PUBLIC MEETING

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

Thursday, April 20, 2017
10:04 a.m.

COMMISSIONERS PRESENT:

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SHARON L. CARTE, MHS
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ALAN WEIL, JD, MPP

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[10:04 a.m.]

CHAIR ROSENBAUM: Good morning, everybody. Welcome to the April 20, 2017, MACPAC meeting. We have a very full agenda this morning, so we're going to plunge right in with our first presentation and take it away.

Federal CHIP Funding Update. The inimitable Rob and Joanne.

[Laughter.]

FEDERAL CHIP FUNDING UPDATE: WHEN WILL STATES EXHAUST THEIR ALLOTMENTS?

* MS. JEE: So good morning. Today, we are going to briefly return to CHIP. I know you've missed it. And as a very brief reminder, in case you needed it, this past winter, MACPAC recommended that Congress renew federal CHIP funding for a 5-year period, and this was part of your nine-part recommendation on CHIP and children's coverage.

In making this recommendation, MACPAC also provided information on when states were expected to exhaust federal funds under current law.

Since that time, we have issued an updated analysis on the exhaustion of federal CHIP funds, which is

the subject of today's presentation.

So, today, Rob is going to be running through some background on federal CHIP funding and the updated projections, and then I'll return to go over some of the implications and next steps.

* MR. NELB: Great. Thanks, Joanne.

So just to start with some background, as you know, federal CHIP funds are allotted to states annually, and under current law, CHIP allotments are only provided through fiscal year 2017, which ends September 30th of this year.

States have up to two years to spend their CHIP allotments, and so some unspent CHIP funds from 2017 may be available for spending in fiscal year 2018. However, under current law, the amount of unspent CHIP allotments that will be available in 2018 is lower than in previous years because of a new provision in MACRA that reduces unspent CHIP allotments by one-third.

Unspent allotments from prior years will also be available for redistribution to states with CHIP funding shortfalls; however, contingency fund payments, which are another type of additional funds for states experiencing

shortfalls that have -- that has exceeded targets, those contingency fund payments will not be available in FY 2018.

In order to estimate when states may exhaust their federal CHIP funds, we looked at states' projections of CHIP spending that were submitted in February of this year. I want to note that these projections are really estimates, and so they may change if actual spending is higher or lower than projected.

Overall, our analysis found that FY 2017 CHIP allotments and available redistribution funding appeared to be adequate to cover FY 2017 CHIP spending. However, in FY 2018, we estimate that available CHIP funding, about $7 billion, will cover less than half of projected CHIP spending, which is estimated at about $18 billion. States will exhaust their federal CHIP funds at different points during the year, depending on their rollover CHIP allotment balances and their projected spending.

This table summarizes when states are expected to project -- when states are projected to exhaust their CHIP funds by fiscal quarter. So, as you can see, four states and the District of Columbia are expected to exhaust their funds in the first quarter of FY 2018, which begins in the

last quarter of this calendar year. More than half the states are expected to exhaust their funds in the second quarter of FY 2018, and all states are expected to exhaust their CHIP funds by the end of FY 2018.

Again, these estimates are projections, and so the actual date that a state will exhaust its funds may change if actual spending differs from what the states expected.

Now I will turn it over to Joanne to talk about the implications of these findings.

MS. JEE: So, Commissioners, as you know, the exhaustion of federal CHIP funds would have different implications on states, depending on whether they operate separate CHIP or Medicaid expansion programs.

The CHIP MOE, or the maintenance of effort, generally requires that states maintain their CHIP eligibility levels that were in place in March 2010 through September 2019. However, if federal funds are insufficient or not available, states can terminate their separate CHIP programs.

Currently, there are two states that run entirely separate CHIP programs and 39 that operate a combination of

separate CHIP and Medicaid expansion.

Your previous analysis found that in the absence of CHIP, of the children losing separate CHIP, about 1.1 million would become uninsured, and it's important to keep in mind that that analysis assumed the availability of federally subsidized exchange coverage, which as you know faces uncertainty as the Congress continues to debate health care reform.

Now, for states with Medicaid expansion, they, on the other hand, must maintain their coverage, but instead of receiving the enhanced CHIP match, they would receive their regular Medicaid matching rate.

There are 10 states, including D.C., that operate the Medicaid expansion CHIP programs.

So, in terms of next steps, the timing of congressional action to address federal CHIP funding thus far is unclear, and as I mentioned, we did recently post the issue brief, the revised issue brief on the state exhaustion of CHIP funds. It's on our website. We've shared it with our key congressional staffers, and there are some copies for the public made available today.

We could further update this analysis once the

next CHIP quarterly reports are available if you all thought that that was an important thing to do.

So, with that, I will leave it to your discussion, and we'd be happy to answer any questions.

CHAIR ROSENBAUM: Marsha.

VICE CHAIR GOLD: Great work.

One factor that I remember we discussed a lot when we were talking about the CHIP recommendations -- and I am channeling Sharon Carte here -- states -- there's when the money runs out, and there's when the states anticipate dealing with the money running out. A lot of states have legislation -- legislatures that only meet every two years. There's people, the uncertainty of it.

And I remember we were very strong. That was the main point of our five-year recommendation, was that the delay, the uncertainty was really a big barrier to states' planning.

So, as we update these, I think it's important that we also make the point that if Congress just went up until the cliff and then gave money, that might still not -- I mean, there may still be problems before the states or the sooner -- in other words, the sooner people can act and

states know what to expect, the better for them.

CHAIR ROSENBAUM: Peter and then Sharon and then Penny.

COMMISSIONER SZILAGYI: Yeah. I was actually going to make exactly same point, and I was wondering if there was a way to kind of overlay the timing in Slide 4, where you have the time that states would exhaust CHIP funds. Which of them are separate? CHIP or combination CHIPs?

And then try to put in a projection about when states would have to make a decision, which precedes when the funds totally run out. So it's kind of a combination of Marsha's point and overlaying, just kind of an estimate.

And then could we make an estimate about when children -- and how many children will lose potentially health insurance and when? So can we project the drop-off in health insurance over the next year, if nothing happens?

CHAIR ROSENBAUM: Sharon.

COMMISSIONER CARTE: Yes. Just to add to the points that the timing is a crucial issue for states, not only in terms of when the allotment runs out, but -- although I think my home state of West Virginia is somewhat

unique. I would just remind folks that they do have a provision that calls for the termination of the program should federal funding not become available. So having the ability to act -- and I know that West Virginia, even though funding doesn't -- there's funding through the second quarter, they would probably need to be prepared to act as early as September to make some decision about whether or not to continue the program.

Also, to Peter's point about the children that are supported with CHIP funding and who would lose access to coverage, I'd just mention that in states where -- there are a number of states where CHIP funds were used to cover the "stairstep" children in Medicaid. So, if that could also be highlighted, I think that would be important.

CHAIR ROSENBAUM: Penny and then Chuck.

COMMISSIONER THOMPSON: I think this is all in the same vein. I think especially for the states that are in the first and second quarter buckets, I think it would be very helpful to just back up in a very practical way, the dates and when beneficiaries start to get notified, when plans start to get notified, so that it becomes very tactile to people.

I mean, we have spoken in various ways about the administrative necessity of shutting down a program and what that looks like, but I think it's time to kind of be really clear about what some of those dates look like and what some of those actions are if states continue in this mode of uncertainty.

CHAIR ROSENBAUM: I have Chuck, Andy, Kit, and Sharon.

COMMISSIONER MILLIGAN: I guess it's in the same vein but a little bit, maybe, different, sort of schedule on the calendar. I am looking at Table 2, which is more of the state-by-state table.

Let me just illustrate if it's available to sort of incorporate this in some of the analysis, and I'll use New Mexico score, where I am and work now.

New Mexico is listed here as April of 2018, and as you reflect there, that quarter, federal fiscal year.

But in terms of the decision-making at the state level, kind of to Peter's comment and Marsha's comment and Penny's comment, that's the state fiscal year of 2018 that ends June 30, and the legislative session to address state fiscal year '18 ended, so -- although it's messy in New

Mexico about the state budget right now.

But I think in terms of translating this into sort of when are actions going to happen that actually affect members, mapping this to the state fiscal year and the legislative session to address that state fiscal budgeting, because what you're reflecting here in terms of the third quarter of federal fiscal is the final quarter of state fiscal '18, and that's when there is going to be a state budget decision to be made about whether to step in or not. So that would be my suggestion.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. We've gotten some questions about this from various Hill offices, and we pointed them to two resources. But we could certainly incorporate them into a MACPAC resource.

One is NASHP has done sort of a timeline of what states have to do in terms of notifications and that sort of thing, and then the other is the state legislative calendar. A couple of folks have asked us: Well, what do you do? Some state legislatures are done for the year already, and there are a couple that are on a biennial cycle. So, presumably, if something happens, those legislatures will have to come back into session, so we're

pretty far into the calendar for states that don't have full-time legislature.

CHAIR ROSENBAUM: Andy, Kit, Sharon.

COMMISSIONER COHEN: I just want to take one step further and think a little bit about the implications of the uncertainty on the programs sort of as a whole. I think it's probably fair to say that most people around the table suspect that at the very end of the day, there will be an action by Congress to extend the funding for CHIP.

But the uncertainty created -- it's not just hard for states. I want to sort of talk and see what evidence and things we have around the impact on beneficiaries. A ton of work has gone into building trust in the CHIP program and making it attractive to families and to children and to make the coverage really robust, and the amount of progress that has been made in this country on children's coverage since CHIP, it really is amazing. Even though it's a small program, it's amazing because it's had spillover effects in Medicaid and in other things, and I just think that the uncertainty of whether something like this is going to move forward, any message that the state sends out that this program might end really undermines

sort of like trust and reliability, and it could have a real impact on our coverage rates in a much bigger way than the actual date that the money is appropriated might suggest.

So I think it would be really helpful to collect some -- whatever sort of literature or other stuff has been done on that and look at maybe what's happened in some cases where states have gone on to waiting lists or other sorts of things and what the implications have been, and I also think it's worth us thinking about what are some lessons for policymaking with respect to this going forward, maybe an extension. It's not just the period of time of extension, but are there phasing elements that could be included in a provision so that it's not always a chicken situation at the end of an appropriation period?

So just thoughts for future work.

CHAIR ROSENBAUM: Kit.

COMMISSIONER GORTON: So if I heard you correctly, Joanne, we have two states that are pure carve-out, stand-alone programs. We have 10 states that are pure Medicaid expansions, and then the remaining 51 programs are some level of hybrid. And I think we've described and

talked about -- and can probably fairly easily map out a timeline and eligibility impacts for the purer ones.

But I guess I'm unclear in terms of the hybrid ones. My guess is there is a spectrum, and some lean more in the direction of Medicaid expansion, and some lean more in the direction of stand-alone. I'm not sure I'm clear how much in those states, how much movement there is between -- do families break across it because there's age cliffs or other things? I think it would be useful to describe a few things, because I at least am not clear on either the impacts or the timing of the impacts.

So this issue of in this third hybrid scenario, here's what happens to the stand-alone piece. Right? It theoretically goes away. Here's what happens to the Medicaid piece. It theoretically over time drops down to the state's FMAP. That has differential impacts on different states because the level of FMAP is different. And I just think it could be useful for us to take these existing timelines and flesh them out a little bit in terms of -- for a group of states that has predominantly stand-alone hybrid model, that's going to either look a lot like the stand-alone, too, or it's not and why, as opposed to

for a group of states that have predominantly Medicaid expansion, is that going to look mostly like the Medicaid expansion-only states or not, and why?

And to, I think, Peter's very thoughtful question -- and how is that going to impact kids and their families as this rolls out?

And then to the comments that multiple people have made about states need time to take action, I'll just put in a plug for health plans. Health plans need time to take action. We have to educate members. We have to tell them what's happening.

Quite frankly, when people know their benefit is going to end in a health plan world, they tend to use as much service as they can cram in before their benefit ends, so that affects underwriting and reserving and other things.

And so I think to be able to say -- and if I'm a health plan, going to send a notice to my members, then I have to get it ready in time for the state to approve it in time for me to print it and mail it. Right?

So all of these things sort of cascade backwards, and so I think if we can shine a light on these operational

issues that Penny and others have mentioned and sort of put it all into a grand scheme, you know, a Gantt chart of what are the dependencies --

CHAIR ROSENBAUM: We should have started two years ago.

COMMISSIONER GORTON: Yeah, we should have started two years ago. So I think that -- anyway, I'm babbling, but my thought being important for people to understand really how complex unwinding a program is. It isn't just shutting the money off and not honoring the cards anymore.

CHAIR ROSENBAUM: Sharon.

COMMISSIONER CARTE: Well, and, Kit, you'll be glad to know that such a Gantt chart exists because --

[Laughter.]

COMMISSIONER CARTE: But I'm really glad that Commissioners are pointing to all these facets because they are so important, which is why the Commission has taken so much time. And as Andy said, it really is about the comprehensive coverage of children. We're not just talking about CHIP here. I feel that that often gets minimalized. When I was a sitting official, people would say to you,

"Oh, you know it's going to get reauthorized," or "The funding will" -- but there are just all of these very important issues. But, Kit, that chart was done after the CHIP directors had met and worked with NASHP. So I think for those of you -- and Joanne's well aware of that, that we could go back and look at that. It might be a help.

But I'd just also remind folks that for many states the level of funding is going to be an important question, and I know in our state the congressional delegation has had questions about what happens to the level of funding for the stairstep children. It gets rather complicated. That's one of the reasons that I think the Commission did look at questions like the maintenance of effort. Many states that are still challenged by their economy -- Chuck and I were commiserating this morning that we both are in states where the legislature just went through a session and were unable to have an approved budget at the end.

So many states are very dependent on the FMAP, the enhanced FMAP, so that's a question that will be important to be resolved.

CHAIR ROSENBAUM: On our Gantt chart, just one

additional thought for yet another flourish, which is that it is possible for a state to step in and decide that if CHIP is going away, it's going to restructure its Medicaid program to offset the loss of CHIP. It would do so at a normal federal contribution rate, but it could expand Medicaid. But there are limits. There are limits both in terms of what the maximum allowable level of expansion is. There are federal implications, obviously. There may be downstream implications in terms of where children would be enrolled, in what kinds of plans that would be in CHIP or not in Medicaid or vice versa.

So I think in the name of being thorough, it would be worth it for us to make the point that Medicaid does permit an offsetting, to some degree at least, of the -- I can never remember now what has been done with the upper limits under what used to be 1902(r)(2). But I think that, you know, we keep talking about the pathway of the marketplace. There is, of course, another pathway, and we probably would want to flag that for people.

Any other questions on CHIP?

[No response.]

CHAIR ROSENBAUM: Well, thank you. As usual,

great work. And now we turn to Program Integrity in Managed Care. Another great panel, Moira and Jess. Take it away.

REVIEW OF JUNE REPORT CHAPTER: PROGRAM INTEGRITY IN MEDICAID MANAGED CARE

* MS. FORBES: Thanks, Sara.

So in your packet, you have a draft chapter for the June report to Congress. Earlier chapters that the Commission has done on program integrity have focused more on general program integrity issues and on eligibility program integrity as it relates to changes in the ACA.

Now that the updated Medicaid managed care rule has come out, we thought it was an appropriate time to look at managed care program integrity in more depth. So in this presentation, we'll go over quickly again the research that we've done, our findings, and some ideas about areas where additional guidance or regulation may be appropriate, as summarized in the chapter.

So we wanted to take a focused look at the issues relating to managed care program integrity in the context of the final rule that was issued last spring. Our work to date, as we've discussed before, has included a study

examining federal and state managed care program integrity efforts, which we completed last fall and presented in January.

With the help of our contractor, Booz Allen, we conducted an environmental scan of state and federal practices, and we held over 20 stakeholder interviews. The Commission also had an expert panel here at the December meeting. And then you asked us to develop a chapter for the June report based on all of these findings.

So the chapter has three main parts. The first section includes a detailed discussion of the program integrity issues that are unique to managed care delivery systems to provide some context. That's based a lot on the discussion that we had at the January Commission meeting. It also summarizes the federal, state, and MCO activities designed to protect against fraud, waste, and abuse in Medicaid managed care, drawing a lot on our environmental scan.

The second section provides an assessment of Medicaid managed care program integrity activities that are based on our stakeholder interviews, the expert panel, and Commissioner discussion. The chapter concludes with a

brief discussion of issues raised during the study that the Commission may want to take up in the future.

So I'll just walk quickly through each part just so that you can understand what we were trying to highlight and see -- then we'd like to get your feedback.

The first major section describes how the differences between fee-for-service and managed care payment and contracting arrangements create the potential for new or different kinds of program integrity risks that require program-specific safeguards. For example, federal and state responsibilities shift when states implement managed care delivery systems, while managed care organizations have direct program integrity responsibilities and must cooperate with Medicaid fraud investigations.

At your suggestion, we included in the chapter the detailed tables that we presented at the January meeting that highlight a lot of these risks and some of the regulatory responses to address these.

The next section of the chapter describes the Commission's findings in a number of areas which I'll quickly walk through here and on the next slide.

In the absence of clear guidance, we found that states had developed their own policies and procedures over the last 20 years, resulting in a lot of variation in what they require of Medicaid MCOs in state oversight of MCO program integrity activities and how states and MCOs work together to reduce fraud, waste, and abuse. These findings are certainly consistent with the findings of other oversight agencies such as the GAO and the OIG.

State managed care oversight and traditional fee-for-service program integrity activities, which have largely operated in separate spheres, even while managed care has come to become a major delivery system in Medicaid, are increasingly coordinated both by rule and by practice. However, managed care still lags behind the fee-for-service program as an area of state and federal program integrity focus. States that we spoke to agreed that additional guidance, training, and tools to support information sharing would further strengthen managed care program integrity efforts. Interviewees identified many practices that they perceived to be effective, but noted that there are few mechanisms for measuring the return on investment of program integrity activities or for sharing

best practices. Again, there's nothing new there.

Some of our other findings regarding data quality, of course, is very important for program integrity and continues to be a concern, particularly at the state and federal levels.

States use different incentives to encourage MCOs to vigorously pursue program integrity. We couldn't find any clear information that indicated -- you know, that favored one approach over others. We do note that it's still early to gauge the full impact of the Medicaid managed care final rule. Many provisions won't go into effect until July of this year, and some don't go into effect until July of next year.

To support implementation, states and MCOs have requested additional guidance and clarity around federal policy in areas such as encounter data, cross-agency collaboration, oversight tools, and payment recoveries.

In the Commission's view, these findings indicate that recent changes in federal guidance, particularly the new rules, have the potential to help strengthen Medicaid managed care program integrity. However, the federal government has not issued complete guidance on all aspects

of the new rules, and states and MCOs have not yet developed all the necessary policies and procedures and developed all of the necessary internal capacity to support these new requirements.

While there's no clear statutory or regulatory intervention identified at this time, based on our findings, MACPAC's June 2011 recommendations regarding strategies to strengthen Medicaid program integrity are still relevant.

So 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. Some areas for potential research are indicated on the slide. You may raise other areas of interest that you want staff to follow up on.

Some of you have also discussed how new approaches being adopted in states could affect how states and CMS approach program integrity. This includes -- folks have raised value-based purchasing approaches such as ACOs that tie payment in part to quality measures and cost savings. So just as the differences between fee-for-

service and managed care payment and contracting arrangements create the potential for new or different kinds of program integrity risk, so do the differences between value-based purchasing and sort of standard program integrity.

So over the next year -- that's an area that we could -- staff could follow up on at your direction. Over the next year, we will continue to monitor states and MCOs as they come into compliance with the provisions of the rule. We'll also follow the actions of the new administration as it determines how to implement and enforce the various provisions of the final rule, and as it issues guidance on provisions scheduled to take effect in 2017 and 2018.

So at this time, we certainly welcome your feedback on the chapter. Thank you.

CHAIR ROSENBAUM: So Kit, Penny, Chuck.

COMMISSIONER GORTON: So really nice work. It's a very effectively put together chapter. I will be proud to have my name on it.

Three ideas for your work in the future to follow up on some of the things that you raised in the chapter.

The first is you sort of tee up -- and I think appropriately don't go into a lot of detail -- on the difference between prospective claims editing and that sort of stuff and the retrospective activities. And I think it would be useful to illuminate how those things in many cases interact and dovetail to give you a complete approach to program integrity. I think many people believe, I among them, that if you're not doing all of the above, then you don't have a complete program integrity program. So I think it's worth elucidating those things and how they work, what they contribute, so -- and in terms of the relative size of cost avoidance versus recoveries, so I think that's worth exploring in more detail going forward.

The second thing I think is worth exploring. Program integrity is a place where there's a lot of administrative investment in order to be able to do it, whether you're buying claims editing software or you're hiring investigators, whatever you're doing, you have somebody checking databases, there's an administrative load that comes in, and I think sometimes people embrace program integrity initiatives, but they don't think about what it costs to actually get it done and whether there's any bang

for the buck.

So program integrity needs to have a very significant return on investment, and so one of the places where our organization has been concerned about some of the stuff that's in the rule is, yeah, you can do that, but you're going to spend a fortune getting it done and have to hire an army of people. And in many states, the administrative component of managed care is either separately capitated or is in some other way constrained. So there is not necessarily the opportunity for plans to engage in that kind of effort. So I think it's worth looking at just the administrative burden at multiple levels. You could look at what, for example, in terms of encounter data or validation, you know, RADV's a great program. It's been in place in Medicare Advantage for, I don't know, 20 years. It costs a fortune, and it takes a lot of time, and you really -- and there's a real question in terms of what's the ROI. Is the bang worth the buck?

And then the last piece is we were all steeped in an idea that if you've seen one Medicaid program, you've seen one Medicaid program. I think it's worth acknowledging that if you've seen one Medicaid MCO, you've

seen one Medicaid MCO. They're different. Some of them are provider sponsored. Some of them are not-for-profit. Some of them are single market; some of them are multiple market; some of them are national in scope. And I do think it might be worth a little bit of work to see whether the approaches differ. Is there more sophistication in a large multi-market national carrier in terms of their program integrity? And what drives that? Is it because they can leverage the administrative costs across multiple markets, and so that makes sense? Is the focus different in a provider-sponsored plan where the people who they may be monitoring are, in fact, the people who write their paychecks?

So I think there are things to be illuminated there that would be worth illuminating, but overall, great work. I think it's important, and I look forward to us expanding on this body of work.

CHAIR ROSENBAUM: I have Penny and Chuck.

COMMISSIONER THOMPSON: Great work. Thank you. Settle in for a second. I have a few things to go through.

[Laughter.]

COMMISSIONER THOMPSON: One is we -- I think with

the attention that has been given the question of whether the administration wants to rethink some of the provisions in the managed care rule or not, or certainly wants to scrutinize where there might be some administrative lift that isn't, in their view, kind of worth the outcome, it would be useful in the chapter to be clear when we talk about regulatory requirements which one of those are associated with new rulemaking versus long-time requirements, and kind of what the change was. And we talk about this in the chapter in terms of the managed care rule having strengthened some of the requirements and so forth. It would be just good, I think, to be clear about what it actually did versus what was already in place.

I think we are making too much in the chapter -- and maybe you can respond to this about whether or not this was the respondents that we talked to making much of this -- about this organizational separation issue, where we talked a lot about how, while there's people who care about managed care oversight and there's people who care about program integrity -- because that's always true. I mean, even in fee-for-service, there are people doing payment policy who are different from people doing program

integrity, and people who are doing provider relations that are different from program integrity, and people who are doing quality measurement different from people who are doing program integrity.

And so there's always a distinction between kind of the program side of the equation and program integrity, and financial management even, as you point out, being something that some people think of as being part and parcel of program integrity or sometimes even separate from that.

