interviewed used an

EQRO to routinely validate encounter data.

Regarding coordination of program integrity across entities is needed. The federal entity, states, and plans all are chasing the same type of provider fraud. All PI entities need to work to coordinate their efforts. This could help to avoid duplication if PI entities who want to know if someone is going to investigate a provider that may lead to a larger investigation. On the other hand, each entity doesn't want to tip off the provider of an ongoing investigation. Entities often don't want to share the credit for tracking of fraud, waste, and abuse, and need to show the results with return on investment.

Managed care adds another layer of coordination, and interviews didn't indicate a lot about the state oversight of managed care, such as this new role as the quarterback of managed care companies.

Each entity has unique investigative resources and remedies. They are appropriate in different circumstances. Managed care organizations cited challenges in maintaining enough providers to ensure access to services unless there is a serious allegation of fraud. States had concerns about the limit on the number of cases

sent for investigation.

A prior OIG report revealed that a quarter of the MCOs surveyed did not report a single case of suspected fraud and abuse in their state Medicaid agencies in 2009. HHS OIG indicated at our December panel that Medicaid is lacking, on a National Fraud Strike Task Force for Medicare, that could help PI partners work across state jurisdictions.

As states begin to implement the various provisions of the managed care final rule and while states had not identified any significant concerns with the final rule, it did express an interest in sharing best practices in managed care program integrity across states.

Currently, state and federal entities agreed that the Medicaid Integrity Institute is an effective way and well-used training tool for sharing best practices and ideas across states.

Additionally, CMS's Center for Program Integrity, which is tasked with working in both Medicaid and Medicare program integrity, has had the opportunity to test several of the program integrity rule provisions with MCOs through Medicare Advantage.

As I already mentioned, there aren't good measures of the effectiveness of program integrity interventions that identify or predict which practices are best at affecting fraud, waste, and abuse, other than to say that states and MCOs need good contracts.

Therefore, it's difficult to measure the return on investment for program integrity practices and to quantify what works and what doesn't, also because of variation among states, difficult to identify best practices in terms of specific PI approaches.

Despite these steps forward, states have cited a number of areas where sub-regulatory guidance from CMS would be helpful as they begin to implement and enforce the provisions of the rule. We have covered a number of these in this presentation, including guidance for payments and incentives and encounter data and collaboration. The memo we provided the Commissioners does expand on additional areas that states, managed care organizations, and federal entities cited where additional guidance is needed.

In thinking of the next steps on the topic of program integrity, particularly in the growing area of managed care, we would appreciate any feedback from the

Commission. Does the Commission want to emphasize any themes or findings on this topic or any course of action or priority? Do you want to do any further work in this area? As MACPAC continues to focus on Medicaid managed care program integrity and states begin implementation, the Commission may benefit from additional research into the impact of specific provisions of the rule.

For example, staff could assess how states validate their encounter data for future rate setting, best practices across states that provide incentives to MCOs to make investments in front-end auditing, as well as post-payment reviews, and how to ensure the effectiveness and the impact of program-related activities and best practices.

Furthermore, new approaches being adopted in states may impact how state and MCOs approach program integrity, such as the new value-based purchasing approaches with accountable care organizations. These organizations rely, in part, on the reporting of quality measures to improve outcomes, but have the potential to accomplish cost savings. However, it's unclear how provider-led organizations such as ACOs would approach

program integrity in cases of potential fraud.

Moreover, the implementation and enforcement of the final rule is key to determining what will work best for all players in managed care program integrity. States, MCOs, and federal entities in program integrity will begin to demonstrate how effective the provisions of the rule may be implied, and MACPAC is prepared to assess the specific requirements as they are carried out.

CHAIR ROSENBAUM: Thank you.

I'd like to actually begin by noting it was an excellent presentation, very thorough. You raised a lot of really important issues for us to think about, but I'd like to add one more, at least to discuss a little bit here, and then whether it triggers some additional thoughts about work in the near term. We can wait and see.

But the program integrity model that we have sort of writ large assumes a highly defined benefit program with highly specific and complex contracts of coverage, very defined eligibility categories. In other words, it is very appropriately a mechanism for looking in great detail and following what is the construct of the Medicaid statute down to the point where it actually -- where service

reaches the person, and over many years, the federal agencies and the states have done this tremendous job trying to connect this broad statutory construct down to actual service delivery for people.