So I accept the point that maybe it's a matter of the relationship having been strengthened primarily around fee-for-service and now needs to be -- the coordination and strengthening of those relationships need to take place with respect to managed care. But I don't think that it's true that simply because you might have people who are managing the contracts in one place and people who are thinking about program integrity maybe across a variety of different delivery systems in another place, that that in and of itself is some kind of problem that needs to be addressed. I just think that it will always be the case that you will have some people in some different places and

they all need to talk together about kind of their common obligations to one another and where, you know, they may be able to rely on similar data and how they distinguish between, you know, certain questions and other questions.

You know, at the federal level, as you point out, that's true too. You have a group of people who are responsible for more of the program side, which includes disallowances and deferrals relating to certain kinds of issues with states, and those are different from the people that might be sitting in the Center for Program Integrity.

I guess I have -- I just in general don't think much about organizational boxes. Whatever boxes you create will create points of dependency and the need for coordination. And so I just don't want us to get overly tied up in that, and I thought that chapter maybe has a little bit too much of a highlighting or emphasis on that.

You mentioned PERM, and I know that you referenced a MACPAC chapter from 2013. I think in this chapter it would just be good to emphasize that PERM provides estimates of error relating to fee-for-service claims, eligibility, and payments by states to plans but doesn't measure any of the accuracy of claims payments

being made inside of plans. I think that's an often misunderstood element of PERM, especially because of the way that it reports some of that data, it reports it as managed care error, but it really is about the state's ability to accurately make a payment to a plan, not anything about whether the plan is making payments accurately inside of its own network.

I also think there's a couple of places where we make some statements that I just would like us to double-check what level of confidence about them. One, as an example, which is that Medicaid fee-for-service operates more on a pay-and-chase model and MCOs operate more on a prepayment, claims payment model. I'm just not entirely sure that that is totally accurate. I think that virtually all claims payment systems in states making fee-for-service payments have claims editing software, prepayment review processes, utilization review processes, et cetera.

So, you know, I think sometimes that is an impression that people have, but I'm just not sure that it is true or that we know it to be true. I mean, virtually every claims payment system, and still most MCOs -- and I'll defer to my colleagues here who have more direct

experience -- are paying on the basis of fee-for-service. They're paying claims systems. They're using in lots of cases some of the same claims editing processes and some of the same solutions inside of their organizations as states are using.

So I wouldn't want us to, again, overemphasize that somehow that world feels really different in a state-operated fee-for-service world versus a managed care world. I think everybody tries to move upstream, tries to detect and prevent as much as possible, but also tries to make timely and prompt payments, and so, consequently, sometimes some of the more in-depth reviews, including those that require medical records, get pushed to post payment. And I think that that happens in states, and I think that happens in MCOs.

And then, just apropos that, on this last point, and Kit touched on this a second, I do think that this issue of return on investment, and how we measure it, and how we reward people for return on investment is huge. You know, it's one of the reasons why some -- there's this question about who should be doing auditing and reviewing inside of a managed care plan, because it has to do with

who gets credit for the recoveries and who gets the money that is recovered. It's also why there's this emphasis on this back end, because you pay it out and you get it back.

It's very clear that that's a return on an investment, whereas a lot of the up-front activities for around education, prevention, network health, which includes making sure that you don't have the wrong kind of people that you're doing business with, but also the prepayment review, the utilization review, the prior authorization programs, all of those kinds of things, how those get charged off against an avoidance and whether or not we really believe that we should get credit for the avoidance, and we think of that as being as real as a recovery is a very important point and has a lot to do with where dollars come from and how they get allocated.

And so I do think this question of where people place their investments and why they place them where the place them, and how they report on the success of those investments is just really, really important. I think all of the areas that you've identified for future work are viable and I hope that we can continue to work on this activity.

Thank you.

CHAIR ROSENBAUM: I have Chuck, Stacey, Sheldon, and Peter. Anybody else? Okay.

COMMISSIONER MILLIGAN: So, did you all stay comfy through Penny?

[Laughter.]

COMMISSIONER MILLIGAN: Just a few points and I'll try to be brief. I think it would be helpful in the chapter to distinguish fraud from waste from abuse, because I do think that there is -- this issue of pay and chase versus avoidance and all of that, I think people misunderstand differences between things like doing coordination of benefits, to try to make sure you're the payer of last resort, from things like preventing overutilization, from things like fraud, where there's intent. And I think that helping, just in terms of definitions, that would be an important thing to do.

And, you know, even just in terms of definitional stuff in the chapter, trying to make sure that you're -- that a managed care company is only paying for that which is medically necessary, or -- and this is a lot of the controversy around managed care, but issues around, you

know, formularies and is surgery really necessary or can less intervention kind of happen first -- those sorts of things. I think just framing it a little bit, I think, would be helpful, because people misconstrue when they hear fraud, waste, and abuse that it's intent, and it's stealing, and it's a lot of other things too.

The second thing, I think, that would be helpful, and I think this is actually important for future work and I would add to the list, is the extent to which access to electronic medical records and more of that kind of real-time validation of medical necessity changes this discussion a little bit, because it does change, you know, is that fourth day in the hospital appropriate? Is that fifth day in the hospital appropriate? Having access to EMR and not having to, like, chase charts and provider abrasion makes a big difference.

So I think as there's more connectivity into state information exchanges and tapping into EMR, and kind of to Kit's point around provider-sponsored plans, I think that's going to be an important thing to focus on in the future.

And I guess the last comment I'll make is there

is a sentinel effect. It's hard to kind of quantify, but if somebody feels watched their behavior changes. And I do think that part of what happens in terms of avoidance is sometimes people don't submit claims that are dubious, or maybe valid, if they feel like there's going to be scrutiny or hassle or they'll be caught. So I just think that there's a sentinel effect here that might be worth some future work as well.

CHAIR ROSENBAUM: Stacey.

COMMISSIONER LAMPKIN: So, thanks. I'm so delighted that we're doing this. I feel like we're adding some really great information at a great time -- at a great point in time, to really help in this evolving -- states evolving and how they think about program integrity in working with their managed care plans. I feel like there's a lot to do here. So thank you for that. Well, what is the state’s role in this setting, is really helpful, I think.

And I'm not sure -- I want to ask or comment, and I'm not sure whether this is an adjustment to the chapter or a future work, but more on the incentives for managed care plans. I know we say that there are a variety and

it's tough to know what's helpful. I think that's an area that could be poked at a little bit more, both how we think about it in terms of capitation rates but also medical loss ratio and the new rule, and how does that treat fraud prevention and why, and is that optimal? So those are areas which, you know, if we want to explore them more deeply later, that's fine, or just maybe bolster a little bit here in the chapter, whatever you guys think is most practical. But really great work. Really appreciate it.

CHAIR ROSENBAUM: Sheldon.

COMMISSIONER RETCHIN: I think this is a great chapter. I think the timing is terrific. I was particularly appreciative of Table 1, that really kind of worked through the differences between a fee-for-service environment and managed care. And I think maybe it's reflective of -- I still think that the managed care transformation in Medicaid is one of the great transformation stories of health care, that really kind of goes underappreciated.

That said, one of the things that maybe could deserve some emphasis, and I don't know whether it's in this chapter or not, but if I go down and look at some of

the program integrity requirements for MCOs, and I'll have to look at my colleagues and ask for them to reflect on it, is whether we emphasize enough the transformation to the adequacy of provider networks, and whether states have been clear in terms of providing time and distance network adequacy standards. And I don't know whether that's true or not, but the reason I emphasize that is particularly because I've listened to people talk about the Medicaid program and have cited, and I think distorted, in some ways, the participation rate and the erosion of participation rates for providers, which actually is not true. As MCOs have grown, the participation rates have really not eroded, and it would be -- I just didn't -- I don't know whether maybe that doesn't belong in program integrity but it seems to me the one thing that transfers from fee-for-service to managed care is the emphasis and the reassurance of an adequate network.

Two other issues, is, one, whether IT systems in the different states, the variations on IT systems, and maybe Penny could comment on that better than I could, whether we see so many variations and states have -- some have moved rapidly to contemporize their IT systems; some

haven't.

And then, the last one is on, now we are going to see more transformation in long-term care and community-based services, and whether we are really prepared there for changing the program integrity standards to reflect that transformation.

CHAIR ROSENBAUM: Peter.

COMMISSIONER SZILAGYI: Actually, Chuck made almost all my comments. You know, when there's such -- so I was involved for almost 20 years with a large Medicaid managed care organization and we kind of did almost like a two-by-two table of low-cost, high-cost versus low-impact, high-impact, and trying to figure out how much effort we should put into program integrity work, and ended up putting maybe lower effort than others, and this is one of the highest-rated quality plans. We didn't find -- we didn't think the ROI was worth it to be -- this is totally piggybacking on what Kit was saying. You know, when you see large variations, this chapter is basically saying there's large variations. That's such an opportunity to try to figure out what's better and what's worse.

I mean, and I recognize this is a qualitative

study they did for this particular chapter, but were there any, you know, examples of, qualitatively, what people thought were good incentives or good models that worked better than the other? Because what I gathered from throughout this chapter, which is an excellent chapter, is that you just can't tell, that there's large variations but it's hard to tell what is working better than the other. But from your deep dive with these interviews, were there any examples of what people qualitatively felt were really good either state incentives or other types of program components?

MS. FORBES: There was pretty universal agreement that the state of Tennessee has developed oversight -- state oversight strategies, you know, contracts and, you know, reporting templates and things like that for its oversight of the health plans, that allowed the state staff to be confident that the health plans were doing their due diligence, and other states have used, and I think even CMS has used, what Tennessee has developed as a model. But that still doesn't get at what the health plans themselves are -- like where they are actually making the specific investments, and there may still be variation among even

Tennessee health plans. They are doing something. I don't know what that is. The state is satisfied that they are doing things.

So we found some agreement around state models, but we didn't find -- it was very interesting doing all of these interviews. Everyone kept saying, "Please let us know what you hear from everyone else," the same question you have.

CHAIR ROSENBAUM: You know, just to sort of pull some of the themes together here, I think one of the things that I heard, as we went around the table, was that the chapter might be strengthened further by a little bit more context. Again, there's this, you know, strange phenomenon, as Chuck notes, of fraud, waste, and abuse, and under fraud, waste, and abuse is like the entire universe. So the question like the four Seder questions, you know, why is this different from other things? Why is program integrity different from contract management, in the case of managed care? Why is program integrity different from normal claims payment and utilization management, in the case of fee-for-service? What's the value added, or what's the dimension added by program integrity? That's number

one. Because I find myself often very confused by this question. You know, is this program integrity? Is this just contract management? What is it?

And another is the different types -- once we sort of lay out what a program -- and what's in the scope of program integrity, how a changing health system -- and you do, of course, a lot of this and I think it's just a matter of sharpening it up -- how the evolution of the health care system means that program integrity evolves. So here are the kinds of questions we've been asking in a fee-for-service world. Here are the kinds of issues. It's not just the managed care plans as agents of the state. It really is managed care as a focus of program integrity. Here are the questions we need to ask, and within the managed care world, I definitely echo Sheldon's point, and the point made earlier, I think by Kit, which is there's no one form of managed care. And so managed care that's a provider, that's a captive entity of a provider organization may be one kind. Managed care that is essentially an arm's-length purchase of a network by an outside entity may be another. Long-term services and supports raises unique questions. So in a more context

setting, so people understand that the scope of the inquiry on the part of MACPAC is more than just the agency inquiry. It is the fact that you have to think about program integrity in a new light, and that's where I think the managed care rule does more than just clarify the agency role. It sort of points to things that we might want to put in a program integrity bucket.

And, finally, from what we know, and this is where I absolutely agree with Sheldon, given -- in fee-for-service, any state, and therefore the federal government, runs the risk of certain kinds of outlier activities. You know, not just the normal to and fro of utilization management but certain kinds of things that belong in a program integrity category. And in managed care, similarly, the state, and therefore the federal government, run the risk of certain kinds of conduct that may go beyond contract management issues, and you may want to have this sort of second dimension.

And the normal oversight tools in Medicaid, and the program integrity tools in Medicaid, as Penny points out, overlap a good deal. And so when, you know, when are you -- when should we be thinking program integrity and

when should we be thinking, you know, normal program oversight? And I think it would also be worth giving some historical sense for readers of what recoveries have been looking like. What recoveries -- you know, when there's sanctionable activities, you know, here's what the -- sort of the history of sanctionable activities if we have anything that we can pull like this, in the fee-for-service world, and, you know, the fact that in managed care there's a lot, there's not so much. Sort of what the trail of sanctions on both sides of the equations look like. Because I think a lot of people, you know, really have no idea.

So a lot of what has been voiced this morning is sort of contextual and an explainer for people, because it's such a crucial part of Medicaid but it also is nested inside a million other operating parts of the Medicaid program.

Any other questions?

[No response.]

CHAIR ROSENBAUM: Okay. Well, thank you very much for a great chapter. It will be a great contribution. And now, as our last session of the morning, we're going to

look at the opioid epidemic, where we started doing some work at the last meeting, and review of the draft chapter.

REVIEW OF JUNE REPORT CHAPTER: MEDICAID AND THE OPIOID EPIDEMIC

* MS. MINOR: Hi. Good morning. Amy and I will provide you with an overview of the draft chapter on Medicaid and Opioid Epidemic.

In response to the continued increase in opioid overdose deaths and the disproportionate impact on Medicaid beneficiaries, the Commission has discussed this topic on several occasions.

In June of 2016, MACPAC published a compendium cataloging state plan benefits for treatment of substance use disorders. In October, you heard the results of a MACPAC analysis of opioid-prescribing patterns in Medicaid. And in March of this year, a panel with representatives from the National Governors Association, Vermont, and Virginia presented their experiences of how state Medicaid agencies are responding to the crisis.

Based on these discussions and others, you asked us to draft a chapter on, Medicaid's role in fighting this epidemic.

The draft before you builds on this past work. It's intended to be foundational and, therefore, does not include any recommendations. It describes the extent of the epidemic Medicaid's responses, both in the form of regulating, prescribing of opioids to prevent overuse and misuse, as well as coverage of services for individuals who already have an opioid use disorder. The chapter also identifies barriers to effectively address the epidemic.

The next slides go into a bit more detail about each of these sections.

The chapter begins with an overview of epidemic’s scope. Whenever possible, we provide Medicaid-specific data. Unfortunately, that level of detail is not always available.

As you can see, prescription opioid use is fairly common. In 2015, more than a third of individuals had a prescription in the previous year to alleviate pain related to a medical condition. About 5 percent of people misused an opioid, and 0.3 percent were heroin-dependent.

Before I go any further, I'd like to just clarify a matter related to terminology. When we talk about prescription opioid misuse, we mean that a person used a

pain reliever without a prescription or in a way that was contrary to physician's directions. Misuse is not the same as an opioid use disorder. An opioid use disorder is a brain disease that typically develops over time with repeated misuse of opioids, and is characterized by clinically significant impairments in health, social function, and control over opioid use, and the development of tolerance and withdrawal symptoms.

Some of the research we present about the prevalence of opioid use disorders reports on opioid abuse and opioid dependence. Both abuse and dependence are instances of an opioid use disorder. The difference is just a matter of severity.

Our analysis, using the 2015 National Survey on Drug Use and Health, the most recently available national data, found that Medicaid beneficiaries have a higher rate of opioid use disorders than privately insured individuals. In 2014, 1.8 percent of Medicaid enrollees had an opioid use disorder related to prescription drugs compared to 0.6 of privately insured. And the numbers were smaller for heroin, with 0.8 percent of Medicaid enrollees being heroin-dependent compared to 0.1 percent of privately

insured individuals.

While less than 5 percent of prescription opioid misusers transition to heroin use, one study found that among people who misuse prescription opioids and heroin, 77 percent reported using prescription opioids before initiating heroin use.

The chapter also includes a discussion of the epidemic's effects on various subpopulations. For example, individuals with mental illness are especially susceptible to opioid use disorders.

In the case of geographic differences, national data are mixed, showing either no significant difference between rural and urban areas or higher misuse rates in urban areas. We found that some studies did document a higher prevalence of pain reliever misuse in certain rural populations, such as adolescents, pregnant women, those who have less than a high school education, those who were uninsured, in fair or poor health, or who had low incomes.

In 2015, Medicaid enrollees were more likely to be in treatment for their opioid use disorders, but a significant treatment gap remains. Sixty-eight percent of enrollees were not receiving treatment.

We do not know the reasons why Medicaid enrollees specifically are more likely to receive treatment, but in the overall population, there are numerous factors that influence whether a person receives care or not. People may not think they need treatment, and out of those that do perceive the need for treatment, individuals cite a variety of reasons for not getting care, such as concerns about the effect on their job, not being ready to stop using, not being able to afford the cost of treatment, or treatment programs not being geographically accessible.

The chapter goes on to present information about the adverse outcomes related to opioid use disorders. Drug overdose deaths in the U.S. nearly tripled from 1999 to 2014, and Medicaid beneficiaries face a higher risk of opioid overdose.

There's been progress in preventing deaths due to methadone when it's used as a pain reliever, and between 2013 and 2015, there's been a reduction in number of opioid prescriptions. But the overdose deaths involving heroin and other synthetic opioids increased across many states. This is likely attributable to the increase in illicitly manufactured fentanyl, which is far more potent than other

opioids.

On the financial side, Medicaid is the predominant payer for hospitalizations of newborns related to neonatal abstinence syndrome. Medicaid also paid for 43 percent of inpatient hospital charges related to serious infections associated with opioid abuse. Heroin use in particular heightens the risk of bacterial infections of the skin, bloodstream, and heart, and viral infections such as HIV, hepatitis C, and hepatitis B.

The next section of the chapter focuses on how Medicaid is responding to the epidemic, beginning with an inventory of the services state plans are covering. These include the multiple elements that make up evidence-based care for addiction, including medication-assisted treatment.

Screening, brief intervention, and referral, which can be conducted by primary care providers, is an important tool in diagnosing opioid use disorders. It also identifies individuals who are misusing opioids and allows the provider to intervene with counseling in this problematic behavior before it can progress to an addiction.

All states cover the overdose reversal drug naloxone for individuals who are at risk of overdoses, but it may not be available for take-home use by an individual or their family or peers, meaning that administration of this life-saving drug may be delayed and rendered less effective.

On this next slide, we have information that reflects what was in MACPAC's state plan compendium on benefits. Some of the highlights are out of the three drugs used in medication-assisted treatment, methadone is the drug least likely to be covered. There are several behavioral therapies that are shown to be effective in treatment of substance use disorders, such as cognitive behavioral therapy, contingency management, and family therapy, but state coverage varies widely.

States are least likely to cover recovery supports, which provide ongoing management and monitoring and emotional and practical support to maintain remission and prevent relapse. These services are offered through treatment programs and community organizations. Peer support and supported employment are two examples of such recovery support services.

The chapter then goes on to describe the different Medicaid authorities states are using to target enrollees, expand benefits, and organize their delivery systems. We provide illustrative examples of several states.

In March, you heard from Vermont and Virginia, which are using the medical home option and an 1115 waiver, respectively, to expand and organize their services. Ohio is engaged on many fronts in addressing the epidemic. In the chapter, we highlight a pilot project specifically targeted to pregnant women, and lastly, we describe the establishment of a substance use disorder benefit for adults in Texas under the rehabilitation option and their efforts to increase uptake of the benefit.

The chapter also includes information about the state efforts to reduce overprescribing and misuse of opioids in the first place. Much of the information included in the section draws from the analysis that Amy had presented on in October. Where possible, we updated the data and the number of states using a particular tool and added some additional discussion of additional utilization management tools states are deploying.

For example, all states, except Missouri, have a prescription drug monitoring program, but not every state Medicaid agency has access to the PDMP. And as of June 2016, all but five Medicaid programs had some type of quantity limit on opioids on their preferred drug lists.

And I'll now turn the presentation over to Amy to outline the chapter's discussion on challenges to effectively addressing the epidemic in Medicaid.

* DR. BERNSTEIN: You heard about a lot of these barriers to treatment at the panel meeting in March, and I am just going to go over them very quickly.

First of all, there's the fragmented delivery system, substance abuse treatment, including treatment for opioid use disorders often provided by different agencies, which is often confusing for both providers and patients, and given the complexity of the substance use delivery system, there have been some efforts to align eligibility and financing services. And oversight across agencies, and these include collocating physical and behavioral health providers, sharing data and information, blending funding streams, and consolidating Medicaid and state behavioral health and substance use agencies. On the other hand,

there are still a large number of people who are either confused or don't know how to get treatment, and there's also confusion among the different agencies as to who pays for what when.

We've discussed the inadequate supply of providers in some areas. For substance use treatment, this may be particularly problematic. The supply of substance use disorder treatment services available to Medicaid enrollees in particular is affected by many factors, including their geographic location, the states' scope of practice laws, such as ones that allow certain clinicians who aren't physicians to prescribe medications, the willingness, of course, of physicians to participate in the program -- you heard about this from both Virginia and Vermont -- and the number of providers with special federal approval to prescribe and dispense methadone and buprenorphine, which requires a waiver and licensing by SAMHSA in order to be allowed to prescribe those drugs. And there's a shortage of physicians who can do this, and you heard about how Virginia is trying to increase the number of physicians who can do so.

The privacy regulations, specifically Section 42

Part 2, called affectionately "Part 2" by those who discuss it, you also heard about in March. Part 2 requires the written consent of patients and to include the name or title of every individual or the name of every organization to which disclosures from entities that hold themselves out as providing substance use disorder treatment primarily are made.

SAMHSA recently updated the Part 2 regulations to make research using patient data a little bit easier, and for the most part, however, the rule covers the same providers and similar patient consent for all providers accessing the data.

It does allow patients to do a more blanket consent form, so they can say, you know, like give consent for all providers in a place to see my data, but it still requires individual consent from every substance use disorder facility from the patient to everyone who might see their data.

So it's also unclear sort of which data have to be redacted in national datasets, and so because it's not exactly clear, it's unclear whether they will continue redacting national data, which makes it more difficult for

research to be done. SAMHSA is supposed to issue sub-regulatory guidance in the future.

The IMD exclusion, we've also discussed in many different venues, usually with respect to mental health. There are specific issues related to substance use disorder, where residential treatment is sometimes considered preferable to other kinds of treatment, and the issues of not being allowed to cover patients in institutions for -- in IMDs for substance abuse patients. The managed care rule does allow patients to be in managed care organizations to admit patients for 15 days a month. There are some complications with that rule. Some people say 15 days is not enough, and there have also been waivers for IMD exclusions under 1115. And several states have them. You heard that Virginia has one, and other states have requested them.

There are restrictive coverage policies, and Nevena mentioned that states vary in what they cover. Some of the major limits that affect opioid use disorder patients are limits on the dosages, prior authorization and reauthorization requirements requiring that other therapies be tried first, and insufficient-related counseling of

behavioral health therapy coverage, which as Nevena mentioned is the least likely to be covered.

The issue of stigma comes up specifically with substance use disorders and opioid use disorders and probably heroin use disorders the most. Physicians and providers may view it more as a -- more a weakness and be less likely to treat it than they might some other physical issues. It may make patients reluctant to seek care, and there have been education programs to try to educate both providers and patients that this is a disease and treatment should be both sought and given. But the stigma, and to some extent, still remains.

And the last issue that we discuss very briefly is the fact that the Medicaid expansion and the ACA did increase access to substance use disorder treatment as part of parity requirements and essential health benefits, and it is not clear what will happen if the situation changes with respect to coverage.

With that, we welcome your comments, and I will stop.

CHAIR ROSENBAUM: Toby, Kid, Andy, Alan. Hold on. Toby, Kid, Andy, Alan.

COMMISSIONER DOUGLAS: Excellent. Excellent chapter.

CHAIR ROSENBAUM: Sheldon, Brian.

COMMISSIONER DOUGLAS: Really good chapter.

I'm going to first start with some specific comments and then just one overall.

CHAIR ROSENBAUM: Okay. Well, we have basically everybody. Everybody has got their lights on. So why don't we just start here and move right around. Everybody, I think, wanted to weigh in.

COMMISSIONER DOUGLAS: Okay. Well, I'll try to be brief.

So, first, just on some of the barriers, on the point around the supply of providers, I think it's really important -- and this came up in the discussion with Virginia and Vermont -- it's not just the inadequacy of the supply, but the ability of providers to change their practices. And this is, in particular, around methadone providers.

And just highlighting -- I mean, this has been -- institutionally, when you think of substance use, methadone providers have been at the -- have been in the substance

use treatment system, but we now have a changing substance use treatment system and the need for the methadone providers to change their practices to be prescribing bupe and other forms of medication-assisted treatment, so just highlighting that, and that's been a challenging in states.

On the IMD, two things. One, I think we need to acknowledge the 15-day. Some view that change in the managed care rule was a good change. For other states, it was actually going backwards, and it's put plans also in an awkward position of it is 15 days, and then what? So there's a cliff that can actually lead to unintended consequences to not providing the right services. So it doesn't solve it.

And then the other piece on the waiver for states is -- and, again, this will get to my final point on the context -- it wasn't really just waiving around the IMD, but really an acknowledgement that the continuum of substance use treatment services, to truly create an evidence-based continuum, needs to include residential as part of that continuum, and so to test out and truly provide an integrated system, it was waiving it, but not just on its own, but part of that true piece.

On the Medicaid expansion, I would like that to be a little bit more expansive. I mean, really, clearly, there are a lot of reasons that have driven this on Medicaid to focus on substance use treatment, but a big piece was the Medicaid expansion, and what happened is many states had suddenly now childless adults were coming on their roll, where the epidemic really was centered and had to respond and have responded because they now have a Medicaid expansion at the same time and need to provide robust services, whereas while it was a problem with families and children, it wasn't to the same level and extent as it is with expansion. So it really brought this to a head as an important piece.

And then that gets to -- I think the state-by-state is good, but I do think there needs to be some type of summary around -- the best practices that state and CMS are seeing is around the ASAM criteria, around this continuum and evidence-based approach of a continuum of drug treatment, but rather than viewing this as a piecemeal approach or different systems that states are moving to a coordinated system based on ASAM practices.

CHAIR ROSENBAUM: Kit.

COMMISSIONER GORTON: So thank you for a thoughtful and I think well balanced presentation of the foundational layer of this. I'm glad we have this chapter as a starting point going forward.

I just have one observation to add for the chapter. On page 7 in the chapter, your Slide 5 in this morning's presentation, you talk about the variance in terms of uses of services by what people's insurance type is, by payer, and the observation is what you have observed. And others have observed it.

I do think it's important to note in the chapter that the data that we have right now doesn't allow us to illuminate what drives that variance, and I think there are a variety of possible causes of that, different benefits available by different kinds of insurance, different coding practices by providers who serve people in different socioeconomic strata. I think we have heard anecdotal evidence that if you are an employer-sponsored service, you may ask your provider to help you get substance use treatment, but you may not want it to be coded under that diagnosis because that would be awkward for a variety of reasons. It might cause you to lose your job or whatever

else. So I think coding practices matter and maybe masking a lot.

The substance use provider community is the flip of the typical provider community. It's a rarity, but some of these people only take Medicaid, and if you don't have Medicaid, you may not have access to this treatment system, or they may only use state dollar-funded categorical funding. And so there's that reason.

And then there's the final piece in terms of stigma and social determinants. Part of what causes people to seek treatment for a substance use disorder is that they've -- to use the 12 Step metaphor, they bottomed out. Right? They've hit the bottom. If you have fairly substantial socioeconomic circumstances, the bottom is a lot farther away, and people's families wrap around them. People have the resources. At the end of the day, all of that didn't help somebody like Prince, but folks last a lot longer if they're wealthy and have a lot of resources. And you noticed that Prince wasn't going to his local county mental health treatment provider. Right? He was importing help from halfway across the country.

So I just think it's important that with a

sentence or two, we say the data don't illuminate what the sources of variance are, and they might be any of the following list of three or four things.

Thanks.

CHAIR ROSENBAUM: Andy.

COMMISSIONER COHEN: Great chapter. I am just incredibly excited not only for the -- well, let me say it again. It's a great chapter. And it's not only sort of great for the content of what's in it, but also I think sort of like as an example of the kind of work that I am so hopeful that MACPAC can do more of in the future. This is sort of really bringing together the program of Medicaid having a positive role to play in improving health and public health in ways other than just providing access to the system that we have, but also in trying to promote things like evidence-based practices, models of care where there's a real evidence base, et cetera. So I think this is a terrific step forward, and I liked the chapter very much. I think it addressed a lot of the really key issues. I just had a couple areas where I thought the emphasis could be slightly beefed up and also maybe a suggestion, and it may be too much for this chapter, but it might be

something that we can think about in the future.

So in terms of I think the areas that you outlined that sort of show barriers to states doing work in this area was incredibly helpful. What I think would also be helpful is just a little bit more emphasis around the states that have been able to do some really innovative things, just how much effort, creativity, and other things that I think, and, look, they all address this from very different kinds of perspectives and angles. And while some of that may be wonderful and reflect great creativity or differences in the underlying infrastructure, some of it might just be everyone was flying blind and just like, you know, took a crack in a different direction without knowing what their state would allow, what federal sort of regulations would allow, and each sort of tried a different approach to being able to support better models and things like that.

So for going forward, I would just love us to think a little bit about what is it that MACPAC can do, what is it that CMS can do, what is it that federal policy can do to really promote an easier pathway for states to allow patients and providers to sort of engage in the right

kind of care that Medicaid can support.

So when I think about, you know, we've had a lot of conversation about how waivers are hard to get and is it good for CMS to do waiver templates or something, I mean, what better place for there to be a waiver template than where there's a public health crisis and states are all struggling with ways to fit our round peg into a square hole and try and get coverage? This is the perfect place for a waiver template, some meaningful TA, technical assistance, and other kinds of things.

So I would just like to suggest that we explore the possibility of whether it's a recommendation or at least floating these ideas I think is just a really important area for MACPAC and Medicaid to focus on. But great job.

CHAIR ROSENBAUM: Thanks. Just a reminder to people, we have about 12 minutes and many people who would like to comment. I don't want to lose the public comment period before we break for lunch.

Stacey, did you want to comment?

COMMISSIONER LAMPKIN: [off microphone].

CHAIR ROSENBAUM: Norma.

COMMISSIONER MARTÍNEZ ROGERS: I just want to say a little bit about Texas. Texas is going to do something a little bit different. There is a bill in Texas, which has passed in the House already -- it's going up to the Senate -- to amend the state's penal and family codes, and what they're going to do is they're going to criminalize substance use during pregnancy and they're going to make it a state felony, which is going to be a 180-day to two years in the state penitentiary. And if they don't go into treatment -- if they don't get treatment and they don't go to jail, they're going to take the child away. So that's what's happening in Texas as of today, so I would ask you to please check on Texas. As I leave the Commission, please keep Texas in mind and their different way of thinking.

Thank you.

CHAIR ROSENBAUM: Yes, Herman.

COMMISSIONER GRAY: I don't want to follow a comment on Texas.

[Laughter.]

COMMISSIONER GRAY: I also think that it's a great chapter and it certainly is timely. I would only,

you know, I think, reinforce or back up comments that Andy made, that it certainly reinforces the notion of Medicaid as a major player in this public health crisis, and points out just how important a role it is that Medicaid can play creatively with lots of flexibility at the state level in addressing what is probably going to be a crisis for some time.

CHAIR ROSENBAUM: Penny? Alan?

COMMISSIONER WEIL: Yeah, I want to align myself with Herman and Andy's comments before and try to say that the chapter is terrific and it is a great road map for those who are trying to figure out what to do.

Forgive this minor diversion, but, you know, it's often talked about when the federal government and states are talking about a big financial swap, why not give the federal government long-term care? And my reaction has always been: And who's going to do the delivery system? And somehow I would like that feeling, which I don't feel is in the paper, to come through, which is not -- you know, it's a great statement of challenges and here are the state responses, but it's this notion of leadership and ownership of an issue that there's a vacuum here -- it's not just an

opportunity. It's that there's a vacuum here. There's no state department of opioid addiction. And someone has to step up, and in many instances it's the Medicaid program that does. And although all of the facts behind that statement are in the paper, I don't think it's ever said that way. And I just feel like that's important to elevate however in your judgment you think can best be done.

CHAIR ROSENBAUM: Chuck.

COMMISSIONER MILLIGAN: Two comments. Actually, one is I want to echo what Alan just said. I think that, piggybacking a little bit on what Toby said, the Medicaid expansion created within Medicaid a population that have a lot of addiction, but it wasn't, I think, so much the insurance coverage expansion that drove a lot of the models that we're seeing; it was the delivery system transformation that was driven out of that. So I think it would be good to distinguish the delivery system innovations from the coverage expansion piece of that.

But the comment I wanted to make that I wanted to kind of go back the slide that's up on the screen right now and go to the privacy regulations piece, I know that in one of our sessions we heard -- I think we heard that SAMHSA

doesn't believe that it can fully address this issue through regulation, that there's a statutory challenge. And so I do think that it would be helpful to illuminate that in the chapter, is this a statutory problem or a regulatory problem in terms of data sharing and really building within a medical home the ability of a medical home to treat comorbid conditions. And I think that putting a little bit more clarity around the regulatory versus statutory implications of this will help inform MACPAC as to whether this is something that we should weigh in in one form or a different form over time.

CHAIR ROSENBAUM: Sharon.

COMMISSIONER CARTE: As quickly as I can, I think that the main thing that jumped out at me was the issue that Kit touched on, the difference in Medicaid and other types of coverage for substance abuse, and if there's any other surveys or data that could shed more light on that as to whether -- I suspect many other insurance plans don't even offer coverage for substance abuse or mental issues. So anything more that could add to that would be great.

But, again, it's great material, and I'm really glad that the Commission has focused on this in the wake of

the information that Vermont and Virginia have presented was very outstanding.

CHAIR ROSENBAUM: If I could just interject for one minute on Sharon's point, and, actually, Kit made something that was on the same issue, not for this chapter but I think a very fruitful area for further work by MACPAC, which I was going to raise at the end, but given what Sharon just said, I want to flag it now. Classically, there are two exclusions in private insurance: the intoxication exclusion and the illegal acts exclusion. They are literally embedded in virtually every private insurance plan. They are part of typically most self-administered plans, employer-sponsored, self-administered, self-insured plans. They don't surface for people until there is a denial, and typically where it comes up is around screening and brief intervention in an emergency department, and the emergency department then finds that it can't collect, it can't get paid. And, typically, it's not just the exclusion, but it's all treatment flowing from an act that falls under the exclusion, so literally a $400,000 emergency bill is disallowed by an insurer because it emanated from intoxication or it emanated from an illegal

act.

NAIC has gone after this provision for years. They actually have model language overriding intoxication exclusions. I don't know at this point how many states have adopted the NAIC model language. Obviously, ERISA contains nothing that would regulate the use of intoxication exclusions.

I think it's a very important area for MACPAC because the third-party liability recovery potential on this one may be quite significant at this point. It's not just a matter of non-coverage. It's a matter of offering coverage, but then actually having it not be available. And it's not the kind of exclusion that one finds unless one sort of deliberately looks at what has been regulatory and litigation activity around the exclusions.

So I think downstream, you know, you may want to note the importance of looking at third-party liability recovery issues here, but it may be a very fruitful area for Congress and for MACPAC.

Sheldon?

COMMISSIONER RETCHIN: Yeah, I'll try to be quick as well, but I was astonished at how quickly this chapter

came together, and I really just applaud the staff. It's just like overnight you did 180 degrees and bam. And it's really terrific.

Sometimes I do wish we had a conceptual framework up front that would maybe even visually show how multifactorial this problem is. It's providers, it's regulatory. So to that end, one point just to emphasize and then I'll make another quick comment, and that is, as a provider, I think the chapter gives me a pass that I don't deserve. And I'll take you back historically, that this -- in the mid-1990s, the medical community decided to make pain the fifth vital sign, and I think the pendulum on that swung way too far in medical education and the whole culture of prescribing was to eliminate pain altogether. And now there has to be a rush back the other way. I hope it doesn't swing too far. But just the -- and so there's almost been a medical industrial collaboration here with the manufacturing of new products that can eliminate pain entirely, and I think that that's a really important point to make.

One other point, and I do think the stigma associated with this explains, at least directionally, the

difference between the Medicaid population and the privately insured, because I think there's a herd comfort in the poorer community. My next-door neighbor's addicted, the teenage class is addicted. And there's a different -- there's a shame factor in other circles that I don't think emerges.

But I do want to ask, on the prescription drug monitoring programs, the fact that there are 20 states that don't allow Medicaid access, what difference would it make -- maybe I just don't follow that. If Medicaid programs have access to those data, what are those that do have access -- what do they do differently?

MS. MINOR: So I think it would help identify patterns of potential overprescribing or misuse or, you know, if there's a patient that potentially is doing doctor shopping. Otherwise, it's just -- the physician would be -- you know, in the states where it's just the physician that has access and they can, you know, verify that their patient's not getting, you know, medications from other providers.

COMMISSIONER RETCHIN: Well, that makes sense to me, because I know in Virginia they were able to respond

much quicker in the ERs in particular to have access to it.

CHAIR ROSENBAUM: Great. Brian, then Peter.

COMMISSIONER BURWELL: I have a lot of things I'd like to say, and I will submit comments on the report.

I do think it's a fantastic product, and, again, I'm very impressed about the amount of work that went into this over a very short period. In regard to meeting our objective of putting together a foundational chapter for future MACPAC work, I think we've met that objective here, and I'm really happy to see this.

I want to pick up one thing that Sheldon said about kind of the medical industrial conspiracy around overprescription --

COMMISSIONER THOMPSON: Complex.

COMMISSIONER BURWELL: Complex, whatever -- of overprescribing of painkillers. I do think we should cite the book "Dreamland," which I highly recommend to everybody. It won the National Book Award. It really lays it out in a great story, and I think it should be recommended reading for anybody who wants to know more about this.

One of my comments is about just data

limitations. I think anybody who reads about this, you know, comes across widely varying statistics around various metrics, and it's like, well, what's going on here? And I think we should just acknowledge that in the chapter. I don't think we should present our statistics necessarily as this is the facts. We're using MSIS data. We don't have encounter data. You know, there's all kinds of things. It's older data. I see a lot of definitional -- you know, some studies talk about overdoses related to, you know, misuse of prescriptions, some heroin, you know, the relationship between heroin and oxycodone is complicated, and that kind of gets mixed up in the reporting of data. So I think we should just acknowledge these kinds of issues. I think the data are getting better. You know, and then the stigma thing, you know, self-report of misuse, et cetera.

EXECUTIVE DIRECTOR SCHWARTZ: Brian, I just want to mention that a lot of the data that we present, that Amy presented in October from the MSIS are not in this chapter for those very reasons.

COMMISSIONER BURWELL: Mm-hmm.

EXECUTIVE DIRECTOR SCHWARTZ: And so, obviously,

there are data limitations associated with surveys as well.

COMMISSIONER BURWELL: Right.

EXECUTIVE DIRECTOR SCHWARTZ: But for that reason it's not reflected there.

COMMISSIONER BURWELL: In terms of I do think -- on the kind of flip side, I do think the chapter could benefit from a few more kind of charts and statistics, and two that I would like to see is just the increase in opioid-related deaths over time. It's hard to get very recent data, and then it only goes up to a certain point. But what to me is very dramatic is not only the curve rising but the steepness of the curve is accelerating. So, you know, the dramatic increase in opioid-related deaths. I'd like readers not to get any comfort as well. This is a problem that has been around for a while and the states are doing a lot about it, and -- you know. So this is a problem that's getting worse, and so I think we should just make that point.

The other chart I would like to see is state-level differences in opioid-related deaths per 100,000. There's dramatic differences across states, and I see that as the foundation for future work. And where I would like

to take this work is to see differences -- I mean, it's not the best metric but it's one of the -- you know, it's there and we can use it. There are differences across states in terms of how -- whether opioid-related deaths are going up or staying the same or going down. And I think we should try to match those changes with the models that state Medicaid programs are using and try to get our arms around, you know, what are the more effective approaches for managing this epidemic than others. That's a tough job to do, but I think it's something that we should take on as a group.

DR. BERNSTEIN: We can certainly present state-level estimates on death rates from opioids. Not for the most recent year, but -- I mean, not for -- I don't know what year it is. I think it's 2014, but I'm not positive. I think it would be a time problem to actually match that up with every state's program for the chapter.

CHAIR ROSENBAUM: I think Brian was suggesting that for the future [off microphone].

DR. BERNSTEIN: Is that for future --

COMMISSIONER BURWELL: Yeah, for future work.

DR. BERNSTEIN: Okay.

COMMISSIONER BURWELL: Yeah, I don't -- I'm just saying --

DR. BERNSTEIN: I didn't want to have to do that tonight.

[Laughter.]

COMMISSIONER BURWELL: No. This is a foundational chapter. That is one of the directions I would like us to go in, you know, in the future.

CHAIR ROSENBAUM: Peter and then Marcia will close.

COMMISSIONER SZILAGYI: Yeah, just very, very quickly because pretty much everybody made my comments. I agree this is a really fabulous chapter. I did want to make the point -- emphasize the point Sheldon made about the context. So I think up front it is important that this is an inadvertent -- partly an inadvertent consequence of trying to do good. So I really agree with that.

And the second context point that I was going to make, Kit started it off, and many people have said this: I read this chapter as the importance of Medicaid in this tragedy. Others might read it as blaming Medicaid somehow if they misread the chapter. So this issue of Medicaid

versus private insurance, why people are more likely to be addicted if they're on Medicaid, I really think we need to emphasize this context. Among other things, if you have a serious disease, you're often poor because you can't -- it just drives you into poverty. There are many, many reasons. And, you know, the way I think we read it around the table may be a little bit different than the way some people might interpret this chapter as Medicaid's a problem and it has led to --

CHAIR ROSENBAUM: Well, and Medicaid covers these things.

COMMISSIONER SZILAGYI: Right, right.

CHAIR ROSENBAUM: I mean, that is the --

COMMISSIONER SZILAGYI: Right, so --

COMMISSIONER BURWELL: Another issue is the relationship between unemployment and use of opioids.

CHAIR ROSENBAUM: Right.

COMMISSIONER BURWELL: I mean, so that's obvious. If you're privately insured, you're employed.

COMMISSIONER SZILAGYI: A couple of very quick points. It may be worth emphasizing that opioid addiction is color blind, and even in Table 1, when you look at the

rate of opioid addiction among blacks versus whites versus Hispanics, it's pretty much the same.

And the final point is maybe a little bit more emphasis on the rural issue because this is a really big problem in rural America. It wasn't even in Table 1. I'm not sure whether that's because the data was missing. But some emphasis -- and I don't know if there's conflicting data as well about what's happening in rural America and there's large variations. But there's a lot of emphasis about rural America lately, for good reason, and it may be worth just emphasizing that context.

CHAIR ROSENBAUM: Marsha.

VICE CHAIR GOLD: Yeah. I think the points I had actually sum up a lot of the discussion. Well, when I read the chapter I really, like others said, was impressed by how much was able to be pulled together relatively rapidly by staff and how valuable it was. What I was concerned about was a little fact dance, and, you know, I think what you're hearing from around the table is a little more context and interpretation. And within that, there was sort of three points I wanted to make.

One is, just to align myself with what, I think,

Herman and others were saying, that, you know, acknowledge that Medicaid is a major -- you know, plays a major role in states in dealing with this problem. But then, this -- Peter started to get at, but I think we really need to explicitly say that, you know, it's not that opioid addiction hits just poor people and that's why Medicaid is there. I mean, opioid addiction -- no one is immune to it. It occurs in all socioeconomic groups and all the rest. However -- and I think this is where the point Kit was making, but I think we can do better.

What the data don't allow us to say is that Medicaid is different from private insurance. You know, X percent of it is due to this factor and X percent of it is due to that factor. But I think there is evidence for various factors, and they've been discussed well across the table. So how much of it is a factor that Medicaid covers a lot of the disabled SSI on disability? If you have pain, you're more -- you know, disability is associated with pain.

Then there is the Medicaid expansion. I think there are some data on benefits in private insurance versus others, and Sara gave an example there. And also the

coding issue, you know, comes in there, if there's differences in practices, and all the rest. And you can look at the Bureau of Labor statistics, the Kaiser Family surveys.

So I think the more, in the beginning, you can set it up, that this isn't -- you know, it isn't a poor people's problem, but because of the nature of Medicaid and the role it plays, for a variety of subgroups Medicaid is really important in serving this, and then go on with the delivery and maybe picking up a bunch on the leadership that is involved in the delivery systems, because like Sheldon, I think, or whoever said it, it really came across to me when I listened to the state people talk, about how much commitment, leadership, moving people around, getting people lined up, is involved in that, and I think if we can pick up a little bit more of that flavor, that might be useful.

CHAIR ROSENBAUM: Great. Thank you, everybody. Thank you for an excellent chapter, an excellent morning, and now we have time for public comment before breaking for lunch.

Any public comment on any of the presentations

this morning?

PUBLIC COMMENT

* [No response.]

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

* [Whereupon, at 11:49 a.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION

[1:05 p.m.]

CHAIR ROSENBAUM: Good afternoon, everybody. We are reconvened for this afternoon and we're going to start with the Medicare Savings Programs, so Kirstin, take it away.

MEDICARE SAVINGS PROGRAMS: ELIGIBLE BUT NOT ENROLLED

* MS. BLOM: Thank you. Good afternoon, Commissioners. Today we're going to talk about the Medicare Savings Programs. Probably not as humorous as the last portion of today, but hopefully interesting updates to some pretty old studies.

I'll start with some background on the MSPs and talk a little bit about eligibility and enrollment in them, in a historical context, and then walk through our analysis. I'll also review several policy options that have been discussed to improve enrollment, some of which we've discussed here before, in deliberations leading up to our March 2015 report, which included a chapter on Medicaid coverage and Medicare cost-sharing and its effects on access to care.

Under the MSPs, state Medicare programs provide assistance with Medicare premiums and cost-sharing. Cost-sharing includes coinsurance, deductibles, and copayments for low-income seniors and adults with disabilities. In calendar year 2013, that was almost 9 million people -- 9 million dually eligible beneficiaries receiving assistance under these programs.

There are four different types of MSPs listed here. They have different income and asset limits associated with each of them, and they help pay for different types of Medicare costs. Of the four, our analysis is going to focus on the first three, the Qualified Medicare Beneficiary program, the Specified Low-Income Medicare Beneficiary program, and the Qualifying Individual program. The final, the fourth program, the Qualified Disabled and Working Individuals program is very small. In 2013, it was estimated to have fewer than 200 people enrolled, and so it was impossible to generate a large enough sample size for our analysis.

This table shows each MSP, including the estimated enrollment in each, as of calendar year 2013, and then the different types of Medicare costs that they help

pay for, as well as income and asset limits. The QMB program, as you can see, is the largest of the MSPs. It's also the oldest. It was enacted in 1989. It helps pay for Part A premiums, Part B premiums, and deductibles, coinsurance, and copayments, for people that have income below 100 percent. Most people don't pay the Part A premium but the people who do buy in, they also have to buy Part B. So just to give you a sense of the costs on the Part A premium in 2017, it's $413 a month and the Part B premium is $134, for a total cost of $547 a month.