I found myself wondering, as you were talking, well, what are some of the program integrity questions that would be raised by a fundamental restructuring of the statute itself? If we were to move away from a program that at its core is a defined benefit coverage arrangement, governed by extensive requirements, what would the aims of program integrity become at that point?

And while it's a little bit of something to ponder, I think, at a minimum, for me, we might want to have just a short memo or some sort of a short presentation on some of the considerations that would arise. I mean, I've really not begun to unpack it in my head, but I was struck by how much of what you presented and how much of your findings grow out of the Medicaid program we know.

So, in addition to further work under this rubric, we might want to start giving some thought to what the key issues would be for the program integrity elements. I assume, going to Stacey's earlier point about what the

accountability requirements in Medicaid in a changed system, what are the state accountability requirements, a lot of that is, in turn, captured by program integrity. So I just wanted to throw that out there.

Penny and then Marsha.

COMMISSIONER THOMPSON: Thank you. This is very helpful and a subject I am very interested in, so I was very happy to see this on the agenda.

A couple of questions and a couple of comments. One question. I would like you to just say more about two subjects that you mentioned at the end, one which is about whether the incentives add up to a robust program integrity activity inside of a Medicaid managed care plan. For all of the language in the regulation around you have to have a dedicated unit and you have to do this and that, I don't know that those requirements overcome a fundamental question, which is if we're a plan, it's a cost to pursue some of these issues, and they don't receive the recoveries, or the rates that they're paid go down as a result. Then is there anything that we're going to say in terms of a regulation that's going to really significantly change the volume or approach to a plan's activity?

MS. FORBES: So I would say what we heard in our interviews was a sense that there are still concerns, I think particularly from the entities that are most focused on fraud, so like the OIG and MFCUs, about the lack of referrals, in particular, and that's where they really see this issue around the incentives not being sort of -- you don't have an incentive to do all of this work, to find a problem that's going to pull a provider out of your network, which hurts you on sort of the adequacy side, and then you're going to have to pay some money back to the state, and someone else is going to go and prosecute them and get some credit for it. So there's sort of a misalignment. There is the concern.

But I think what we heard is that there's a hope that between the rules requiring the contract to specify that health plans now have much more formal structure, have training, that there be greater reporting, that there be -- and then all of those other things that we have been talking about, that there's a desire for more routine coordination, that there be more guidance around clarity of roles, and when something is sort of an administrative investigation, it's the plan's responsibility, and when it

becomes a criminal investigation that they need to refer.

I mean, we definitely heard from everyone that there's a request for a lot more of this sub-regulatory guidance and ongoing process about communication to supplement what is now a much stronger regulatory framework but is only going to work in the implementation. So I would say that's what we heard. It's a start, but no one thinks that just having this rule on paper is going to be the thing that really makes the difference in the end.

COMMISSIONER THOMPSON: Right.

MS. FORBES: We talked to 10 states.

COMMISSIONER THOMPSON: I mean, my question is not to suggest that any plan wants to have bad providers in their network, but just that the -- some of what you discuss in the chapter or the memo that we reviewed was a little bit about how the incentives are all really about -- if I have somebody that is causing me concern, I'd rather just deal with them quickly and on the basis of some concern than try to develop a case that could end up getting referred to law enforcement. I solve the problem for myself by simply acting more quickly to just say I don't have to come up with an excuse for you as to why I

don't want to renew your contract. I'm just not going to renew the contract. I don't have to figure out if the anomaly that I'm seeing in terms of how you're treating patients that I am sending to you is a reflection of bad judgment or an attempt to defraud me or aggressive billing. I don't have to parse all that out. I can just decide that I don't want to continue this business relationship, and that decision is going to be one that I can take without incurring the additional cost of trying to help law enforcement develop a case.

I understand why from a law enforcement statement, it's like, "Bummer." But from a program and plan point of view, I don't know. I mean, that person is, yes, free to go, try it again, move from Toby's plan to Kit's plan, and I guess that's a problem that we have that we need to address, and then Kit has to kind of learn what Toby learned all over again about that.

But I just point out that I think that some of the ideas about the flexibility of plans to choose the network and to evaluate the network on a basis broader than just integrity, which is different than what happens in the fee-for-service world, is actually an advantage, and I

would not want to see us sort of replicate the rigidity of the fee-for-service system in which you have to kind of continue to do business with somebody for a long period of time, after which you've become comfortable, and you have to engage in a very formal legal process in order to do something about that provider.