Also, you're all familiar with, I think, the state lesser of payment policies, but just as a quick reminder, most states, about 32 as of December of last year, choose to limit their payments to the lesser of the full amount of Medicare cost-sharing or the amount, if any, by which the Medicaid payment rate exceeds the amount already paid by Medicare.

The SLMB and QI programs, as you can see, both cover Part B premiums for people with income up to 135, and then the QI program -- oh, and the QI program is different than the others in that it is fully funded by the federal government.

Before the passage of the Medicare Access and CHIP Reauthorization Act, or MACRA, in 2015, it was subject to regular reauthorizations by the Congress, but it was permanently reauthorized in that legislation.

One final thing to note on this table is the asset limits. You'll see that they're all the same for QMB, SLMB, and QI, and that is because they were updated to align with the Part D Low-Income Subsidy program that is available to people for assistance with prescription drug programs.

So eligibility and enrollment. Low enrollment has been an ongoing concern in the MSPs and has been documented in prior studies, including studies by the Social Security Administration in the late '90s. Only a decade after the QMB program began, the Social Security Administration estimated that 63 percent of eligible individuals were enrolled in both the QMB and SLMB programs. And then, in 2004, a more recent estimate from the Congressional Budget Office estimated that only about a third of eligible beneficiaries were enrolled in the QMB program.

Reasons for this low enrollment are varied.

State Medicaid policies probably have an impact. As you know, Medicaid eligibility requirements vary state by state. States are also able to make the eligibility standards for the MSPs more generous than the federal standards, and so, as a result, a beneficiary might be eligible for an MSP in one state but not in another.

Also, the process of enrolling in Medicaid may be burdensome because of the complexity of the application. A study in 2003, conducted focus groups with low-income seniors, many of whom cited that the Medicaid application and renewal process, especially income verification, was a barrier to enrollment. That focus group also found that many eligible individuals were not familiar with the MSPs or did not think that they would qualify.

Also, GAO has noted that state incentives for enrolling individuals into the MSPs might vary, depending on what level of benefits that person is eligible for. For example, enrolling individuals eligible for full Medicaid benefits into an MSP could reduce state spending by making Medicare the primary payer for certain services, but enrolling partial duals who were only eligible for assistance with Medicare cost-sharing probably increases

state spending.

In 2008, the Medicare Improvements for Patients and Providers Act was passed by the Congress, and this included provisions to try to increase enrollment in the MSPs. It required that the Social Security Administration transfer information from Part D LIS applications, for which SSA determines eligibility, to state Medicaid programs. This was done because the LIS program serves many of the same low-income beneficiaries who were eligible for MSPs. In fact, someone who is enrolled in an MSP is deemed eligible automatically for the LIS program.

MIPPA then required that the state use that information to initiate an MSP application for the beneficiary. SSA told GAO that they transferred almost 2 million applications between January of 2010 and May of 2012.

As I mentioned, MIPPA also more closely aligned the asset limits for the MSPs with the LIS program. It also increased funding for outreach to potential beneficiaries and required that SSA coordinate outreach for LIS and the MSPs.

GAO found that enrollment increased in the first

two years after MIPPA went into effect by about 5 percent in each year, although that increase can't solely be attributed to MIPPA. But states also reported an increased work load. GAO explained that at least 35 states re-verified application information that had already been verified by SSA, particularly related to income.

Also, because many states count income and assets differently from the Social Security Administration, that made it difficult for states to act on the information that SSA had transferred to them. For example, states required that income for each spouse be verified separately, but the LIS application information that SSA was transferring combines the income for a couple.

So with that historical context I'll walk through our analysis. We contracted with the Urban Institute to estimate MSP participation in three of the MSPs: the QMB, the SLMB, and the QI programs. We estimated participation for adults under 65 and over 65 separately, using data from mid to late 2009 and 2010. We also looked at participation rates by state for the combined QMB and SLMB programs for all ages. Because of small sample sizes, about 10 states' results were suppressed.

This analysis set out to update prior studies but also to expand on them, not only by looking at each MSP separately, which hadn't been done before, as well as that state-by-state data, but also by comparing the eligible but not enrolled to the enrolled population, to try to identify characteristics that might predict enrollment, or that might make individuals less likely to enroll. To do this, we linked household survey data from the Survey of Income and Program Participation with administrative data from the Medicaid Statistical Information System. We used the survey data from the SIPP to identify MSP eligibility and the MSIS data to identify MSP enrollment. One important thing to note is that because that data is from 2009 and 2010, it does not include any effects of increased participation from MIPPA.

So we found that participation rates remained low across the MSPs. This table shows our estimated rates for the three programs for adults under and over 65. For each MSP you can see the share of eligible individuals who were enrolled and not enrolled, and we estimate that about 63 percent of adults ages 18 to 64 enrolled in the QMB program and 37 percent did not enroll. You can see that that

percentage goes down for people over 65. For the SLMB program in the same age range, we estimated that about 42 percent of adults enrolled. Enrollment in QI was low across both age groups, with only 18 percent of eligible adults under 65 enrolled and only 14 percent over 65.

There are similarities between our findings on participation and those of prior studies. Although you don't see it on this table, when we look at participation rates for the QMB and the SLMB programs combined, our estimate was about 61 percent compared to SSA's 1999 estimate of 63. And like CBO's 2004 estimate, we found participation rates to be higher in the QMB program than in the SLMB program.

To better understand the low MSP enrollment, we compared adults eligible for QMB and SLMB but not enrolled, with enrollees in those two MSPs, and we studied them together, in part, to increase our sample size, and we found that adults who were enrolled were more likely to be 65 and over, more likely to have slightly higher levels of education, more likely to be white, more likely to be married, and more likely to have private health insurance coverage. I have not included the detailed percentages

here but you have those in your materials.

We also estimated which characteristics might predict enrollment in the MSPs, and we found that enrollment in other public programs was a statistically significant predictor of enrollment. For example, adults enrolled in the Supplemental Security Income program were much more likely to enroll in the QMB program than adults not enrolled in SSI, and the same was true for the Supplemental Nutrition Assistance Program, or SNAP.

We also found that age was a statistically significant predictor of enrollment. Adults under 65 were more likely to enroll in the SLMB program than older adults. Also, people with limitations on their activities of daily living were more likely to enroll.

We also looked at characteristics that might make someone less likely to enroll, and we found that having private coverage, being non-white, having a college degree made people less likely to enroll in the MSPs.

So to recap, we found that enrollment is still low, just like in the studies from over a decade ago. As a result, people who have not enrolled in an MSP that they qualify for might have difficulty accessing their care

because they can't afford the premiums and cost-sharing associated with their benefits, and this raises the question of whether federal policies are needed to address this long-standing issue.

I will go over a few of them that have been raised by other agencies and organizations as ways to reduce barriers and boost enrollment, and as I said, some of these are policies that we, at the Commission, have already gone over. In fact, the March 2015 report discussions led to this analysis that I'm walking through today.

One option that's been discussed is additional education and outreach for beneficiaries. It seems like this could increase enrollment since many studies have found that including the focus groups that I mentioned earlier, that eligible adults are not familiar with these programs. Also, MIPPA increased funding for outreach and GAO found that enrollment did go up, although, as I said, other factors might have contributed to that.

Others have recommended additional support for education and outreach, including MedPAC. Prior to passage of MIPPA, MedPAC recommended increased funding for the

SHIPs, or the State Health Insurance Assistance Programs, which offer counseling to Medicare beneficiaries, local and personalized counseling, and answer questions about benefits and premiums.

Another policy option is aligning MSP eligibility with the Part D LIS program. This has been raised, in part, because the two programs both provide benefits to low-income people and individuals with disabilities. Aligning them would streamline the application process and would allow people to apply for both programs at the same time. MIPPA took a step in this direction by expanding the asset limits, but the income thresholds are still different. Expanding income to 150 percent, to be consistent with LIS, would increase the number of people eligible and it would effectively raise the upper income limit for the QI program, since that's the highest level that there is currently. It also would be fully funded by the federal government since QI is fully funded by the federal government under current law. MedPAC has recommended this is the past, and included it as an illustrative scenario in a June 2016 report on issues affecting duals. It is an approach that would allow more

individuals to access the MSPs and would leave states with the flexibility they have under current law to continue to expand above the federal standards.

Another aspect of aligning eligibility between these two programs would be that income and assets would be counted in the same way, which would streamline the process for beneficiaries and remove the barriers that have been created by re-verifying information that SSA has already signed off on. GAO points out that states have the flexibility under current law to do that, but not all states have done so, in part, perhaps, because it would increase enrollment, increasing state costs. Also, it would create a method for counting income and assets for the MSPs that would be different, perhaps, from how states assess Medicaid eligibility more generally, which could be burdensome for the state.

I wanted to mention here that with regard to the LIS program, we don't have data on the participation rate in that program relative to the MSPs, but that's something that we could look into, and links certainly do exist now between the two programs, as I said, an MSP enrollee is deemed eligible for the LIS program. It is largely the

same pool of beneficiaries.

Finally, an option that has been discussed is federalizing the MSPs. Some people have argued that all health care services for duals should be federalized and transferred from Medicaid to Medicare, as was done with the Medicaid pharmacy benefit. Federalizing the MSPs would make them part of Medicare. This option would require a change to the Medicare statute, which is outside of our purview, but MedPAC has included this idea in several of its reports, although they did not recommend it.

Variations of this idea would make the federal government financially responsible for the benefits that are currently paid for by Medicaid, with states making maintenance of effort payments to Medicare based on their historical MSP spending. MedPAC estimated, in 2016, that this option would increase federal spending and could produce winners and losers among beneficiaries, because of the variation that exists under current law from state to state, where states are able to go above the federal standards. This would create one uniform standard across MSPs.

That concludes my presentation. I'm happy to

take your questions, and am also interested in any thoughts you have on how we might disseminate this information going forward. Thank you.

CHAIR ROSENBAUM: Great. Thanks so much. Questions?

So I'll start us off. Oh, Toby did you --

COMMISSIONER DOUGLAS: No.

CHAIR ROSENBAUM: Are you sure?

COMMISSIONER DOUGLAS: Yeah.

CHAIR ROSENBAUM: So you note federalizing the MSP. So one of the things that struck me as I was reading the materials in preparation for the meeting is whether it might be better to think about it as restructuring the LIS program to cover not only the purchase of prescription drug coverage for lower income beneficiaries but to, in fact, expand to include the other premiums, deductibles, and cost-sharing that Medicaid programs pick up today with a provision very much like what is done all the time under the Supplemental Security Income Program today, which is that states can always supplement, can always be somewhat more generous if they choose to be.

But, you know, whether -- if we were -- if MedPAC

is thinking along similar lines -- let's do something to sort of federalize this system -- to me, the policy question which would require more work from MACPAC and MedPAC together is do you think about this as an expansion of the LIS? Do you think of it as a federalization of the MSP? What are the pros and cons of doing it either way? And because, of course, in the LIS you start with a uniform program that you can then build on. With the MSP, you sort of end up, you know, having to reconcile yourself to the fact of state variation, and does the Medicare Part D program offer the precedent of some sort of a minimum state payment on an ongoing forward basis, but a federalization?

So that's the point that I would raise, is if we are thinking remedially, which I think is incredibly important here, and I would also be interested in knowing how LIS penetration compares to MSP penetration, and whether the characteristics of enrollment are the same or different.

VICE CHAIR GOLD: And that's an important point.

CHAIR ROSENBAUM: I would think of it as it's not just MSP to LIS but the other way around.

VICE CHAIR GOLD: Yeah. I was actually going to

raise that, Sara. I think it's really important to look at. My assumption -- but it needs to be checked -- is that there's more people in Medicare A/B than there is LIS, because some of the people who may be low-income but have good union benefits or other things may have a Part D that's subsidized, and so you disqualify a certain number of those from being able. So you'd want to look at the populations that are captured by that, as well as the logic of the program, which I agree, otherwise makes a lot of sense.

CHAIR ROSENBAUM: Yeah. I think the question is, should we have a unified structure for subsidizing Medicare costs for lower-income beneficiaries, regardless of the state they live in, that should key off of certain key characteristics. And for that reason, I think this represents fertile area for joint work with MedPAC to look more deeply at both forms of subsidization, do the additional research that basically would help inform us. If you were going to move to a more unified subsidy system, which structure may be the better way to go? Which one appears to get better enrollment among the target population, and should states have the flexibility to --

you know, to go above.

CHAIR ROSENBAUM: Toby.

COMMISSIONER DOUGLAS: So the question I have is kind of the intersection with the QMB and the SLMB groups with Medicaid benefits and if there's any analysis just to understand how much that drives enrollment, too, whether they get full Medicaid benefits, because I'm assuming -- I actually don't know for sure. The income levels vary considerably for these groups on the Medicaid side.

MS. BLOM: Right, well, so full-bene duals I think have less incentive to enroll in the MSPs, so I think there's fewer of them in the programs in general. So if a person is a full-benefit Medicaid person, they're probably less likely to be in an MSP.

CHAIR ROSENBAUM: Well, it's paying for -- Medicaid [off microphone].

MS. BLOM: Right, right.

COMMISSIONER DOUGLAS: So is there any -- I mean, but you said -- so maybe this is my lack of understanding. Are some of these individuals getting Medicaid benefits?

MS. BLOM: Yes.

COMMISSIONER DOUGLAS: And is there a way to show

-- I just don't know -- that varies by state, and showing that -- is that a driver or is that a wrong assumption?

MS. BLOM: I'm not sure. I think we could look at that, though. I think we might already have that.

COMMISSIONER DOUGLAS: Okay. Thank you.

CHAIR ROSENBAUM: I have Brian, I have Chuck.

COMMISSIONER BURWELL: Kind of low participation in these programs has long been known from a number of studies, but I'm more curious about the implications of those who are eligible but not enrolled before we make any kind of policy conclusions around how to address that population. They're higher income, they're more educated. You know, they're not the ones at the bottom. They're generally better off. A third of them have private insurance, so there's, you know -- so they have their Part B, those benefits covered, we assume, under private insurance. I just think we need to know more -- what are the ramifications of being eligible but not enrolled? How are these people paying their Part B premiums? How are they paying their Medicare deductibles? Are they just not paying them and the providers aren't collecting them? Or do they have other sources of coverage?

It's a difficult population to research, but I think we need more focused research on that population and how they are accessing -- you know, how are they getting those services covered?

MS. BLOM: Yeah, I mean, we can think about ways to dig more into that. I think to your point, talking about expanding any of the MSPs given how many people are already not enrolling, you know, I'm not -- that's a question. So looking into why the people who are already eligible aren't enrolling is a fair point.

CHAIR ROSENBAUM: Chuck.

COMMISSIONER MILLIGAN: Two things, but the first one is a question. Well, actually, let me start in reverse order.

I think one of the issues for states -- and I haven't sort of intimately been living this recently, but -- is that with limited kind of bandwidth in terms of state priorities and state resources to kind of tackle an issue, a lot of times this wouldn't be one of the higher-priority issues. And one of the reasons, I think, is that -- and this was actually, you know -- I know we're going to be talking about some of the federal form stuff later on this

afternoon, but it was in the Republican governor letter that has gotten some attention regarding the sort of bigger reform discussions.

One of the issues is that the Medicare cost-sharing Part B premiums and so on are increasing at a very high rate year over year, and a lot of that reflects, I think states would argue, unmanaged Medicare and unmanaged kind of utilization, and that the year-over-year increases in Part B premiums over time vastly exceeding medical CPI, CPI state revenue, and so over time, even if the enrollment stays constant, the amount of state tax resources or state general fund resources that are going toward QMB/SLMB-related costs is increasing faster than other rates of growth typically for constant membership levels because Part B premiums have grown, I don't know, 5 to 10 percent a year, I'm guessing.

And so I do think that one of the elements in this discussion and as we kind of think about this and write about this is that states I think see the value from a public policy point of view of helping make this more affordable for people, but I do think that you often hear states talk about the effect on the state general fund to

subsidize a program that is unmanaged, that states have difficulty even in dual demos getting the Medicare side of CMS to manage. And I think that that political science piece of this is kind of missing from the discussion.

The comment I'll come back to then -- and it is sort of more of a question -- is you talked about different options. Part B premiums now are on more of a sliding scale. The wealthier Medicare beneficiaries pay a higher Part B premium. It isn't sort of a fixed Part B premium anymore. One of the options, it seems to me, is to have Part B premiums be on a sliding scale and to have it not be $134 a month and to just have that be part of how the Medicare sliding scale arrangement, like Part B premiums are higher for more affluent Medicare beneficiaries. And I'm wondering whether that is from your point of view an option that is under consideration or could be under consideration.

MS. BLOM: You're saying have the Medicare Part B premiums -- which are already -- can you say that again?

COMMISSIONER MILLIGAN: Well, there's no reason that they have to be $134 a month for low-income Medicare beneficiaries.

MS. BLOM: So I --

CHAIR ROSENBAUM: That's essentially what I was trying to state before, that you could have a much lower premium exposure, whether it's through an overt subsidy or just simply adjust the premium, just like we do in the marketplace.

COMMISSIONER MILLIGAN: Yeah, I mean, the point I'm making is that affluent Medicare beneficiaries don't pay $134 a month for Part B. It's on a sliding scale. It didn't used to be. In the history of Medicare, it's a relatively recent change. But there's nothing that says the floor has to be $134 for somebody at 100 percent of poverty.

CHAIR ROSENBAUM: Yes, that is -- Chuck expressed it much better than I did, which is why are we not focused on lowering the Medicare premium as opposed to using -- coming up with a more efficient way to use Medicaid to supplement the Medicare premium.

COMMISSIONER MILLIGAN: With clawbacks and crazy math -- there's a simpler solution if we're going to do sliding scale premiums, which we're doing.

MS. BLOM: Yeah, I understand. That makes sense

to me. I haven't seen a lot of literature on that, but we can --

CHAIR ROSENBAUM: No, only up, only [off microphone].

MS. BLOM: I'll look into that.

CHAIR ROSENBAUM: Any further questions -- oh, yes, Leanna.

COMMISSIONER GEORGE: I was looking at the table on [off microphone] -- sorry. I forgot about the mic - about the qualified disabled and working individuals program. It says only 200 individuals are in this program. I'm also noticing, though, that the federal asset limits are $4,000 for an individual and $6,000 for married. I'm curious how many people with disabilities who are working would fall within the higher limit set for the lower income, just because I know several people that have disabilities that are working that -- it just feels like they are really struggling as it is. And I'm just wondering if there would be more people that would qualify for the program if those federal asset limits were changed, because it looks like it was set back in 1989.

MS. BLOM: Yes.

COMMISSIONER GEORGE: And that was a long time ago.

MS. BLOM: That was enactment. They haven't been changed since the program began.

COMMISSIONER GEORGE: I don't know if that's something we can do or we should do, but I just want to bring that out.

CHAIR ROSENBAUM: Well, I think the nursing home supplemental payment for out-of-pocket costs is the same today as it was 35 or 40 years ago. I mean, there's so many of these items in the programs that just don't change.

Any other questions?

[No response.]

CHAIR ROSENBAUM: All right. Thank you so much, Kirstin. Good discussion.

We are now up to an overview of the proposed legislation to reform Medicaid, and this is going to be a relatively long and complex presentation by Chris Park because of the -- and Martha, because of all the material that we have to cover -- oh, and Ielnaz. So we have a three-fer here. And so what I suggest we do -- and I think the Commissioners concur -- is that we're going to let the

presenters go through the entire presentation. I am sure everybody is going to have questions, so we will hopefully get in the full presentation and at least two rounds of questions and answers. We have allotted 90 minutes for this session with a short public comment period afterwards.

When we start the questioning, we will just move quickly around the room. Any Commissioner who has questions, staff, to the extent you can answer the questions on the spot, if there is not a readily -- there may be questions for which there's no readily available answer. We should note that as well. So why don't I let you guys plunge in.

MEDICAID REFORM: IMPLICATIONS OF PROPOSED LEGISLATION

* MS. HEBERLEIN: Thank you. So today I'm going to start us off on this three-fer. I'm going to begin the presentation by reviewing our past work examining restructuring federal Medicaid financing and then provide a brief overview of recent legislation. I'll then pass it off to Chris to provide a more detailed analysis of the financing provisions and Ielnaz to discuss additional state flexibility that was provided under the block grant option.

So first a look at our past work on this subject. A chapter in the June 2016 report presented the Commission's initial analysis of the major federal financing alternatives. Then at this year's January and March meetings, we reviewed these alternatives, provided some illustrative examples of the various design decisions, and summarized prior proposals.

Since our last meeting, we have issued two publications. The first was an issue brief based on the presentation in January comparing managed care rate setting, Section 1115 budget neutrality limits, and per capita caps. The second is a set of fact sheets looking at state plan requirements and options regarding eligibility, benefits, and provider payments. Additional fact sheets looking at enrollment and renewal procedures, cost sharing, delivery system design, and premium assistance will be released later this spring.

So looking at the Medicaid provisions of the American Health Care Act. The American Health Care Act was the House-drafted bill to repeal and replace the Affordable Care Act and restructure Medicaid. The Congressional Budget Office estimated that the coverage provisions of the

bill would reduce federal Medicaid outlays by about $840 billion, or 25 percent, over the 2017-26 period. This is about $41 billion less than it would have been without the managers' amendment that increased the growth rate in the per capita cap for the aged and disabled groups that Chris will discuss shortly.

The effect of the legislation would be to lower Medicaid enrollment by about 14 million, or 17 percent, over the 10-year window. Prior to a vote, the bill was pulled from the floor on March 24, 2017. While it is unclear what the next steps will be, we wanted to provide the Commission with an overview of the Medicaid provisions of the legislation, and I just want to note that because this bill was designed to repeal and replace the ACA, there are provisions related to the private market, such as premium subsidy changes, that we will not be discussing here today.

So beginning with the Medicaid expansion, the AHCA would codify that the new adult group is optional. It would also eliminate the option to expand coverage to people with incomes above 133 percent of the FPL as of December 31, 2017.

It would also eliminate the enhanced FMAP for the new adult group as of January 1, 2020. However, in states that expanded as of March 1, 2017, people who are enrolled under the plan on December 31, 2019, and do not have a break in eligibility for more than one month would still be eligible for the enhanced matching rate.

It would also end the enhanced FMAP for childless adults in states that expanded prior to the ACA as of January 1, 2020, and similar to the ACA expansion adults, grandfathered enrollees will still be eligible for the enhanced matching rate, although the legislation would lower what that matching rate is.

The AHCA would also repeal several Medicaid-related provisions that were in the ACA. Specifically, it would end the requirement for states to cover children ages 6 to 18 with incomes between 100 and 133 percent of the FPL in Medicaid, often referred to as the "stairstep provision." It would also end hospital presumptive eligibility which gave hospitals the option to make preliminary eligibility determinations for Medicaid regardless of whether the state had adopted the option for specific populations.

The AHCA would also end the option to use PE for the new adult group and individuals with incomes above 133 percent of the FPL. And I want to note that this is the group that was -- the XX group that was added in the Affordable Care Act.

The AHCA would also end the increased FMAP for home and community-based attendant services and the requirement that the alternative benefit plans include the ten essential health benefits.

The AHCA also included a number of additional Medicaid provisions. It would direct states to count qualified lottery winnings and qualified lump sum income as income over multiple months for MAGI-based determinations. This is as opposed to counting it in the month in which it is received.

The AHCA would also eliminate the state option to establish a higher home equity limit for eligibility for long-term services and supports.

Beginning October 1, 2017, the AHCA would eliminate the requirement that states cover benefits retroactively for up to three months -- a three-month period prior to the month of application if the individual

would have been eligible during that period if he or she had applied.

It also requires individuals in the new adult group or that group I mentioned before with incomes above 133 percent of FPL to have eligibility redetermined at least every six months.

Finally, it establishes a state option to require non-disabled, non-elderly, non-pregnant individuals to meet work requirements in order to receive Medicaid. States will receive a five-percentage-point increase in their administrative FMAP for activities related to implementing this work requirement, and states would also receive a time-limited five-percentage-point increase in their administrative FMAP for costs attributed to implementing the six-month renewal period.

The AHCA would repeal the DSH allotment cuts for non-expansion states that were scheduled to begin in 2018. For expansion states, it would keep the scheduled DSH allotment cuts in place for FY2018 and 2019 but repeal the cuts scheduled to begin in 2020.

The AHCA would also provide a $10 billion pool over five years to allow non-expansion states to make

additional payments to providers for services at 100 percent of the FMAP for fiscal years 2018 to 2021 and 95 percent in fiscal year 2022. Payments could not exceed providers' cost for services provided to individuals who are eligible for Medicaid or who are uninsured, and the allotments would be proportionate to the share of the population below 138 percent of the FPL among the non-expansion states.

Finally, the AHCA would shift federal Medicaid financing from an open-ended matching to a per capita cap system. States would have the option to use a block grant for coverage of non-disabled, non-elderly, non-expansion adults or these adults and children.

I will now pass it off to Chris to discuss these alternatives in more detail.

* MR. PARK: Thanks, Martha.

My presentation will describe the per capita cap and block grant provisions in the AHCA, and I'll provide a few illustrative examples of how certain elements in the calculations may affect the calculation of per capita cap, including the enrollment mix, level of supplemental payments, and the different growth factors used.

The next few slides are on the per capita cap calculation. Several populations are excluded from the per capita cap, including limited-benefit enrollees and those receiving services under Indian Health Services. For these excluded groups, Medicaid financing continues under current law, which is the open-ended financing structure. These groups account for about 15 percent of the Medicaid financed population in fiscal year 2013, and also enrollees who are covered under the block grant option would be excluded from the per capita cap.

The per capita cap also excludes some expenditures such as DSH and Medicare cost sharing. In addition, the additional funds that Martha just mentioned that are available to non-expansion states to increase provider payments are also excluded.

The per capita caps are established for the major eligibility groups, including the new adult group. I should also mention throughout the bill when they mention the number of enrollees used the calculation, this is an average monthly enrollment figure or a full-year equivalent.

Their per capita cap calculation uses two base

years of experience: fiscal year 2016 and fiscal year 2019. The per capita cap is generally based off of fiscal year 2019 enrollment and spending experience, but it's constrained by fiscal year 2016 experience in two separate steps. The first is the amount of non-DSH supplemental payments included in the cap is based on the proportion of these payments in fiscal year 2016, and the second, fiscal year 2019 actual spending gets compared to fiscal year 2016 spending that's been trended forward at the medical care component of the Consumer Price Index. And I'll talk a little bit more in detail on these two adjustments later.

As I mentioned, generally speaking, CPI medical is a basis to trend the per capita caps forward except for once you get to 2019 and going forward, the aged and disabled groups get an additional one-percentage-point increase on their trend.

Fiscal year 2019 enrollment and spending is calculated for each enrollment group. Spending is also calculated to exclude non-DSH supplemental payments, and non-DSH supplemental payments includes those supplemental payments made under the upper payment limit and those made under Section 1115 waiver expenditure authority.

So this is the first adjustment that I mentioned before, and this is where the 2016 data is used to adjust the non-DSH supplemental payment amount. As part of the calculation, the ratio of non-DSH supplemental payments to total spending in fiscal year 2016 is calculated.

This fiscal year 2016 ratio is then used to gross up the fiscal year 2019 spending that excluded non-DSH supplemental payments for each enrollee group. This basically locks in the 2016 relationship between non-DSH supplemental payments to total spending for future years.

The other adjustment based on 2016 experience takes the overall spending per enrollee in 2016 and trends it forward to 2019, using the CPI medical trend. This amount is multiplied by the number of enrollees in fiscal year 2019 to get the calculated or projected 2019 spending amount. This projected spending is then compared to the actual 2019 spending to calculate a ratio, and then this ratio gets applied to the supplemental payment adjusted 2019 spending per enrollee that I just mentioned on the prior slide to get a provisional FY 2019 per capita target amount for each enrollment group.

Going forward, the first capped year spending is

fiscal year 2020. The provisional 2019 per capita target from the prior slide for each enrollment group is trended forward to 2020 by the applicable trend factor that I mentioned before, either CPI or CPI+1 for the aged and disabled groups.

The 2020 per capita amount for each enrollment group is multiplied by the respective enrollment in that category and then summed all together to calculate a total target for medical assistance expenditures.

If a state spends more than this target on total spending, then the federal share over the target amount gets offset the following year on a quarterly basis. This is an aggregate comparison. So a state may spend more than the per capita target for a particular group and less for others, but total spending across all groups is limited to the cap.

So the following illustrative examples are based on fiscal year 2013 data from the Medicaid statistical information system and CMS 64 data, and these are the data we use in our MACStats data book. Because 2013 doesn't include the new adult group, we also use fiscal year 2015 data from CMS 64 enrollment and spending data for the new

adult group, and then we use spending per enrollee and enrollment trends from the CMS Office of the Actuary's 2016 actuarial report on Medicaid as the basis for our trends.

So the first thing I want to talk about is enrollment mix. Because the adjustments made on the fiscal year 2016 data are based on the overall spending per enrollee, it doesn't fully take into account the effect of enrollment mix and the associated spending per enrollee.

Here, you can see the CPI medical trend versus the projected trend in spending for spending per enrollee for each of the five different eligibility groups. You can see that the aged group and the new adult group are -- the aged group is right at the CPI medical trend, and the new adult group is lower, and the trend for the disabled, children and the non-expansion adults is higher than CPI medical.

Because of this, the actual fiscal year 2019 spending for a state with a high proportion of the disabled, children and non-expansion adults is more likely to exceed the trended fiscal year 2016 amount compared to a state that had more of the aged or new adult groups.

So to show how these differences across

enrollment groups could impact a per capita cap calculation, we created an example of an expansion versus non-expansion state. For these examples, we used the same total number of enrollees and the same spending per enrollee for each enrollment group. The only difference comes in the changes in enrollment mix that occur because enrollment in the new adult group in the expansion state.

Because the trend for the new adult group is projected to be less than CPI medical, the proportion of enrollment in the new adult group affects that 2016 to 2019 spending ratio used in the calculation.

So here is the example for a non-expansion state. Going through the math, which I won't go through in detail, the calculated trended 2016 to 2019 ratio is 98.6 percent, which means that the trended 2016 amount was 1.4 percent less than the actual 2019 spending, and thus, the per capita cap calculation would be reduced compared to the actual 2019 experience.

Here is the example for an expansion state. We'd still have the same 6.2 million enrollees that we had on the prior example, but we've changed the enrollment mix to account for the new adult group, which is a little over a

quarter of the enrollment.

The calculated 2016 to 2019 ratio here is 102.4 percent, which means the trended 2016 amount was 2.4 percent higher than the actual 2019 experience, and so the per capita cap calculation would be increased compared to the actual 2019 experience.

Because the actual spending per enrollee for new adults went down from 2016 to 2019, the enrollment mix gives the expansion state an increase in the calculation where the non-expansion state would get a decrease in these two examples.

And this is the same expansion state, except for there's been a 20 percent reduction in enrollment into the new adult group between 2016 and 2019, and because of this reduction -- and it changes the enrollment in 2019 away from the new adult group -- you can see that that ratio is now 100.4 percent versus the 102.4 percent shown on the prior slide.

These next few examples are on the non-DSH supplemental payment adjustment. As mentioned before, the per capita cap calculation locks in the overall proportion of non-DSH supplemental payments to the levels seen in

2016.

Like overall spending, states' proportions on non-DSH supplemental payments to total spending is variable from year to year. The per capita cap also applies the same non-DSH supplemental payment proportion to each enrollee group, which may be different from how a state would choose to distribute those payments across groups and could shift some spending between groups in terms of calculating the per capita caps.

So this chart shows the proportion of non-DSH supplemental payments to the total payments for a few years, from fiscal year 2012 through 2015. I've shown similar charts in the past. The important takeaway here is that the ratio of non-DSH supplemental spending for any given state can vary substantially from year to year, and here, I've highlighted three states. State A, which is that light blue line, you can see it steadily increases over this time period. State B, which is the green line, goes up and down, so that the odd years a higher proportion of supplemental payments than even years. And State C, which is the red dashed line, reached a peak in 2013 and then decreased from then on to 2015. As you can see, the

AHCA's provisions locking in a particular year's relationship can have different effects on different states.

And so here is an example of the non-DSH supplemental payment adjustment, assuming that non-DSH supplemental payments were 10 percent of total spending in fiscal year 2019. This first example under the calculation is similar to State A, where there's been an increase from 2016 to 2019, and so it increased from 5 percent in 2016 to 10 percent in 2019. And you can see that making this adjustment back to the 5 percent level seen in 2016, lowers spending per enrollee and, thus, the per capita cap calculation.

The second example is similar to State C on the prior graph, where they used -- non-DSH supplemental payments decreased from 2016 to '19. So this example says there was 15 percent non-DSH supplemental payments in 2016, and it decreased to 10 percent. So adjusting back to that 15 percent level actually increases the per capita cap calculation compared to the actual 2019 experience.

Here, this chart shows the projected spending per enrollee growth for each of the enrollment groups compared

to the trend used in the AHCA for fiscal years 2020 through 2025. The bolded numbers show where the trend is greater than the AHCA trend. You can see that for children and non-expansion adults and the new adult group, these are all higher than the AHCA trend for each year. For the aged and disabled, that additional 1 percentage point helps keep the trend either at or very close or even below the AHCA trend. And you can see that the aged group for every single year is lower than the AHCA trend.

So going back to the enrollment mix discussion I had before, under these trends, a state with a higher proportion of children and adults will have a harder time staying under the cap going forward.

For the block grant, there is an option for a 10-year block grant starting no earlier than fiscal year 2020. Block grant funds can only be used to provide health care assistance to those covered under the block grant, and Ielnaz will talk about this in her presentation a little later about what health care assistance actually means. The block grant can be used for the non-elderly, non-disabled, non-expansion adults only or those adults and children.

So for the calculation of the block grant, for the initial fiscal year, you take the target per capita and medical existence expenditures for that year for each enrollment group as calculated under the per capita cap formula, multiply that by the number of enrollees for that enrollment group for fiscal year 2019, and then to calculate the federal portion of funds available under the block grant, you would multiply it by the average FMAP for fiscal year 2019.

For future years, the block grant amount is increased by the consumer price index for all urban consumers, or CPI-U, which is projected to be lower than CPI medical trend use for the per capita cap calculation. Any unused block ground amounts may be rolled over to the next fiscal year.

States draw down from the block grant amount based on the CHIP enhanced FMAP rate for that fiscal year. The state is responsible for the remaining balance to provide health care assistance during that year.

The higher FMAP used for drawdown means that federal dollars from the block grant will be fully dispersed before a state reaches the projected total amount

of spending.

So this graph shows -- kind of just demonstrates that. So going along the x axis is the state spending as it moves from zero dollars to $100 million and total projected spending in this example. Because this is a 50 percent FMAP state, there is a $50 million federal block grant amount.

By drawing down at 65 percent, you can see here at the dotted line, the federal funds would run out when the state reaches around $77 million, and so anything to the right of that dotted line means that spending is comprised solely of state spending only.

And so because of this faster drawdown, a state may make decisions to spend less than a projected amount, because that last bit of spending is all state dollars. Additionally, the faster drawdown makes it harder for a state to roll over any block grant funds to the next year, because they would have to be to the left of that dotted line for there still to be some federal funds remaining.

And this is just a similar example but with a 60 percent FMAP state, and you can see that the state will exhaust the federal block ground amount at a later point,

which is around $83 million out of the $100 million example.

In here, this chart shows the spending and enrollment growth by enrollment group for fiscal years 2021 through 2025, and you can see that the projected total spending for children and the non-disabled, non-elderly, non-expansion adults is higher than the CPI-U trend used under the AHCA for the block grant portions. And so going forward, it will be hard for a state to maintain the block grant levels.

And with that, I will pass it over to Ielnaz.

* MS. KASHEFIPOUR: Okay. I am going to walk through some of the other parameters of the AHCA's block grant option, the non-financing provisions. So unlike the per capita caps proposal, the block grant --

CHAIR ROSENBAUM: Put the microphone in front of you.

MS. KASHEFIPOUR: Am I not speaking into it? Sorry about that.

Unlike the per capita caps proposal, the block grant option offers enhanced state flexibilities in a number of areas listed on this slide.

I will go through each of these in a moment and describe the differences between the block grant option and current law.

It is not clear what, if any, additional federal rules regulating block grants, waivers, or state plan amendments would accompany implementation of the block grant option. Also, in this presentation, I have left out a discussion of the flexibilities under current law that states can access through the state waiver process.

Eligibility. As Chris and Martha mentioned, under the block grant option, states would have the option to cover children and non-elderly, non-disabled, non-expansion adults, or the adults only. If children are included, the state would have to cover deemed newborns and currently mandatory children. If the adults mentioned are included, the state would have to cover currently mandatory pregnant women.

Current law includes a broad range of mandatory and optional eligibility groups. I don't mention them all here, but there is a list of mandatory and optional populations under current law in your binder under Tab 9.

Current law also includes aspects of eligibility

in addition to the categorical and financial definitions of eligibility. For example, there are requirements affecting the application process, such as the requirement for timeliness, under which eligibility determinations must be made within 45 days, or 90 days for disability-based applications. There are guidelines for counting income and household size, such as the requirement to use MAGI, as well as other requirements such as retroactive coverage and 12-month eligibility renewals.

Benefits. Under the block grant option, states would have flexibility to specify benefits, except that they must provide the items and services listed on the left-hand side of the slide.

Under current law, certain benefits are mandatory, and many benefits may be provided at state option. I've listed some of the federal mandatory benefits on the right-hand side of the slide, those relevant to the populations that could be covered under the block grant option.

Examples of optional benefits that all or nearly all states currently provide include prescription drugs, optometry services, and prosthetic devices. A list of

mandatory and optional benefits under current law is also included in your binder under Tab 9.

Scope of coverage. Under the block grant option, states would have flexibility to specify types of services as well as the amount, duration, and scope of those services. Under current law, states have flexibility within federal guidelines to define benefits packages, breadth of coverage, and utilization management strategies, such as prior authorization to manage adult enrollees' use of certain services.

For children, the EPSDT requirement limits the extent to which states may apply criteria other than medical necessity to covered benefits.

Additionally, under current law, in general, states must offer the same coverage to all enrollees, known as the comparability rule, offer the same benefits throughout the state, known as the statewideness rule, provide freedom of choice of provider, and comply with mental health parity requirements.

Premiums and cost sharing. Under the block grant option, states would have flexibility to specify cost sharing for covered services. It is not clear how plan

premiums would be affected.

Current law includes a number of financial protections, such as eligibility groups and services that are exempt from cost sharing and eligibility groups that are exempt from premiums. For example, under current law, premiums may not be charged to children and pregnant women with family incomes below 150 percent of the FPL, and cost sharing may not be charged for children with family incomes below 133 percent of the FPL. Cost sharing also cannot be charged for certain services, such as preventive services for children and emergency, family planning, and pregnancy-related services.

Overall premium and cost sharing amounts for a family may not exceed 5 percent of household income, and balanced billing is also prohibited.

Provider payments. The block grant option does not mention provider payments specifically but does say that states would have flexibility to specify the method for delivery of health care assistance under a block grant option.

Under current law, states have considerable flexibility to design their own Medicaid payment methods

and set their own payment rates. In general, federal statute requires Medicaid provider payments under fee-for-service to be sufficient to provide access to care, equivalent to the general population, and managed care capitation payments to be actuarially sound.

Current federal requirements also seek to ensure that states pay providers timely and accurately and are compliant with conditions for payments to certain provider types, such as the use of the prospective payment system to pay FQHCs. Federal rules also include certain payment prohibitions and limits, such as upper payment limits.

State plan approval. Under the block grant option, the state would have to submit a plan to HHS specifying the applicable block grant category or categories to which block grants would apply; the conditions for eligibility; the types of services, amount, duration, scope, and cost sharing for such services; and the delivery system to be used. The plan would be deemed approved unless the Secretary determines within 30 days that the plan is incomplete or actuarially unsound. The plan is then in place for a 10-fiscal-year period, at the end of which it can be extended for a subsequent 10-fiscal-

year period.

It is not clear whether states would be able to make changes to the state plan within the 10-year period and whether state plan amendments or waivers would be needed to make such changes.

Under current law, every state must have a state plan submitted by a single state agency and approved by CMS that describes the state's administrative structure and operations; indicates which optional group services or programs are covered; and describes the state-specific standards to determine eligibility. Methodologies for provider payments and processes to administer the program.

Finally, accountability and oversight. Under the block grant option, a state would be required to contract with an independent entity to conduct annual audits of its expenditures to ensure that funds are used consistent with the terms of the statute. The state must make such audits available to HHS upon request.

Under current law, states are required to implement a number of federal program integrity provisions related to overpayments and recoveries, routine audits of cost-related payments, and suspension of payments when

there is potential fraud. States submit files to CMS each month with eligibility and paid claims details. States also submit quarterly expenditure reports and periodically report data on enrollment and eligibility performance indicators, children receiving EPSDT services, drug utilization and payments, and managed care enrollment.

This concludes our presentation, and we can take questions and look forward to your discussion.

CHAIR ROSENBAUM: Thank you, and thank you, Ielnaz. I pronounced your name wrong.

MS. KASHEFIPOUR: That's okay.

CHAIR ROSENBAUM: My vision is failing me [off microphone].

Let me find out, who would like to start the questioning, and we will just proceed clockwise around.

VICE CHAIR GOLD: Are these technical questions?

CHAIR ROSENBAUM: Yes. These are technical questions. Everything that we're asking is designed, at this point, of sort of understand. So would you like to start?

VICE CHAIR GOLD: Yeah. I want to throw something back at Chris, because it was hard to follow some

of the analysis and it's certainly crucial.

I want to go back to when we were reviewing information to write our report to Congress, I guess it would have been last June, and we were comparing per capita caps to block grants. And if I recall, you know, the per capita cap idea was that states would continue to be paid fully based on enrollment changes and changes in enrollment mix, and, in a way, you know, as opposed to the block grant, when all those things -- you know, instead of money, and you could lose it. But -- and most of the growth so far has been in eligibility or in enrollment mix. So, you know, the question was how much that would save.

But as I was looking through the way the calculations are done and the way the legislation is written, the question I have is, how much on the hook still -- I mean, is there still that flexibility or is spending constrained if you -- it seemed like you were saying that some states who might change their enrollment some way had more -- would do better than other states who might change it another way, and that the trending forward from 2016 to 2019 locked in certain things.

And then there was -- I don't know if there's a

roll-up. I'm not asking it very well, but the question is, is it really the case, when you run the numbers through, the way you did it, that the per-capita cap makes -- leaves states unharmed by changes in enrollment mix and enrollment numbers.

CHAIR ROSENBAUM: Well, and a put a slightly different way, or added to that, can you please define the term "excess"? I want to know what a state's excess expenditure is. Is it dollar spending per person or is it excess over projected enrollment.

MR. PARK: It is the per capita cap targets that were calculated per enrollment group, multiplied by the enrollment in that enrollment group, and then you sum all that together. So you get the total spending for the state across all of those enrollment groups, and that would be -- you know, based on the per capita cap amounts, that would be your target total spending. And then the state, in 2020, would submit their CMS-64 and say this is how much we actually spent. And then at the end of 2020, you would see how much their total spending is in 2020, compared to that kind of target amount. So if their target amount, say, was $1 billion and they spent $1.1 billion in 2020, then the

following year you would take that $100 million and offset the federal share -- so we'll just say 50 percent, for simplicity. So you would have $50 million going forward.

CHAIR ROSENBAUM: Let me stop before you get into recoupment. Is the excess -- could the excess result from more enrollees versus more cost per enrollee? That's what we want to know.

MR. PARK: Yeah. So it should not -- you know, there shouldn't be an excess in terms of the number of enrollees. Like if you were able to match your target spending per enrollee group that was set, it doesn't matter how many enrollees you get in that group, you will still be at the cap. And so in terms of taking into account enrollment and changes in enrollment mix, from 2019 forward, it does take into account enrollment mix and changes in enrollment mix.

Where enrollment mix can come into play is these adjustments back to 2016, and because the adjustments back to 2016 are not done at the enrollment group level, but only -- you take the total spending per enrollee across all groups in 2016, and compare that to kind of the spending in 2019, that's where some shifts in enrollment mix and the

trends between the different enrollment groups --

CHAIR ROSENBAUM: -- could change the rates.

MR. PARK: -- could change the rate, in terms --

CHAIR ROSENBAUM: It's like a rate-setting system.

MR. PARK: Yes. So in terms of developing that initial 2019 amount, there are some places where changes in enrollment mix could affect the calculation.

CHAIR ROSENBAUM: Well, would the aggregate -- if, suddenly, you had a surge in, say -- I was just at the CDC the other day and we had a presentation, a very depressing presentation on Zika. And there are places where there are surges in infants with certain characteristics. What happens if that surge happens after your base year? And if you had an unexpectedly high number of enrollees -- so two different scenarios, one being characteristic shift within the enrollment groups and their service consumption shifts, and the other being just a surge in enrollees within a group.

MR. PARK: Just a surge in enrollees should be accounted for, if those enrollees who came in were similar cost to what the cap was set at.

CHAIR ROSENBAUM: Got it.

MR. PARK: If it's a different mix of enrollees -- so these, as you mentioned, children from Zika, if they are higher cost, then, you know, it wouldn't -- anything above medical CPI trend wouldn't be taken into account, going forward, with the cap.

CHAIR ROSENBAUM: So why don't we move -- Gustavo, go right ahead.

COMMISSIONER CRUZ: I have question about the benefits that are under the grant. I'm naturally very surprised and concerned that all health services for children are not mentioned at all, in this summary. So I want to know if it's the intention of this legislation to eliminate all services for children, or is this, from your read, is embedded into something? Because that would be a major change in the Medicaid program with devastating consequences for children and their oral health.

MS. KASHEFIPOUR: Oral health. So all it says in the legislation is health care for children under 18 years of age. It's unclear what services are included. EPSDT is not mentioned, so we don't know exactly what --

COMMISSIONER CRUZ: And that's a really major

concern for services for children. And not only that, but will it create a disparity within federal programs, because the children that are enrolled in CHIP will receive oral health services, and the children that are enrolled in Medicaid apparently would not.

CHAIR ROSENBAUM: Stacey.

COMMISSIONER LAMPKIN: Do I understand correctly that the way the per capita caps work is a ceiling, so that if a state, in fact, spends less than the per capita cap it may get an extra year to continue to spend that money, but then if it doesn't, because it's implemented some wonderful cost-saving arrangements, then the Fed fully shares in the savings that the state realizes. Is that the right way to think about it?

MR. PARK: That's right. It's a ceiling, so that if the state came in under the per capita cap, they wouldn't necessarily have any additional funds to roll over to the next year. Under the block grant, there is a provision where they could use some of the unused funding.

COMMISSIONER LAMPKIN: And so if, in year one, they spend below the per capita cap and they have some funds left over than can be spent in year two, that can be

spent on services delivered in year two. It's not a claim lag or anything like that, where they're still paying on claims related to year one. It could be new money, in effect.

MR. PARK: That is a good question. I'm not sure, because everything is based on the CMS-64, and that is based on the payment date. And so I'm not sure whether -- yeah, I think in terms of claims lag, if it was incurred in one year and was paid the next year, it would count for the next year's cap.

CHAIR ROSENBAUM: I have --

MR. PARK: It depends if it -- okay.