CHAIR ROSENBAUM: Well, that's why every provider network contract that I've ever looked at has a no-cause termination clause in it.

COMMISSIONER THOMPSON: Right, exactly.

CHAIR ROSENBAUM: I mean, it's essential.

COMMISSIONER THOMPSON: Exactly.

MS. FORBES: Could I respond to that really quickly, though?

CHAIR ROSENBAUM: Yeah, yeah.

MS. FORBES: So this is a good example of something we heard, which was some states, to get around that specific issue, they have learned that that is a concern by bringing the MFCU and the plan and the state people together and have heard sort of “why are we not getting referrals?” “Well, it's because we're managing people out of the network.” So the state's response has

been to say, "Aha. I will now request from you a provider termination report with much more specific coding about why, even if it's not for cause, "why did you get rid of that guy," so that the state can sort of take on the responsibility for looking across its MCOs or talking to the fee-for-service people.

And so what we heard, I would say, from a lot of people we talked to was the states and the plans and everyone is really craving opportunities to share those kinds of learnings across each other. That's not a regulatory issue. That's a knowledge-sharing issue, and that's -- I'm not sure what the federal policy intervention is, but that's what we heard.

COMMISSIONER THOMPSON: Right. But I guess I would rather see us go to some of that kind of operational detail about how does that work. I would rather kind of go at this ground-up than from the state -- I would like to get out of the world of just what regulations say or what contracts say and into real-life practical -- how do these really hard-to-sort-out issues get sorted in a way that makes sense for everybody.

Just a couple of other points, and then I know

others want to jump in.

So one is this recoveries issue, which is I think something that we should highlight. I really, for a long time, was very clear with myself that the answer for how to deal with a recovery in a managed care setting was to plug that result back into the rate-setting process, that plans get paid on the basis of rates. If we find out that some of the amount of dollars that went out from plans to providers was wrong, that the dollars associated with those improper payments really needed to get plowed back into the baseline in order for them to get reflected in the rates.

I've kind of maybe come 180 on that, which is to really wonder whether that would ever really work, and Stacey maybe can comment on that a little bit, and just in terms of if you have recoveries, how they get baked back into the baseline and how they get distributed among the plans and whether or not there could ever be equitable justice in that process and whether the federal government could ever -- or the state government could really ever see the savings associated with those recoveries through that mechanism. But maybe Stacey can talk more about that.

And then, lastly, I just wanted to -- well, maybe

-- yeah. Lastly, I think I just wanted to say we talk about program integrity. It's a term of art. Everybody has an idea about what program integrity means. I think there's a real difference between how you think about and pursue fraud from how you cost-avoid errors from how you deal with kind of validation and auditing to provide assurance to stakeholders and shareholders around the management control system that you have, and I think that we need to separate those things out a little bit more into some different buckets because I think they're subject to different kinds of best practices and different kinds of players involved and different kinds of responsibilities.

I would also say that it was disappointing to me that CMS said to plans, "Okay. You can go out and make sure that services are actually being delivered to beneficiaries by sampling 100 beneficiaries a year," because if you look at the estimate of administrative burden, CMS has estimated that there would be 100 surveys of beneficiaries a year. That does not seem adequate to me.

And in the fee-for-service world -- well, not in the fee-for-service world. In the general program world,

we have PERM. PERM has lots of issues. There are lots of reasons why it may not be the best model, but it's a measurement program that's intended to try to say, "How are we doing? Is what we're doing compliant with what we intended to do?" So they look at eligibility, they look at fee-for-service payments, and they look at managed care payments. Of course, the managed care payments are the best-looking ones because those are only measuring the states' payments to the plans, and a lot of people say, "Look how good managed care is, how low their payment error rate is." That's not managed care's payment error rate, and sometimes I think that the government programs do themselves a little bit of disservice by putting out all of this data about the error rates when private insurers or employers or anybody else aren't publishing the same kind of data.

But I do wonder if we think that the incentives aren't quite in the right place, whether or not there ought not to be a little bit more of a demand on a plan. I mean, CMS does it on a state basis every three years. It doesn't have to be an annual requirement, but that there be some kind of reporting involving some kind of reasonable sample

of whether or not the payments made to providers comported with the contracts that that plan executed and the expectations for what they were going to deliver.

CHAIR ROSENBAUM: [Speaking off microphone.]