CHAIR ROSENBAUM: -- Penny, Chuck, Peter, Alan.

COMMISSIONER THOMPSON: Yeah. So we're just trying to get some clarifying questions here. Right? I just want to touch on a couple of other points.

So just to be clear, under either the per capita cap or the block grant, there's still federal matching for state expenditures. Right?

MR. PARK: Yes.

COMMISSIONER THOMPSON: I mean, there's different systems by which that's constrained, but there still is the

existing system of states come up with their share, they make expenditures, federal government match, that still is operating underneath of that. I just want to clarify that.

MR. PARK: Yes.

COMMISSIONER THOMPSON: You mentioned in things that are outside the cap, individuals enrolled in premium assistance. What is the definition of that?

MR. PARK: So I'll let that -- I'll give that to Martha.

MS. HEBERLEIN: So -- sorry, let me go back. So when you -- let me find the actual verbiage. So it says individuals enrolled in premium assistance and it says -- it references 1906 and 1906A --

COMMISSIONER THOMPSON: Okay.

MS. HEBERLEIN: -- and so that would be employer-sponsored insurance. So it's unclear whether or not that would include some of the waivers that have picked up -- well, exchange coverage would be -- is the bigger thing. So it's not the 190 -- it doesn't reference 1905. It just says 1906 and 1906A.

COMMISSIONER THOMPSON: Okay. Thank you. And then just to -- you know, when we talk about the adjustment

for non-DSH supplmentals, it seems logical that I think I understand what they're trying to do there. Right? I mean, they're trying to avoid a state being able to just push out a whole lot of dollars in order to inflate the base that becomes used for the per capita. Right?

But is there a different effect? So we've talked a lot about the issue of base years and variations. Is there a big difference if you do this on one year versus three years, or if you apply the caps over one year versus, say, three years? I mean, some of this variation issue can get smoothed out, to some degree, at least, by the multi-year approaches, both with the base year and then with re-basing, and then with the attribution of savings over a period of years, so that if something happens in one year you can kind of recover from that the next year without necessarily having to send cash back to the federal government, which is always a little bit of a difficulty.

MR. PARK: Sure, and I went back to this graph. This is only a four-year period, but you can see that if you took the entire four-year period, State B, that smoothing amount, would help --

COMMISSIONER THOMPSON: Yeah. Okay.

MR. PARK: -- in terms of, you know, picking one particular year. State A, I think you would, you know, still have a similar result --

COMMISSIONER THOMPSON: Yeah. Right.

MR. PARK: -- because they're continuing to see growing. State C, you know, again, there's these weird patterns. So smoothing can definitely help smooth out the variation but depending on that particular two, three, however many year window --

COMMISSIONER THOMPSON: Okay. Yeah.

MR. PARK: -- you could still have some variation that occurs.

COMMISSIONER THOMPSON: And then just the last question, weren't -- so is there any money -- so one of the other things that we talked about -- we've talked about it with CHIP. We've talked about it with respect to this -- is that, you know, if you're expecting states to change behaviors, if you're expecting states to be able to adjust to something that could be, you know, a significant pressure on them, and you want them to respond by improving program performance, or improving program efficiency, as opposed to, you know, other steps to control costs, which

could just be cover less people, pay providers less, et cetera. If you preferred to try to emphasize efficiency and performance, that needs time.

Is there any pool of money contemplated here to infuse some dollars into the states to help them get ready, help them accelerate some of the stuff that they have in progress?

MR. PARK: There was some additional funding in terms of administrative -- increases in match, to, at least to improve the data systems in order to calculate and provide the data that was required for the per capita cap, but there were no specific, like, bonuses or anything for quality.

COMMISSIONER THOMPSON: Okay. Or up-front funding to get ready.

MR. PARK: Correct.

COMMISSIONER THOMPSON: Thank you.

COMMISSIONER GORTON: Chris, if can just --

CHAIR ROSENBAUM: -- follow up --

COMMISSIONER GORTON: -- I just want to follow up on this point because my question, I have a couple but they're about the administrative piece. So -- because as

we have discussed many times, there are a variety of these other administrative adjustments that encourage states to pursue behavior that people like. Right? So there's the IT system upgrades that we incentivize with enhanced FMAP. There's care management systems that we incentivize with enhanced FMAP. And I want to focus -- I think I heard you say, and I think I read in this sort of complicated piece of legislation, about the enhanced FMAP that could be directed towards states that undertook the administrative burden of implementing this work requirement, that people have contemplated.

And I guess my question on that is, the numbers are 5 percent, that I've read -- I think you said that as well today -- and I'm wondering, does MACPAC have data, does anybody have data that says that that 5 percent is the -- I mean, a 5 percent bump in FMAP is real money. And so my question is, is that the right amount of funding? Is that what states need to implement a work requirement? Has anybody done that analysis?

MS. HEBERLEIN: I don't know that anybody has done that analysis. It's a 5 percentage point but it's just in the administrative FMAP. It's not across the board

--

COMMISSIONER GORTON: Okay.

MS. HEBERLEIN: -- and it's only tied to the expenditures for implementing that work requirement. So whatever --

COMMISSIONER GORTON: Okay.

MS. HEBERLEIN: -- the state is doing in order to, you know, track people, to connect them to job services, whatever the state is doing, it would be 5 percentage points on that administrative matching rate.

COMMISSIONER GORTON: Okay. Thank you. That's very helpful.

And does --

EXECUTIVE DIRECTOR SCHWARTZ: And it's not for job training.

CHAIR ROSENBAUM: Right.

EXECUTIVE DIRECTOR SCHWARTZ: It's just for --

CHAIR ROSENBAUM: -- to implement --

EXECUTIVE DIRECTOR SCHWARTZ: -- it's just to implement and track the fact that you verified that someone is working, is in the right kind of training program, and if you do --

COMMISSIONER GORTON: Okay. Okay.

EXECUTIVE DIRECTOR SCHWARTZ: -- but it's not to actually --

COMMISSIONER GORTON: -- not to implement the job training --

EXECUTIVE DIRECTOR SCHWARTZ: -- not to pay for the training.

COMMISSIONER GORTON: Okay. Thanks. That's helpful. And along that line, I remember we went through this when the work requirement was added, in some places, for TANF. Do we have some sense about what -- of the adults currently in the program, not in the excluded groups, obviously, what percent of them work now? I mean, do we have good information that says that, you know, what the numbers are? Because I guess I would be interested in knowing -- we had a conversation earlier about return on investment. If we're going to put a requirement in, that costs a substantial amount of money to operationalize, and I would also include the contemplative requirements around cost-sharing that some people have entertained.

The administrative overhead for those requirements is substantial, and I guess, do we have a

sense about what would change by putting these requirements in? What we would gain? How many people would go to work? Have you seen analyses about that?

MS. HEBERLEIN: There's been a few recent Health Affairs blogs, and I'm not going to remember the numbers exactly so I'm happy to share those with you after this. But a fair number of Medicaid enrollees are currently working or are in households who are working, and those who are not often have reasons why they're not. For example, they're, you know, caring -- they're a caretaker, they're going to school -- and some of those exemptions, the work requirement follows the TANF rules, and some of those exemptions, you know, if you are a single parent of a child -- a young child under the age of six, you wouldn't be subject to the work requirement.

So some of those people may be excluded from the work requirements, but there's been some recent studies that have shown the number of Medicaid enrollees who are currently working, and we can get you the specific on those. I don't have them with me.

COMMISSIONER GORTON: And we could provide them to the broader conversation in an issue brief or something.

I just have one last question and it follows up on yours and them I'm done. I just want to be certain that I understand, Chris, what I think you were saying, which is to the extent that there is any, air quotes, broadly defined risk adjustment in this rate-setting methodology, or per capita cap setting methodology, it's really embedded in the eligibility groups. But there's nothing contemplated, that we're aware of, that would allow for -- in Sara's case, the Zika example, right -- a substantive change in the risk profile of a state's population that didn't involve a change in the numbers in an eligibility group. So whether on a -- on a preexisting basis you could argue that if they always had excessive numbers of hepatitis C cases, then that would be built into the base and somehow allowed for. But if there was some substantial shift in their experience --

CHAIR ROSENBAUM: Like opioids.

COMMISSIONER GORTON: -- opioids is a great example but hepatitis C is not a bad example because some states were all in, in terms of buying Sovaldi, and Norma's great state of Texas said, "Hell, no." You know, everybody for the right reasons. But that changed the total cost of

care in those eligibility groups substantially, and I haven't heard, and I just want to validate, that nobody has contemplated a mechanism for dealing with that in this per capita cap rate-setting methodology.

MR. PARK: That's correct. There's nothing in the ACA that would take into account, like diagnostic risk adjustment, for example.

COMMISSIONER GORTON: Okay. Thank you.

CHAIR ROSENBAUM: I have Chuck, Peter, Alan, Brian, Andy, Toby, Sheldon.

CHAIR ROSENBAUM: Sheldon -- Chuck.

COMMISSIONER MILLIGAN: And this is just on the technical question round even.

CHAIR ROSENBAUM: Yes, it is, but not the lightning round.

COMMISSIONER MILLIGAN: Yeah. So I'm going to ask just clarifying questions. You mentioned excluded expenditures. I want to just test whether -- or ask whether there's others that are material that are not on the list, just that you had to sort of highlight the big ones, so things like GME and -- I'm wondering what other big things aren't -- or is GME considered supplemental?

I'm trying to figure out other big buckets, how they're treated, that you don't on this slide have time to mention.

MR. PARK: Right, and so these were the ones that were specifically called out in the legislation, and so GME was never mentioned, so my assumption --

COMMISSIONER MILLIGAN: We don't know whether it's treated like DSH or treated like supplemental --

MR. PARK: My assumption right now would be that it is included as the non-DSH supplemental payment adjustments.

COMMISSIONER MILLIGAN: Okay. Somebody mentioned earlier different FMAPs for different things. There are certain FMAPs that apply to like Indian Health Services payments where it's 100 federal. I'm wondering if you know special treatment or whether they would be retained or not retained, whether that's an exclusion or not for things like that.

MR. PARK: Yeah, so in terms of Indian Health Services, all those individuals would be carved out, and so their associated spending would also not be part of the per capita cap.

COMMISSIONER MILLIGAN: Okay.

MR. PARK: In terms of other specific --

COMMISSIONER MILLIGAN: So it relates to the population, not the provider type, but we think it would align.

MR. PARK: At least in terms of like Indian Health Services. There are other things that, you know, I don't -- I can't think of them offhand where they maybe would be receiving an additional FMAP bump. But those were not specifically mentioned.

COMMISSIONER MILLIGAN: Okay. Penny asked -- and I want to ask -- make sure I'm tracking.

VICE CHAIR GOLD: Chuck, talk into the mic.

COMMISSIONER MILLIGAN: Okay. So the block grant or per capita, the state is coming up with its share sort of like a matching program that's not an MOE version of a block grant. Correct?

MR. PARK: Correct.

COMMISSIONER MILLIGAN: And are there any prohibitions on the source of state funds, like does it touch on some of the provider tax controversies? And are there issues about how the state comes up with its source of financing?

MR. PARK: Generally speaking, there's no prohibition, but there was one provision specifically -- if you go through the language, it was targeted towards New York.

COMMISSIONER MILLIGAN: Yeah, the county-specific --

MR. PARK: Right.

COMMISSIONER MILLIGAN: Okay.

MR. PARK: And so that was the only place where kind of the source of funds was brought up.

COMMISSIONER MILLIGAN: But otherwise was silent as to how the state generated its share of match.

MR. PARK: Yes.

COMMISSIONER MILLIGAN: Okay. And I think the last technical question I wanted to ask is: When you mentioned excluded populations, there were the partial benefit, like breast and cervical cancer. Is that exclusion focused on partial-benefit populations that exist in law today?

MR. PARK: Yes.

COMMISSIONER MILLIGAN: As opposed to a partial-benefit population that might be created in an 1115 waiver,

for example?

MR. PARK: They specifically mention those eligible for emergency services only, family planning and the partial duals. So I don't know and it's not specified whether if there were partial benefits under a waiver, whether they would be carved out or left in the per capita cap.

COMMISSIONER MILLIGAN: Thank you.

CHAIR ROSENBAUM: I have -- oh, sorry.

EXECUTIVE DIRECTOR SCHWARTZ: I have two clarifying things, one to Chuck's point. The legislation, while difficult to read if you're not like -- if you don't know the statute chapter and verse the way Sara does, it's complicated, but it's actually relatively short, and the block grant portion in particular. So lots of things, it's not clear whether that's saying everything. Are there regulations to come that will tell more.

So I would say almost nowhere on these -- mostly on the slides, what you see is everything we know. We didn't really have an issue of a slide that wasn't, you know, we abbreviated. So just to share that. I mean, please ask away.

COMMISSIONER MILLIGAN: No, and that in itself, Anne, is a helpful observation.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. The other thing I just want to mention, to Kit's point about work, I did find -- this was from one of the blogs that Martha mentioned, data from the National Health Interview Survey for 2015, and this is for expansion adults. Only 13 percent of expansion adults are able-bodied, not working, and -- not working, in school, or seeking work. So 13 percent of the expansion adults would be sort of the group that would be the target for that work requirement.

COMMISSIONER GORTON: So said the other way, 87 percent of them, in fact, already would meet the requirement that we're trying to --

EXECUTIVE DIRECTOR SCHWARTZ: Correct.

COMMISSIONER GORTON: Okay.

CHAIR ROSENBAUM: Peter.

COMMISSIONER SZILAGYI: Yeah, a couple questions on the caps as well as the block grants. Not surprisingly, I kind of focused on children. But first one question. The last time we met, Chris, do you remember you were showing the graph about multiple potential growth factors?

And if I remember, the CPI was the lowest growth factor? Did I have this right?

MR. PARK: In those examples, I had shown CPI-U, GDP, and the National Health Expenditure trend --

COMMISSIONER SZILAGYI: And then the actual -- and then the actual cost.

MR. PARK: The CPI trend in terms of what was projected was lower than the others.

COMMISSIONER SZILAGYI: So for the caps, the selected one is the lowest one?

MR. PARK: For the block grant, it's CPI-U, which is what I showed. For the per capita caps, it's CPI medical, which is generally higher most years than CPI-U.

COMMISSIONER SZILAGYI: Okay. I was a little confused. Okay.

VICE CHAIR GOLD: That's [off microphone].

COMMISSIONER SZILAGYI: Yeah, that was my next -- that was the next logical question, is: Where is the CPI-MC?

MR. PARK: I don't have that offhand, but I think it's probably similar at least to -- somewhere in between like GDP and NHE trends.

COMMISSIONER SZILAGYI: Okay. The next question is: Was there a rationale for why the 1 percent bump in the growth rate for some populations but not others?

MR. PARK: I can only -- you know, there was nothing very specific, but I think in terms of priority they wanted to emphasize spending -- you know, ensuring that spending would try to keep up better with the projected trends for the aged and disabled groups.

COMMISSIONER SZILAGYI: Then for children --

MR. PARK: I don't --

CHAIR ROSENBAUM: My assumption is they didn't think that they had to spend the money on --

COMMISSIONER SZILAGYI: Okay, yeah. I'm just trying to understand the numbers. So let's say I'm in a state, and my actual costs ended up being higher than the cap. So I think what you're saying is that if the enrollment -- and we're hitting a recession or an economic downturn, so there are going to be more and more people enrolled. If the case mix stays the same, essentially, then I'm in the same situation. So one way to reduce my state's cost is to discourage certain groups for which we're losing money versus the others. Is that right?

MR. PARK: That is one possibility.

COMMISSIONER SZILAGYI: That's one potential way. And that might be children.

CHAIR ROSENBAUM: Or adults.

COMMISSIONER SZILAGYI: Based on the --

CHAIR ROSENBAUM: Or adults.

COMMISSIONER SZILAGYI: I'm just looking at the deltas here.

EXECUTIVE DIRECTOR SCHWARTZ: You get savings for everyone, and for some more than others.

COMMISSIONER SZILAGYI: Right.

EXECUTIVE DIRECTOR SCHWARTZ: I mean, depending upon what's considered mandatory and optional, less spending for the state and less spending for the federal, but I think the point you're saying is that the difference is -- it's different for different groups.

COMMISSIONER SZILAGYI: You could try to change the case mix.

CHAIR ROSENBAUM: Yeah.

COMMISSIONER SZILAGYI: Okay. And one quick technical question. Were the stairstep children included here in these calculations?

MR. PARK: In terms of my examples, it was --

COMMISSIONER SZILAGYI: In your examples.

MR. PARK: -- using fiscal year 2013 data, so it was before any of the ACA changes.

COMMISSIONER SZILAGYI: Okay. And a quick question about the block grants. So EPSDT is no longer a component. And are there major changes for the 19- to 21-year-olds as well?

EXECUTIVE DIRECTOR SCHWARTZ: What you see on that slide is what it says.

CHAIR ROSENBAUM: I read the block grant language as ending what -- the EPSDT benefit, it's gone, but then for pediatric, what they would call services for children, stops at age 18 as opposed to --

COMMISSIONER SZILAGYI: As opposed to 21.

CHAIR ROSENBAUM: Yeah.

COMMISSIONER SZILAGYI: Right, so I wanted to point that out.

CHAIR ROSENBAUM: Okay. Alan.

COMMISSIONER WEIL: Just as narrow and technical as possible. How much detail do we have about the definition of the different eligibility groupings that are

used in calculating the per capita caps? I'm just thinking a lot of people are eligible for this program under more than one pathway and how much room there is to --

MS. HEBERLEIN: So, for example, under elderly, it says a category of 1903 enrollees who are 65 years of age or older. So it does not cross-reference and go back and say 1902(a)(10).

COMMISSIONER WEIL: It doesn't, okay. And so take foster care children, where are they?

MS. HEBERLEIN: It is not clear, but I would guess that they would be under children. But it doesn't --

COMMISSIONER WEIL: Okay. Again, I'm just trying to --

MS. HEBERLEIN: I think it says under age 19. It doesn't get more specific than that.

COMMISSIONER WEIL: Okay. That's all it says. That's what I thought.

The only other question, and given your answer to the last one, I can easily answer this next one. But this notion of subsequent year recovery of overexpenditures, presumably on December 31st of one year -- or September 30th, fiscal year, one does not know the complete spending

for the year. Is there any discussion of a multi-year reconciliation -- the notion is you take it back the next year, but you don't know at the end of one year how much you're taking back. So is there any more detail on how that works, or is that just sort of a rhetorical flourish to be filled in?

MR. PARK: Yeah, there's no more detail on that.

COMMISSIONER WEIL: That's what I thought. Thank you.

COMMISSIONER THOMPSON: But just to follow up on that just real quick.

CHAIR ROSENBAUM: Yeah, go right ahead.

COMMISSIONER THOMPSON: So there are current provisions around when states have a disallowance of repayment terms, but those aren't cross-referenced here, but do they still exist?

MR. PARK: It's not specified, so I'm not sure.

CHAIR ROSENBAUM: Yeah, and I was going to make the same point. There's also no -- I mean, there's no cross-reference to current recovery provisions. And am I correct that there's no -- while the clawback can begin apparently right away, are there any time frames for

situations in which a state believes it has been underpaid during which the federal government would have to reconcile?

MR. PARK: I didn't see anything specified on that either.

CHAIR ROSENBAUM: Yeah, I don't think so.

COMMISSIONER THOMPSON: Well, but that sort of also raises the question again, there are other procedures, right?

CHAIR ROSENBAUM: Right.

COMMISSIONER THOMPSON: There's federal procedures in the case of a disallowance and a finding by which there are due process rights and --

CHAIR ROSENBAUM: Right, so we just don't know whether --

COMMISSIONER THOMPSON: -- hearings and appeals and courts involved, et cetera.

COMMISSIONER GORTON: It's more than that. No, there's still the law. If this act doesn't repeal them, then they remain in place, right?

EXECUTIVE DIRECTOR SCHWARTZ: It doesn't tell you how that relates to the clawback of your excess

expenditures.

CHAIR ROSENBAUM: No, and the reason why we have devoted this amount of time -- I mean, you're raising exactly the point, and Penny's point is right one, and many of the questions are right on, that because the Medicaid provisions are an overlay on one of the most complex statutes there is, the challenge we're having here and the technical challenges that would, you know, persist in a law like this or a bill like this are how to reconcile the new language with the underlying statute. And many of the situations in which Chris or Ielnaz or Martha are saying they're not sure is precisely because we don't know how to interlineate the new provisions with the old provisions. And everybody's sort of making an educated guess.

Chuck?

COMMISSIONER MILLIGAN: I'm sorry. I want to go back to the byplay between Peter and you, Sara, about EPSDT. We also don't know if the block grant provision became law and a state elected a block grant, whether CMS by regulation in an administration that believed in EPSDT might mandate you have to do EPSDT inside of the block grant. So there's a lot of ambiguity about the rulemaking

that might happen downstream by an administration that might interpret things differently than previous administrations.

So the block -- I mean, one of the concerns governors have always had about block grants is it isn't going to be as flexible as people think, and that could, arguably, lead to EPSDT by regulation. So I just -- I wanted to interject because a statement was made that it wouldn't exist, and we don't know how the rulemaking process would unfold.

CHAIR ROSENBAUM: Yeah, let me just take the prerogative of the Chair, since we still have many, many, many questions and many people on the list, we are going to skip the first public comment period at -- is it 2:45? We're going to do public comments at the end. We're going to use the additional time for the Commissioners, then take a break a little after 3:00 and reconvene. And then we'll do public comment at the end.

EXECUTIVE DIRECTOR SCHWARTZ: We're going to skip over public comment that's in the middle of the day and do it at the end of the day.

CHAIR ROSENBAUM: Yes. Brian.

COMMISSIONER BURWELL: I was a little surprised by the provision under the per capita cap you would have a target expenditure rate, but you could draw down federal funds at an enhanced FMAP, so on a cash basis, you would be getting a greater percentage of federal funds earlier rather than later. And you would use up your federal allotment say in the tenth month of the year. Am I right about that?

MR. PARK: Yeah, as shown on this graph.

COMMISSIONER BURWELL: And the rest of the year would be -- yeah, as in --

MR. PARK: You know, if you assume the bottom is like percentages because it's out of 100 million. You can see that around, you know, 77 percent of your spending --

COMMISSIONER BURWELL: So my technical question, was there any policy rationale around that? And are there any dynamics or incentives created by that process? So I assume if a state spent less than their target amount and they had received the enhanced FMAP, you know, for that lower amount, there would be a reconciliation to the actual FMAP at the end of the year?

MR. PARK: No. In terms of the way the formula

and the drawdown works out -- and I mentioned this -- you know, there might be an incentive or a state in this example, like those last few dollars that they're spending are all state funds, and so maybe there's this incentive to try to reduce that spending because they've already drawn down their entire federal amount.

Another thing is that -- effect of this is that, like I said before, you would draw down your federal funds faster, so it would make it more difficult to roll over any unused block grant funding to next year.

COMMISSIONER BURWELL: But the FMAP at the end of the year is the regular FMAP. It's not the --

MR. PARK: It depends on -- in terms of your relative FMAP, it would depend on exactly how much you ended up spending. In this example, if you spent the $100 million, you would still end up with a 50 percent FMAP. If you spent less than 100, your FMAP would be a little bit higher than 50 percent. And if you spent more than 100, your FMAP would be a little bit lower than 50 percent. And so it kind of depends. You know, at the end of the day, you would only get that $50 million of federal funds, and where that percentage ends up being is depending on how

much you actually spent during that year.

COMMISSIONER THOMPSON: Can I ask a question about that? So I just want to follow up I think on Brian. Let's suppose that you're a state that draws, you know, under this scenario, $100 million projected, $50 million federal, I spend 50.