COMMISSIONER THOMPSON: Yeah.

CHAIR ROSENBAUM: I have Marsha and Stacey.

VICE CHAIR GOLD: Let me ask Stacey: Do you want to go first? Because she had mentioned something that you might pick up on.

COMMISSIONER LAMPKIN: If you yield the floor to me on this one, I may not give it back.

[Laughter.]

VICE CHAIR GOLD: Well, no, I'm going to be back after you.

COMMISSIONER LAMPKIN: Okay. So I would say I really appreciated this work, and I think one of the questions that was posed to us is do we want to move this towards a chapter, either in June or later, and I would like to see us do that because I think it's a critical topic.

I do think, as compared to what's presented today, we do need to dive in and emphasize a few things and

maybe explore them a little bit more to get it chapter-ready, I think.

And my personal interest of the area to dig in a little bit more, were we do to that, are the incentives and payment area and then also the area that you talked about here. I'm just trying to remember what you call it. Oh, differences between MCO and state program integrity approaches. It has to do with the cost avoidance versus pay and chase.

And this is not to discount the importance of coordination and data quality and strong contractual provisions and enforcement of those provisions because all of that is super important too, but I think we could provide a role by helping to flesh out especially the incentives area and the way managed care plans approach things a little bit differently.

So I think, Jessica, you might have said whether the MCOs have to pay the money back to the state or whether they get to keep it might influence the capitation rates, and I would say it absolutely has to influence the capitation rates. Capitation rates have to be aligned with what your responsibility to the -- what the MCO's

responsibility is with respect to that and everything. So we have to think about what happens to our incentives based on what decisions are made in there. It's not just enough -- a capitation rate doesn't produce automatically every incentive that you think that it might, and I think we could play a role in explaining why that's the case, how actuarially sound rates, they do good things, but they can sometimes get in -- not get in the way, but give us a foundation where -- it constrains us a little bit in how we do this. So we can have conceptually an idea of how to align the incentives in the best way, but there are challenges with operationalizing that.

I'm not as pessimistic as Penny about whether they can be overcome or not, but there are certainly challenges that we could flesh out and talk about what those challenges are and what it might take to get around them. I think we could play a good role there.

Then the cost avoidance, one of the things that I have confronted in the past is look at all these recoveries we have in the fee-for-service world. The managed care plans have only a fraction of that; therefore, all this historical base is ripe with fraud, waste, and abuse

because they're not generating. And some of that is approach and technique, and to the extent that we can explore that and talk about measurement challenges there, if there are good solutions there, expose those, I think that could be very valuable.

CHAIR ROSENBAUM: And it's been a big area of Medicaid policy now for about 35 years, so the more we can dig into this issue, the better off we will be.

VICE CHAIR GOLD: One thing -- well, I had one comment, but before I do, I just -- because Chuck's not here, and I think I'm remembering what he said right. But he was very concerned, I think, at one point that, you know, if this plan does a whole lot to make recoveries, they have to have some incentive to be doing that. And so as we think about all this, we might also be thinking about how we make sure the rates are fair, but also that there's an incentive for the plan to do the right thing as well and that they gain by it.

I think my comment that I wanted to make -- I think this is good. I actually do agree with it being a chapter in June. I think that's a good idea. And most of what's in here rings right with me.

There's one area that I've heard about -- and I haven't heard it as much recently because I haven't heard recently, but I think it's probably still the case, that you may want to check out, and it has to do with Penny's side. I mean, I don't -- I think we need to be careful not to get into such a regulatory mindset that we forget that what we're talking about is relationships and effective management between the feds and the state, and the state the way they are working with the health plans to meet the requirements of the federal act. And so it's called program integrity, but that's a part of effective management and oversight of your program in managed care.

And the one area that doesn't seem to be as much here, although there was a little bit, that I've heard is just the difficulty -- it's sort of the -- the difficulty of staffing, the reality at the state level of being able to get qualified staff, to maintain qualified staff. If you get good people -- the Medicaid directors turn over every 18 months or something. If you get a really good person who can work on the rate setting, the plan hires them, and then they're gone, sometimes you can't even get them because the companies are paying more. And I think --

I don't know if you talk to them as part of this, but the Center for Health Care Strategies used to have a Medicaid Leadership Institute. I checked on the website. They still work with at least four states in doing that, and you might just call Steve Somers or one of the people over there and find out whether they have any information that you can use to beef up that side, because it's a real challenge for states, being able to get and keep people who have the kind of knowledge and skills required to effectively interface with managed care plans.