MR. PARK: Then --

COMMISSIONER THOMPSON: It's all federal money.

MR. PARK: No, because it's still --

COMMISSIONER THOMPSON: Is that okay?

MR. PARK: It's still like the 65 match --

COMMISSIONER THOMPSON: It's not okay?

MR. PARK: So even if you spent a total of $50 million, 35 percent would be state funds and 65 would be federal, and you would have unused federal dollars that you could roll over to the next year.

COMMISSIONER BURWELL: So there is an incentive to spend less than your target. You would get more federal funds. You would get an enhanced FMAP if you spent less than your target.

MR. PARK: That is one effect of --

COMMISSIONER THOMPSON: I was trying to figure

out whether the enhanced FMAP is about cash flow or if it's about the match, the effective match as calculated by the end of the year.

MR. PARK: It's hard to say, you know, what the exact intent is, but the effect is that, you know, as shown here, if you spend less dollars, the federal dollars as a percentage of your total spending would go up. You know, the maximum in this example would be 65 percent because you would always be drawing down at a 65 percent rate until it's gone.

CHAIR ROSENBAUM: There's also, I think, on a related point to all of this, something that, again, goes to how to read the amendments when drafted onto the legislation as we -- or federal law as we know it today. The amendments, as you all pointed out, do not expressly give certain flexibility around certain aspects of the program. In the block grant case, they do. But the other amendments appear not to deal with pieces of the statute, but I think it's important to note, as a related matter, that the interpretation of changing the entire federal-state financial relationship -- okay, the legal meaning of changing the federal-state financial relationship could

swing in one of two directions. One is the direction that Chuck had identified, which is there's far less given than one would think even though the entire federal-state financial relationship has changed.

The other direction it could swing in -- and we just wouldn't know, we don't know, we can't know because the legislation doesn't tell us -- is that the legislation is interpreted as giving states additional tools for managing the end of federal funds in a given year that they wouldn't otherwise have, for example, making very expedited reductions in benefits, making very expedited reductions in targeted population groups that are costing more. Those things are not so workable today for various reasons. We just don't know what the give is. And all we can say here, as we're sort of struggling to understand the bill, is that this goes into the bucket of unknowns, which is exactly how is this funds flow supposed to work, and if you are running out of funds flow, what mitigation steps would you have available to you as a state? The legislation doesn't answer that, not clear.

I have Andy, Toby, Sheldon, Chuck, Gustavo.

COMMISSIONER COHEN: Thanks much.

CHAIR ROSENBAUM: And Leanna.

COMMISSIONER COHEN: I have questions in a couple of different areas.

Let me start with the enrollment process changes. So I guess my first question, you listed a number of them, changes and retroactive coverage and presumptive eligibility, 6-month eligibility stuff. And I just wonder-- well, I guess my first question is, when CBO did its analysis of the bill, did they look at the impact of those provisions as separate from the other provisions in the AHCA in terms of like their impact on enrollment?

MS. HEBERLEIN: Sort of. So part of the issue with -- I shouldn't say issue. Part of how CBO does their scoring is they put lots of things in sort of the coverage bucket, so there's interactions between some of these things and the coverage provisions that I talked about, which was the 840. But they did say that -- so some of the other sort of non-coverage provisions, when they scored them out, it was about -- let me find the page.

So the reductions to states' Medicaid cost, which is what that title -- or part of the legislation was called, which was the lottery winnings, retro, and then the

home equity stuff saved about 7 and -- billion -- 7 billion over the 10-year period.

COMMISSIONER COHEN: And there's no way to connect, though, the numbers of people or sort of coverage rates or anything like that?

MS. HEBERLEIN: No.

COMMISSIONER COHEN: Did you say "billion" or "million"? Million.

MS. HEBERLEIN: Billion.

COMMISSIONER COHEN: Billion.

MS. HEBERLEIN: 7 billion over 10.

COMMISSIONER COHEN: And we know there's not a lot of lottery winners. Okay. So that is really substantial. I assume there has not been other analysis that would sort of illuminate any more, but that seems like a fairly substantial enrollment impact.

Okay. So that was one area.

MS. HEBERLEIN: Well, it's 7 billion, but the coverage --

COMMISSIONER COHEN: Oh, seven? I thought you said 700.

MS. HEBERLEIN: Seven. But then the coverage

provisions were 840. And so I think there's probably some interaction between, you know -- and the 14 million people that would lose out, I think they anticipated that most of that would be as a result of new states not taking up the expansion and states rolling back because of the loss of enhanced FMAP. And so I think a lot of the loss in coverage was really due to that Medicaid expansion changes, but there may have been some loss of coverage due to these. But it wasn't -- they didn't specify.

COMMISSIONER COHEN: Specifically laid out. Okay.

And, now, going back to Peter's question about the CPI-M -- and I know these questions are hard because you're not an encyclopedia, although I am, apparently, an encyclopedia, but --

[Laughter.]

COMMISSIONER COHEN: But can you just talk a little bit about what CPI-M, whatever, what you know if you can, just sort of like what it reflects, and how -- do we know anything about how -- so we know something about how that trend relates to some other trends that you mentioned, national health expenditures, GDP, and CPI-U. But do we

know anything else about how it relates to trends in other health care spending? So, first of all, what is it, and second of all, how does it relate to some other trends in health care spending?

MR. PARK: I don't have that off the top of my head. CPI, you know, medical is kind of the estimate of the spending for medical services, both like prescription drugs, inpatient hospital stuff.

VICE CHAIR GOLD: It's a price index.

MR. PARK: Yeah.

VICE CHAIR GOLD: It's a price index, and it assumes a fixed market basket of goods.

COMMISSIONER COHEN: Okay.

VICE CHAIR GOLD: So that if a treatment changes or other things change, it won't capture it.

EXECUTIVE DIRECTOR SCHWARTZ: It's economy-wide.

COMMISSIONER COHEN: Okay.

EXECUTIVE DIRECTOR SCHWARTZ: It includes private. It's how much the price is for buying a bucket of medical care services, compares in price this year to what it did last year.

COMMISSIONER COHEN: Got it.

EXECUTIVE DIRECTOR SCHWARTZ: And it's higher than the general rate of inflation, which would include things like food and housing and cars, et cetera.

COMMISSIONER COHEN: So, but we know -- so, but what this is going to be used for is not just for price adjustments. So, I guess, do we know anything about how CPI-M has related to other health care trends over the last decade or -- and, again, I'm not anticipating --

MR. PARK: Again, yeah, I --

COMMISSIONER COHEN: -- that you know this off the top of your head, but it would seem like that is -- I don't know if anyone has done any analysis on it.

MR. PARK: I think the Office of the Actuary -- I just tried to pull that up to see if they have --

EXECUTIVE DIRECTOR SCHWARTZ: We had some of these numbers in the June report, where we showed the trends in GDP, national health expenditures, the different pricing.

COMMISSIONER COHEN: We just didn't have CPI.

EXECUTIVE DIRECTOR SCHWARTZ: We had all of those in the June report with different time periods.

COMMISSIONER COHEN: Okay.

CHAIR ROSENBAUM: Why don't we move on and assume that we will come back around maybe on some of the differences.

COMMISSIONER COHEN: That's great.

And then my last question for now was around actually -- it was around the approval, but the sort of process for approving the block grant changes, so again, bouncing around in subject area a little bit.

As I understood the slide and what you said -- and I'm going to assume there's not much more than what's on the slide -- a state that wants to do a block grant submits a plan. It has a few categories of information that has to be on there, and then it's deemed approved in 30 days, unless HHS says there's something missing. Is there any -- so, currently, a state plan amendment, which is sort of the easiest thing for states to usually get, much less than a waiver, requires an affirmative approval. Is there --

COMMISSIONER THOMPSON: There is a clock, and it's deemed approved if an action isn't taken within that period of time. So there is a similar construct.

COMMISSIONER COHEN: And what's the clock?

COMMISSIONER THOMPSON: Ninety days.

COMMISSIONER COHEN: A 90-day clock.

COMMISSIONER DOUGLAS: But there's plenty of time to stop the clock.

COMMISSIONER THOMPSON: You can stop the clock with a question.

COMMISSIONER COHEN: Right. And here, it's stopped with a determination that it's incomplete or actuarially unsound, and I guess my question kind of was -- I wasn't quite sure where the actuarial element comes into this --

CHAIR ROSENBAUM: I have the same question. What does that mean?

COMMISSIONER COHEN: -- because when you look at the elements of what a state has to submit, I wasn't really even quite sure where the actuarial element comes into that at all.

CHAIR ROSENBAUM: There's no more in statute than that, so -- or in the legislation.

MS. KASHEFIPOUR: Yeah. There's no more in the statute than that. I mean, we could guess about -- I'm not sure.

COMMISSIONER COHEN: Okay. There's nothing more that we know than what's on the slide.

Okay. Thank you.

CHAIR ROSENBAUM: Toby.

COMMISSIONER DOUGLAS: Mine are policy, and I'll wait until we get --

CHAIR ROSENBAUM: Well, I think we have a sort of slid around, so why don't you get your questions out.

COMMISSIONER DOUGLAS: All right. I'll go ahead and I'll jump into policy questions.

Okay. I'll start on the PMPM or looking at it from the different categories of aid, the question it raises to me -- so if we're looking at the slide that breaks it out -- age, disabled, child -- and clearly, the questions raised around -- Peter talked about the child not keeping pace, and the same is the case with disabled. And the dollar amount is huge, so from a state perspective, when you start adding up that disabled amount -- and so is there a way, I think, policy or analytically for us to determine both aggregate but state by state what the impact is on the disabled? It raises questions from a policy of how that's going to play out on benefit decisions across

categories of aid on disabled and others.

So it's both a policy and analysis, I think is important, and if we haven't done it, that we need to kind of --

CHAIR ROSENBAUM: Well, I had a related question, which is asking Chris and Martha and Ielnaz, if they can't do it today, but what are the incentives under this methodology? What are the things that this kind of methodology would encourage a state potentially to consider doing or not doing in terms of eligibility, in terms of coverage, in terms of --

COMMISSIONER DOUGLAS: Delivery systems.

CHAIR ROSENBAUM: Delivery system reform.

COMMISSIONER DOUGLAS: Yeah.

CHAIR ROSENBAUM: That's what I think a lot of us probably are wondering as we're listening to the methodology.

COMMISSIONER DOUGLAS: And will -- I mean, and just to build on that point, do they -- you know, there are some -- you know, delivery system reform can bend the cost or curve by X. How do these types of changes that we all know and envision -- could they match up to the dollar

amount that we're talking about for disabled or for a child, or does that lead to other needed decisions?

The other piece on this is around the duals and the intersection of that disabled, what the duals and just understanding the implications on the Medicare side for those that are full duals under that group and just being able to break that apart.

EXECUTIVE DIRECTOR SCHWARTZ: I think Kaiser has done an analysis on the duals.

COMMISSIONER DOUGLAS: Oh, okay.

EXECUTIVE DIRECTOR SCHWARTZ: Although I don't know if it's Medicare effects. It might be.

And you know that when you have them do all this stuff, they're all going to leave to go be consultants for states, so thanks a lot, Toby.

COMMISSIONER DOUGLAS: Okay. Well, I'm not done on that.

COMMISSIONER THOMPSON: There's nothing wrong with consultants.

COMMISSIONER DOUGLAS: Okay.

[Laughter.]

CHAIR ROSENBAUM: [Speaking off microphone.]

COMMISSIONER DOUGLAS: Yeah. Maybe it's not analyses or questions that need to be raised. So you decide. You're the boss. You decide what to actually do, but I'm going to raise the policy questions.

MR. PARK: I should just point out on the duals side that Medicare cost sharing and premiums is one of the excluded expenditures, and so --

COMMISSIONER DOUGLAS: Well, but I'm not talking about just -- in fact, full duals are included.

MR. PARK: Yeah. But the remaining services, so like LTSS would still be under the per capita cap.

COMMISSIONER DOUGLAS: Exactly. Yeah. Okay.

And then more just a question -- it's not technical, but it gets back to what Stacey was saying. When states envision this idea of the per capita caps, it was always around the joint incentive, and so how will it play out when there isn't -- you know, there's no true incentive on the state to get underneath these caps, and so -- and I don't know how we analyze this, but it's just a policy question that needs to be raised around -- you know, from a managed care perspective, it's always about you give a PMPM, and it's aligning incentives. The savings go to

the plan. Here, there's no incentive, and so what are the underlying issues on that?

On supplemental payments -- and I'll try to -- I know I'm monopolizing. On the supplemental payments, we talked about the issue of the nonfederal share, and here again, I don't know how to assess it, but the policy implications, when you cap, in essence, the amount of these supplemental payments, it's going to have some issues, interactions at a state level on providers and counties and other entities actually being willing to put up the nonfederal share, and so how does that play out on the ability of the state to actually keep pace with the nonfederal share when you have this kind of capping, in essence, of this piece of the pie?

And that is it. I will be quiet.

CHAIR ROSENBAUM: I'm sorry. Stacey, did you want to jump in on this? Yeah.

COMMISSIONER LAMPKIN: I do. I just want a quick clarification.

So I don't think it's fair to say states don't have any incentive to come in under the cap because their own dollars are still at stake.

COMMISSIONER DOUGLAS: But that's today. That's today's --

COMMISSIONER LAMPKIN: Well, it would be -- they would also be the case under this design, as they've described it to us.

COMMISSIONER DOUGLAS: No, I get that, and that's how -- I mean, just think the idea from a state perspective today, there is no -- what states have always wanted, a shared savings.

COMMISSIONER LAMPKIN: And this is not that.

COMMISSIONER DOUGLAS: Exactly. That's my point.

COMMISSIONER LAMPKIN: We agree on that.

COMMISSIONER DOUGLAS: That's my point.

COMMISSIONER LAMPKIN: It's just I think the states do have some dollars at stake is what --

COMMISSIONER DOUGLAS: Yeah. No, no, no. It's a fair clarification, and I would agree with you. Today, we have the incentive -- a state has the incentive not to spend.

COMMISSIONER BURWELL: Well, going back in the -- isn't the incentive also they do get the enhanced FMAP if they come in under the cap?

MR. PARK: The enhanced match is only on the block grant in terms of the drawdown.

COMMISSIONER BURWELL: Oh, okay.

CHAIR ROSENBAUM: Sheldon.

COMMISSIONER RETCHIN: Yeah. I'm going to stay a little technical, just asking Chris -- because there have been other questions on this -- on the CPI-M, and maybe it's addressing some of the other issues. So the CPI-M, I know it really is consumer out-of-pocket expenditures in terms of pricing, so it excludes the cost for the employer-based insurance. Right.

So, but in general, it should reflect the increases in consumer costs and reflect the cost of increases in medical care. In fact, over the last 25, 30 years, with I think one exception, there's been about a 300- to 350-basis-point difference between the overall CPI and the CPI-M in favor of the CPI-M increases. Right.

So wouldn't the CPI-M be expected to reflect slow increases in costs like opiate addiction, which would -- I mean, it would all be blended in. It would miss something that would be a surge, like a Zika infection, but it seems to me that it's actually not a bad index in terms --

The only other question I have in there is the CPI-M that would be used is or is not a regional CPI-M? I think there are four regions for CPI.

MR. PARK: It did not mention anything about regional CPI medical, so I assume it's kind of the overall national level.

COMMISSIONER RETCHIN: Yeah. That would concern me with the regional differences. It would actually compound some of the spending things.

Lastly, actually, can you go back on the change in spending per enrollee and enrollee group, which is on Slide 25? Looking at the CPI medical index, which is a blend of all payers -- it's a consumer price index. So it has Medicaid in there or Medicaid beneficiary spending. Right. As I think of it, Medicaid spending per enrollee is actually beating, on a constant basis, other cohorts in terms of price? So it seems to me --

MR. PARK: Yes. It depends exactly on what time periods you choose.

COMMISSIONER RETCHIN: Right.

MR. PARK: And recent trends, I think because of the new adult group, has kind of shifted the enrollment mix

in Medicaid from -- you know, because they're in between kind of adults and children and the aged and disabled. It has shifted that overall spending per Medicaid enrollee down a little bit, and that's an enrollment mix effect versus purely just like efficiencies or anything in terms of --

COMMISSIONER RETCHIN: So I guess what I'm asking is, why wouldn't this CPI-M almost always outstrip the increases -- or you'd expect in Medicaid?

MR. PARK: Again, I think it kind of depends on this enrollment mix, this enrollment mix issue in terms of like when you look at a lot of the numbers on spending per Medicaid enrollee, that's across the entire Medicaid population. And particularly trends, like in 2014, the new adult group comes in. This is a lower-cost population than the overall average, and so that brings the trend down.

COMMISSIONER RETCHIN: Right.

MR. PARK: But it's not necessarily every single group spending went down.

COMMISSIONER RETCHIN: Yeah, yeah. Okay.

CHAIR ROSENBAUM: Yes, Peter.

COMMISSIONER SZILAGYI: I'm still confused. This

is what's partly confusing me, the same thing as Sheldon. I mean, if the growth rate in Medicaid is less than the growth rate in commercial insurance, which I think is established -- and that was brought up in prior meetings -- and the CPI-M includes Medicaid plus private -- well, maybe that also includes Medicare.

COMMISSIONER COHEN: But growth is different than just price growth.

CHAIR ROSENBAUM: Yes. I think that the issue is --

COMMISSIONER SZILAGYI: So it's that it's price.

CHAIR ROSENBAUM: Versus price growth. You could end up, I mean, something like he said. Something like opioid epidemics are examples of where your real spending per person may be much higher than if you'd held the same basket of services constant and just priced it forward.

COMMISSIONER COHEN: Or even without a surge, people are not getting --

CHAIR ROSENBAUM: Right.

COMMISSIONER COHEN: -- mental health services and people are paying more attention --

CHAIR ROSENBAUM: A new drug.

COMMISSIONER COHEN: -- and getting better results and better quality --

CHAIR ROSENBAUM: Yeah, yeah.

COMMISSIONER COHEN: -- from getting mental health services, but none of that would be factored into --

CHAIR ROSENBAUM: Intensity, technology, so that we may be seeing real spending growth. But the price, underlying price that is being paid for Medicaid may stay relatively low. Certainly, John Holahan's work shows that, our own work shows that Medicaid is a low payer, but Medicaid can be quite costly.

We have about seven minutes. I want to be sure we hear from Leanna, who has not had a chance at all, and I want to leave a minute -- [speaking off microphone] -- at the end, so lightning round.

Chuck, Penny, Gustavo. Leanna is up first.

COMMISSIONER GEORGE: Okay. My question is more back towards EPSDT. And I noticed in the letter from the governors it specifically had separated children with disabilities from the primarily children category. My concern is when you consider what is the definition of disability, a lot of kids who really need EPSDT services do

not fall into that umbrella of the SSI definition of disability. And considering I was reading an article back in the '60s, they found that half of the young men that they drafted for the Army were not qualified, were not permitted into it because of disability that could have been prevented through things like EPSDT.

So is there any definitions that are pertaining to that yet?

MS. KASHEFIPOUR: Definition of disability, or EPSDT?

COMMISSIONER GEORGE: Separating disability into, obviously, adults with disability or significant disability, but also, perhaps, children with a lesser disability but not to the severity of, say, SSI, which I think is what Medicaid mostly grades off of.

EXECUTIVE DIRECTOR SCHWARTZ: I think in the governor's letter it sort of -- each -- it has a -- it's sort of bucketed by the kinds of flexibilities that they want but it's not an accompanying rationale for it, and so we can't speculate on why they would want to retain for one versus the other, and I think your point is well taken, that those services are useful for all kinds of children.

So we don't have any more information to say, like, why would you do one versus the other?

CHAIR ROSENBAUM: There is nothing -- as the word "disability" is used, either in the legislation or in the governor's letter, there's nothing that would tell us whether the term "disability" is to be read as disability equivalent to the SSI program, a state's definition of disability, a more restrictive definition of disability. It's just, we don't know, but it's another unknown issue. You're right to raise it.

I have Chuck, Gustavo, Penny.

COMMISSIONER MILLIGAN: Actually, let me just start with the disability thing because one of the questions I had more at a policy level is, if there were work requirements and people with disabilities were exempted from work requirements, the definition of disability isn't clear, in terms of work requirement implications. I'm assuming that's yes, based on that same conversation. Yes? Okay.

I wanted to just do a couple of things. So one of the things is, let's assume there's a hypothetical state that wants to stay the course with what it's got now, and

doesn't -- you know, doesn't want to get thrown into this sort of new model. I wanted to try to illuminate what that state's response might be, and the implications, just to try to illustrate what the change in law would do for that state, that really is kind of happy with the status quo.

One is -- so I'm going to say this and then just correct it or, you know, amplify however you wish -- one is the state could choose not to do the options that we've talked about, like not to do the option about walking back, retro eligibility, not to do the option of work requirements, not to do the option of assuming of eliminating presumptive eligibility. So all these optional things that states could do, they could choose not to do.

One is, for that state in that hypothetical situation, they could not add, at some point in time, more expansion in adults, so, you know, they could carry into the future however many expansion adults, but they can't add, at some point, more expansion adults. They would lose the enhanced FMAP, so they would have to come up with a difference for the expansion adults. So that's a cost the state would have to incur, I'm assuming.

And the other one that I just want to highlight

is that state would have the risk of spending any spending above the per capita cap, any spending above the federal max. I just -- there's one or two other questions I have but I just -- I wanted to highlight, and see if I've got the major categories, or the major implications of a state that's happy with the status quo -- this is some hypothetical state -- what it would be confronted with if the law were to change in the way we've just been talking about. Did I say it correctly?

MS. HEBERLEIN: Well, I don't think some of those things are options.

COMMISSIONER MILLIGAN: So -- so --

MS. HEBERLEIN: Retroactive coverage is eliminated.

COMMISSIONER MILLIGAN: Okay.

MS. HEBERLEIN: It is not a state option.

COMMISSIONER MILLIGAN: So, but -- but --

MS. HEBERLEIN: The work requirement is a state option. States can keep their expansion and new adults could be added. They would just not get the enhanced match for them.

COMMISSIONER MILLIGAN: Okay.

MS. HEBERLEIN: So there are some things. Like the work requirement is a state option. Six month redeterminations for the new adult group and the new above 133, that's a requirement. So are the changes to lottery winnings counting and home equity.

[Comment off microphone.]

MS. HEBERLEIN: Yeah, and elimination of hospital PE is also a requirement.

COMMISSIONER MILLIGAN: Okay. That was helpful. Thank you for correcting a couple of things I misstated. So I wanted just to -- I think it's helpful in this discussion to talk about that, you know, comparison.

I wanted to -- and I'll do this really quickly -- I'll punch a couple of points that have come up. One is, how might a state respond? And we don't know and we don't know the tools, but I think, going back to the hep C example that Kit gave earlier, and some other things, states could manage inside a per capita cap if the states, then, changed the fibrosis scores that would qualify somebody for medical necessity for treatment. Or there are ways of -- and I'm not saying this is good policy or bad policy. I'm just saying there are ways of, if there are --

hypothetically, if there are tools around benefit design, or eligibility design, there's ways to do selection, in a certain way of speaking, which is -- I mean, I want to say it quite like that -- you could do benefit design to cherry-pick populations who come into your per capita cap world. And so I just -- I do want to say that explicitly.

The second thing -- and I think I'll -- two other quick points. One is -- or question. This is a question and one final point I'll make. The question is, my assumption, based on this whole discussion and listening is that the majority of the savings really come from people losing eligibility, or choosing not to pursue eligibility. It might be, with a work requirement world, somebody elects -- I'm not going to apply for Medicaid because I don't want to have to chase that job. I'll just go get a job -- or whatever. That assumption that you're going to lose -- or the assumption you're going to lose eligibility because you're doing redeterminations more frequently and people are churning off. Or the assumptions about states not taking up the Medicaid expansion, or walking back the Medicaid expansion because the FMAP changes.