COMMISSIONER BURWELL: Not a lot to say. I think this is excellent work, and I think we have a lot of good information here. I just want to say I would also support a June chapter kind of wrapping it up. My only recommendation is that I think that we could kind of push our findings and conclusions a little further than they currently are, I mean as best as we can. There's no -- we could obviously continue to work on this, but I would go back, you know, to the original objectives of doing this work and try to address the questions that we posed at the beginning the best we can and don't be shy in terms of our observations and conclusions.

I mean, we'll have draft chapters. If the Commissioners think that, you know, we've gone too far, we'll say so in the draft chapter. But I think, you know, we could wrap -- you know, put together -- and it's not to say that we wouldn't revisit this at a later time. But I think we do have enough material for a very good chapter in June.

COMMISSIONER THOMPSON: So can I make one final observation? You mentioned VBP arrangements, and I think that's another area where it could be very fruitful, because I don't -- it's not as though there's an existing regime under fee-for-service as there is -- you know, sometimes I worry that when we talk about program integrity in managed care, people want to just take the existing regime and methods that have been used under fee-for-service, import them over to managed care, and there's not always a fit, and it doesn't always -- what we've been doing in fee-for-service isn't always the answer to what we should be doing in a managed care arrangement.

But under value-based purchasing arrangements, I think there is a completely different kind of situation facing us, which is that however and under whatever

arrangements value-based purchasing arrangements are being created, there's some new questions that are being posed about what does this mean for us and what does this mean for our management controls and what does this mean for an auditing approach. And I think that it could be fruitful to try to think about that and sort of again kind of more -- irrespective of who happens to be making the payment to that arrangement, whether that is a state or a plan, to be thinking about what kinds of approaches make sense that would avoid possible integrity problems in those arrangements, while at the same time encouraging providers to be a part of them and, you know, avoiding imposing unnecessary administrative burden on them.

CHAIR ROSENBAUM: I have Stacey for one more comment, and then, Toby, why don't you close us out?

COMMISSIONER LAMPKIN: Or, Toby, you can go first. Mine is kind of miscellaneous.

COMMISSIONER DOUGLAS: Sure, mine's just -- I mean, as we break it up between fraud and program integrity, you know, on the fraud area, I just think it's important to call out or to look at the fact that fraud continues to evolve in the Medicaid space all the time in

terms of the way the technology's sophistication, and the tools that plans as well as states need are going to continue to change, and how does that work and the role of the state and federal government but just, you know, it all -- I mean, it intersects with all the cybersecurity, all that other stuff. But there are very, very sophisticated actors out there, and they're always one step ahead. So the processes that might have worked five years ago in fee-for-service aren't necessarily going to work, and it does get to, you know, one plan seeing one thing is not going to necessarily open up the full picture of what's going on. So just how does the federal government and the state act and help with that?

COMMISSIONER LAMPKIN: Okay. My last comment is really miscellaneous and probably doesn't factor into the June chapter, but it's an interesting example of trying to port the fee-for-service world into managed care and having it not fit very well. This ties into program integrity, and I'm curious about whether it's a really isolated circumstance or something broader that we're more interested in. And that has to do with legacy cost-based reimbursement designs where typically facilities in my

experience have had their Medicaid reimbursement based on cost reports that they submit periodically that get audited -- in the old world get audited, and if an audit finds something, the rate gets changed, and retroactively the Medicaid program pulls money back, for example, from the facility.

To the extent that managed care plans benchmark their payment rates on top of a cost-based reimbursement structure, whether that's statutorily required or whether it's culturally the thing that happens in that state, this can really cause a very strange incentive structure and outcomes, because it's much more difficult in a managed care setting to recoup dollars from a cost-based reimbursement rate that's been inflated, intentionally or unintentionally.

So, again, it's something I've encountered in a very thorny, painful sort of way. I don't know how widespread it is, but it is one of those weird kinds of things between fee-for-service and managed care related to program integrity.

CHAIR ROSENBAUM: All right. Excellent work. Lots more to go. Thank you very much. And we have time

once again for public comment.

PUBLIC COMMENT

* [No response.]

CHAIR ROSENBAUM: Seeing no public comment, we are adjourned.

[Whereupon, at 4:03 p.m., the meeting was adjourned.]