Is there a way of, just rough order of magnitude,

the magnitude of savings associated with eligibility coverage changes as the driver? Is there a way to just quantify that?

MS. HEBERLEIN: Sort of. So they roll in -- they say that 14 million people will lose coverage under the coverage provisions, and the way they talk about it is they sort of -- they don't give explicit numbers to say -- or they kind of do. So they think that -- there's 31 states and D.C. that have already expanded, and they don't say, state by state, how many, but they assume that by 2026, CBO had assumed that 80 percent of newly eligible people would -- so 80 percent of people who could be covered, would be covered, because more states would expand. But because fewer states would expand, that would roll back. And so because no new states would expand, they thought it would be about 30 percent of people would be covered by Medicaid in 2026.

So, you know, a large chunk of their change is because states were not -- new states were not adopting the expansion, and existing states were rolling back because of the FMAP.

COMMISSIONER MILLIGAN: Okay. And I want to end

on a comment that I'm going to be sort of giving a shout out to Toby in California. The per capita cap, basically, in effect, locks a state into the spending they've -- an individual state has had. And so it locks in the variations across states, so a state that might have been very efficient is locked in, and a state that has maybe been very inefficient benefits, quote-unquote, from its per capita cap. So it's not a national; it's not a regional. It is state-specific. So a California that had low per capital spending now, in current status quo, that would drive its future. Correct? Okay.

CHAIR ROSENBAUM: Thanks so much, Chuck. We have, and we're going to end here. We have Gustavo. We have Penny. We have Norma.

COMMISSIONER ROGERS: I'll keep my comments for later.

CHAIR ROSENBAUM: Are you sure? Okay. Gustavo and Penny.

COMMISSIONER CRUZ: I just have a question on Section 103 that prohibited entities that are -- the entities are prohibited from getting federal funds for a year. I'm not sure if this is a way the sentence is

written, but it says here that a definition of prohibited entities is an entity that is tax-exempt, an essential community provider, provides elective abortions, and receives more than $350 million.

Does that mean it has to be three things: tax-exempt, an essential community provider, and provide elective abortions, or it means that it's all tax-exempt organizations, and essential community providers?

MS. HEBERLEIN: It's all three, right, in that it's --

EXECUTIVE DIRECTOR SCHWARTZ: That's the prohibition on Planned Parenthood.

COMMISSIONER CRUZ: I see.

EXECUTIVE DIRECTOR SCHWARTZ: They cannot, under the rules, name the organization, so they describe the organization with enough specificity to show it.

COMMISSIONER CRUZ: Oh, okay. Okay.

EXECUTIVE DIRECTOR SCHWARTZ: And they only do it for one year, because if they do it for longer it becomes a coster, because of the children who otherwise wouldn't have been born.

COMMISSIONER CRUZ: I see. Okay. And a quick

question about the $10 billion for -- to help with rates for providers. Is there any definition of providers, or is it meant for the state to define providers?

MS. HEBERLEIN: There's no definition for providers except that they have to provide services to Medicaid and uninsured, and that the rates cannot be -- what the state pays them cannot be more than what the services cost.

COMMISSIONER CRUZ: So it could be --

MS. HEBERLEIN: But it could -- it does not --

COMMISSIONER CRUZ: -- practitioners and physicians and --

MS. HEBERLEIN: Yeah. It doesn't define who those providers would be.

CHAIR ROSENBAUM: Penny, you're going to close us out on questions.

COMMISSIONER THOMPSON: So just -- this is sort of a combination of a technical question, so maybe it's a policy question and it's kind of building on the conversation about, you know, this is -- I, for one, conceptually don't think that it's impossible to conceive of a different kind of system that tries to create some

different kinds of incentives, but obviously you can get mired in very technical details because of the variation in state decisions, and how do you adjust for any of that, and how do you predict what's going to happen in the future.

So I just want to emphasize a couple of points about under this current proposal, just thinking about other models, which we've talked about a little bit in some of our publications, about whether that's managed care contracting, or whether that's value-based purchasing, or whether that's 1115 waivers, and some of the things that could be pulled from those concepts. I'm generally an incrementalist so I like glide paths in, and glide paths out. So the idea of being able to kind of take this in chunks or phases, about -- you know, when I think about a lot of value-based purchasing arrangements, they start with participation and reporting. Then they move to sharing and upside. Then they move to two-sided risk, so that you can kind of get your feet underneath of you. There can be an opportunity to refine the model, so that if it turns out the model itself is accounting for some variation that is unacceptable or not intended, that there can be, you know, some kind of an adjustment on that side.

You know, so the idea that you could come up with maybe more categories. You could work on risk adjustment. You could create safety values, corridors, ways to account for some of the variation. You could actually also -- and I know, you know, there's a reason why some of this stuff isn't in this particular proposal, but, you know, the other side of a lot of these arrangements is expectations about accountability and performance, and maybe one of the ways to address some of the issues about efficiency or inefficiency is to try to create a reward system on the other side of this as well, for hitting certain targets about coverage and outcomes and quality, so that there can be a recognition that states were willing to take on those objectives can also do well under the system.

CHAIR ROSENBAUM: Toby. Close us out.

COMMISSIONER DOUGLAS: So not to -- I agree with Chuck that a lot of this will impact eligibility and there's no question about that, but it still, for the remaining -- states are going to still need to figure out, for those who are eligible, given it's a per capita cap, to be able to live within that mean, and what are the -- it's still a question of what flexibilities do they have under

their control to do that.

And then there's the other piece that's very hard to quantify, that we haven't really talked about. To the extent that the states are able to use provisions to reduce enrollment through more eligibility checks, what usually happens is those are the non-users, those who are the healthier population are going off, which would distort, again, the acuity of the population, which gets to the question of how that would impact the per capita caps, based on the remaining members.

And so, again, it's just I'm not asking for an analysis, but it does raise that policy question of the implications of less enrollment but higher acuity, based on the cap.

CHAIR ROSENBAUM: Let me just try and -- I'm not even going to try and sum up.

[Laughter.]

CHAIR ROSENBAUM: Let me just try and do something akin to closing out this segment. This is probably -- well, not probably -- this is the most substantial public discussion of the Medicaid provisions of the American Health Care Act we've had. They'd really not

received much. I mean, it's sort of quite notable, given the extraordinary nature of the amendment, that it simply has not been subject to a close inspection. We hopefully began the process this afternoon. I think we probably could continue for another three hours on the provisions.

The changes in the act, or the legislation, as it's drafted, really go to the program's foundation. So this is -- these are provisions that are way, way beyond simply altering those parts of the Medicaid statute that were added by the Affordable Care Act. We're talking about very fundamental changes in the program, going back 50 years.

And what this session -- we're now almost at two hours and we still have many questions that are going to go unanswered, at least for now -- what this session, I think, has told us is that there's a lot of uncertainty around the financial mechanics. There's a lot of uncertainty around the legal mechanics. We don't know the relationship between these amendments and the underlying law. We could have devoted two hours just to the financial mechanics, and clearly we don't -- you know, we're just beginning to understand what those might be.

We are finding ourselves sitting here guessing at the policy underpinnings. You know, what would be the policy of doing X or Y, which is a very strange thing to find oneself doing in legislation, to completely remake the Medicaid program.

We have been mostly surmising, and despite yeoman's work, I mean, the staff has no way of being able to tell us today what the management effects of this would be, what the program effects would be, what the financial effects would be, what the policy effects on state programs would be. And we've really -- we've devoted no time at all to the question of putting Medicaid policy and management to one side, what the bigger reverberations are -- because we're talking about a program that covers 74 million people, or thereabouts. So the reverberations go well beyond the outer limits of just Medicaid management.

And so I think it is extremely important to have these kinds of discussions, to have what I assume will be ongoing discussions within the Commission about what is and what is not known, and we thank the staff for doing this amount of legwork for us today, and we assume that this is a discussion that will continue in the coming months,

because the issue of Medicaid reform will, I'm sure, continue.

So with that, why don't we take a break. It's now -- what time is it, 3:20? Yeah, come back at 3:30.

* [Recess.]

CHAIR ROSENBAUM: All right. Because we have not had enough to think about today, we are now moving into a discussion about the 1115 evaluations, which clearly could take every bit as long, if not longer, than the last discussion because of the complexity of 1115. So take us -- start the process.

PRELIMINARY FINDINGS FROM EVALUATIONS OF MEDICAID EXPANSIONS UNDER SECTION 1115 WAIVERS

* MS. BUDERI: Thanks. This session, we will continue the Commission's discussion of key considerations for Medicaid's future role as a source of health care coverage to low-income adults.

Notwithstanding possible legislative reforms to Medicaid, Section 1115 waivers have been in focus as a likely vehicle for states to make changes to their Medicaid programs for this population. So in this presentation, I'll be focusing on the seven states that have used Section

1115 waivers to expand Medicaid and the early results we've seen from their programs.

I'll begin by providing some background on Section 1115 waivers, highlight the key design features of expansion waiver programs, discuss some of the early evaluation findings and the limitations of drawing lessons from those results, and end by bringing up some policy considerations as the Commission, states, and the Secretary think about the future role of Medicaid for this population.

Section 1115 waivers allow the Secretary broad authority to waive most Medicaid state plan requirements under Section 1902 to the extent necessary to carry out a demonstration that furthers the goals of the program. And while this authority was initially used infrequently for narrow policy experimentation, it has broadened in scope over time and is today primarily used to negotiate flexible program parameters.

Seven states are currently operating their Medicaid expansions through Section 1115 waivers, and states implementing these waivers cite a desire to implement policy changes to more closely align Medicaid

enrollment and benefit design with those used in commercial insurance and create incentives for enrollees to use resources more efficiently.

So here you can see, if your eyes are really good, the key features of each state's program, which generally involve one or more of four key elements. These waivers do not generally involve a substantial change in benefits, although four states have sought waivers of non-emergency medical transportation or retroactive coverage.

All states are charging some level of cost sharing, often beyond what is normally allowed under Medicaid. Six states provide incentives such as discounts on premiums based on the completion of certain healthy behavior requirements. And four states are currently or planning to use some form of Medicaid-funded premium assistance. Generally, only the new adult group is covered through state Medicaid expansion waiver programs.

Some of the states requesting expansion waivers have also asked for other provisions to be included, such as work requirements, but because this presentation focuses on evaluations of state programs as implemented, we do not have information on the potential impact of any of those

policy changes.

So because Section 1115 waivers are experiments, they require evaluation at the state and the federal level. The federal evaluation is being conducted by Mathematica Policy Research, and we expect an interim evaluation from them this year. The states are also required to conduct independent evaluations, and because the waivers were approved at different times and have different demonstration periods, their evaluation schedules vary. Currently, interim evaluations are available for Arkansas, Iowa, and Indiana, and we also have partial results from Michigan and the interim evaluation plan for New Hampshire.

The available evaluations contain information on the impacts of key program features, so I'll go through some of the findings in each of those areas now.

So for benefits, as I mentioned, the waivers do not involve substantial changes in benefits. Indiana and Iowa have waivers of NEMT, and Arkansas, Indiana, and New Hampshire have waivers of retroactive coverage, which is not a benefit in itself but confers benefits.

Both Indiana and Iowa have evaluations available for their NEMT waivers, which both focused on the impact of

the waiver on unmet need for transportation and the implications of any unmet need on access.

The findings suggest that individuals with lower incomes may be more likely to experience transportation-related barriers to access regardless of whether or not they have an NEMT benefit. In both states, members of the lowest-income group were the most likely to report unmet need. In Indiana, these were enrollees below 100 percent of poverty regardless of whether or not they were receiving NEMT coverage through their managed care plan, which about half of them were. And in Iowa, these were low-income parents enrolled in the state plan package who actually do receive state-provided NEMT.

The findings also suggest an association between unmet need for transportation and the types of care waiver programs have sought to encourage, including care like well visits. For example, in Iowa, waiver enrollees with incomes below 100 percent FPL were 40 percent more likely to have a well-care visit when they did not have an unmet need for transportation.

In terms of the impact of retroactive coverage waivers, we don't have much information. Indiana's

evaluation does not discuss the direct impact of the retroactive coverage waiver on coverage gaps, and Arkansas and New Hampshire have not yet implemented the retroactive coverage waiver.

So the states with approved waivers also sought changes to the premiums and cost-sharing structure, so that all enrollees pay something toward the cost of coverage with the goal of incentivizing appropriate health care use. Currently, evaluations are available for Indiana and Iowa, and more limited results are available for Michigan. The areas of focus in these evaluations include the relationship between the premiums and cost-sharing structure to beneficiary plan choices and health care use, beneficiary engagement with health savings-like accounts, and affordability and other barriers beneficiaries face in meeting their obligations. Overall, the evaluation results do not clearly a indicate that changes to the premiums and cost-sharing structure are significantly altering beneficiary behavior.

In terms of the relationship between the premium and cost-sharing structure and beneficiary choices, this primarily applies to Indiana, which is testing an approach

that essentially allows individuals with incomes below 100 percent of poverty to choose between paying monthly premiums of 2 percent of income to be in the Plus program which also comes with enhanced benefits and enhanced healthy behavior incentives, or choosing not to pay premiums and instead have a more limited benefit plan through the Basic program and pay point-of-service cost sharing. And the hypothesis behind this is really that individuals in Plus will be more active stewards of their health care consumption, and other states, including Kentucky and Ohio, have proposed similar designs in their waiver applications.

The evaluation found that individuals in Plus had higher utilization for every type of care except for emergency room care. Plus members who enrolled in Plus voluntarily had the highest prevalence of chronic conditions. Together, these results suggest that individuals enrolling in Plus are motivated by the lower financial obligation associated with choosing the monthly premium option, and that this is particularly the case with individuals with chronic conditions who would likely have more frequent trips to the doctor and in turn many point-

of-service cost-sharing payments if they were enrolled in the basic option.

So Arizona, Indiana, and Michigan also have approved health savings account-like programs in their waivers, and they cite a desire to give beneficiaries a financial stake in their health care decisions, responsibility for managing their health care costs, and incentives to adopt healthy behaviors. But beneficiary understanding and engagement with these programs was mixed.

In Indiana, although all members have an account, only 60 percent of members knew that they did. And of those, only about one-third reported regularly checking the balance. Half did not know that costs for preventive services were not deducted from the account.

In Michigan, understanding was higher, with 75 percent of members reporting that they received account statements, 90 percent of whom reviewed the statements regularly. However, I will note that in Michigan the statements indicate what a beneficiary must pay, while in Indiana, an account statement would indicate how much was already deducted from the account.

So in terms of affordability, beneficiaries

generally found the premiums and cost sharing in the waiver programs to be fair and affordable, and this was for the most part the case across evaluations. For example, in Indiana, in the first demonstration year, only about 8 percent of enrollees were transitioned into the Basic program, and only 6 percent were disenrolled for non-payment.

One caveat to that I will just mention is that these numbers don't include an additional 111,000 people with a presumptive eligibility segment in that first demonstration year, and less than a quarter of them were actually enrolled in full Medicaid, and this could be because they never made a premium account contribution, which is a condition of enrollment for individuals over 100 percent of poverty in Indiana.

The evaluations also indicate that beneficiaries are facing non-financial barriers to payment. For example, beneficiary surveys in Michigan show that they are confused about the billing structure for premiums and copays which are applied retrospectively and not at the point of service. Also in Michigan, you cannot pay these liabilities with a credit card, and beneficiaries, for

example, reported that the cost of a money order to make the payment was often higher than actual payment amounts. Beneficiaries in other states reported barriers along similar lines as well.

So most waiver states also offer healthy behavior incentives that encourage the use of preventive care. Interim evaluations in Indiana and Iowa and beneficiary surveys in Michigan examined beneficiary knowledge of and participation in healthy behavior incentive programs and the effect of incentives on outcomes and beneficiary choices about health care utilization.

The evaluation findings show that enrollees are using preventive services at relatively high rates, but not necessarily in conjunction with a healthy behavior incentive program. Also, substantial portions of members were unaware of or did not understand the programs. For example, in Indiana, 50 to 60 percent of enrollees were able to correctly answer questions about how to reduce their premium obligations through the incentive program structure. In Iowa, only 18 to 25 percent of enrollees received one of the two specific qualifying services, which was well short of initial projections of about 50 percent.

So transitioning over to premium assistance programs which are in effect or planned in four states, we have evaluations for Arkansas, which uses premium assistance to purchase exchange plans for its waiver population, and for Iowa, which was using premium assistance for members with incomes over 100 percent of poverty through 2015.

The evaluations primarily address the premium assistance programs' impact on access and its costs. So, in general, there are few data currently available to evaluate the extent to which premium assistance affects access. In Arkansas, premium assistance enrollees reported better access on most measures than Medicaid state plan enrollees, but in Iowa, the pattern wasn't as clear. Where there were significant differences across comparison groups, waiver enrollees below 100 percent FPL who were enrolled in managed care reported better access than premium assistance enrollees.

Consistent with other findings on premium assistance, it costs more to purchase exchange plans for enrollees in both Arkansas and Iowa than it costs to provide traditional Medicaid, likely due to higher

physician payment rates. We don't have any information on the externalities of premium assistance on the exchange market, but this is something Arkansas is planning to explore in its final evaluation.

So in interpreting these early evaluation results from expansion waiver programs, there are several limitations to consider. One is the early stage of implementation. There really isn't that much available data at the state or the federal levels. We only have complete interim evaluations from three states, none of the final evaluations, and the interim evaluations we do have typically use one year of data at most. We also don't have the federal evaluation which will compare the waiver states to traditional expansion states. And while other research may give us additional insight, we probably won't see the full impact of these programs in systematic data for many years.

Evaluators also face challenges in getting the data they need to create the full picture for several reasons, including the fact that this population is often hard to contact and survey. Additionally, there are some of the typical methodological challenges we see in health

services research, particularly with the lack of a strong comparison group. Most of the states were not previously covering these populations, or if they were, it was through a limited-benefit plan. And in many cases, this results in having to compare waiver populations with Medicaid state plan populations who have different circumstances and needs.

It's also very difficult to isolate the impact of the waiver programs themselves versus the impact of other initiatives at the state level and even versus the impact of Medicaid expansion itself. For example, a series of studies has shown that Arkansas performed similarly to Kentucky, which is a traditional expansion state, in terms of improvements in access, outcomes, preventive, and outpatient service use, self-reported health status, and more.

And, finally, it's difficult to generalize the findings and experiences of each state given their varying circumstances and the different ways they designed and implemented their programs.

So, with that, I'll turn to some of the policy considerations that the Commission may wish to consider as

states and the Secretary think about moving forward with new approaches to covering members of the new adult group.

First, how can the evaluation results inform future decisions around approval of future waivers and waiver extensions? And as additional flexibilities are granted to the states by the Secretary, what changes, if any, to the evaluation requirements and expectations are appropriate?

What have we learned about design elements that could be introduced more broadly for the new adult group without harm? And are some of those design elements more appropriate for some populations than others given different health needs and barriers? And how should states identify and categorize those populations? For example, how should states define medically frail individuals?

Looking forward, we will continue to monitor the implementation of current Medicaid expansion waivers and further evaluation data and information as it becomes available. We will also monitor requests from current expansion waiver states to modify or extend their waivers and new requests from traditional or non-expansion states seeking to use 1115 authority to expand or change their

programs for this population.

With that, I'll conclude, and I look forward to your thoughts on these policy questions and possible next steps for MACPAC work.

CHAIR ROSENBAUM: Thank you.

Who would like to start us off? Kit.

COMMISSIONER GORTON: Did you find in any of the evaluations any examination of what the administrative cost of administering these new programs are? I'm interested because in the commercial world there's not much more complicated than trying to administer accumulators, copays, deductibles, coinsurance, balances on HSAs. It's all technically very difficult. It's hard to get it right. And I'm just wondering, is that something that we should expect to be forthcoming in future evaluation cycles? And I guess it would be interesting to other states to know what does it cost to set this up. You know, is it just something that is pretty easy to roll out, or is it more complicated? And, you know, sort of associated questions. Is part of the reason the beneficiaries don't understand it because there were limited funds deployed to explain it to them, you know, in languages they understood, in culturally

competent ways?

I'm just sort of interested in the operational implementation, how it went, and what it cost, and, you know, ultimately in an ROI point of view, is the game worth the candle in terms of trying to do all of this?

MS. BUDERI: Yeah, so that's not a big focus of the state evaluations as I've seen so far, but there's definitely some anecdotal examples of that kind of thing. I think it kind of depends on the state. A lot of the accounts, for example, Indiana already had a health savings-like account structure with its previous version of Healthy Indiana. So I think for a state like Indiana setting that up, it's obviously a different administrative lift than a state completely adopting that from scratch. But I think there are anecdotal examples of whether it's operationally worth all of this. We could look more into that.

COMMISSIONER GORTON: Thank you.

CHAIR ROSENBAUM: I have to say I have the same reaction, which is sort of at two levels. One is what was the cost of implementing certain designs. And the other which I have been struck by is did all elements of design

proposals get implemented. You know, for example, is the State of Indiana really collecting cost sharing from people with no income? And, you know, did that part of the design launch at all? And I think that it would be helpful to know whether a state evaluation design -- since states are able to design -- essentially work with a contractor to design their own evaluation, are they taking enough care to make sure that the evaluator looks carefully at how they're doing what they said they would do as opposed to simply outcomes, and then the costs and the tradeoffs that come from implementation of the design.

VICE CHAIR GOLD: I can say because I've done implementation. One is just to note that the Mathematica study, which is across them, is supposed to look at that. Now, how much resources they put in what they're doing, I don't know, but that is one of their cross-cutting questions about administrative cost to states and health plans.

The other thing is it costs a lot of money to really look at the process of implementation. I think it's critical. It often involves interviews, site visits, burdens on states. They are usually underfunded in

research, and half the time, you can't distinguish whether the program didn't work or it just wasn't implemented well.

COMMISSIONER GORTON: Well, and I guess there's no shortage of experience of states using cost sharing in Medicaid. Fifty years of history suggests that, periodically, states want to do this. CMS has allowed them to do this, and at the end of the day, what you find is the providers aren't collecting the copayments, because there's always some reason. Right? You're not allowed to deny service because the person doesn't have the money on them, it's an emergency, it's one of the excluded conditions, blah-blah-blah. And so what you end up with is this enormous paper construct of how it is that you're doing cost sharing in a program and then some new gubernatorial administration comes in and says, "What the heck are we spending all this money on? It doesn't change any outcomes, and it doesn't produce any revenue for the state. Maybe we should spend our money elsewhere."

I would be interested over time if somebody could give us some insight. Is there something different about this go-round? Because if there is, let's learn from it, and old dogs like me can try and learn new tricks, or if

there's not, then what are we about?

CHAIR ROSENBAUM: So I have Peter, Chuck, Brian, Sheldon.

COMMISSIONER SZILAGYI: Yeah. Thank you, Kacey. I had a similar line of questioning to Kit. Do you know how large the premiums were or how large the cost sharing -- for some reason, I missed that in the chapter. And did it affect children?

MS. BUDERI: The premiums are usually 2 percent of income.

CHAIR ROSENBAUM: It's a parity with -- for the 100 percent and above.

MS. BUDERI: Right.

CHAIR ROSENBAUM: It's a parity with the marketplace, 2 percent.

COMMISSIONER SZILAGYI: With the market. Okay. That's 2 percent.

MS. BUDERI: Yeah. So, for Indiana, if you have income less than 5 percent of poverty, you would have a $1-a-month monthly premium. I can get you more details, information on the states.

COMMISSIONER SZILAGYI: And the cost sharing?

MS. BUDERI: The cost sharing, it's usually -- it's different by state.

COMMISSIONER SZILAGYI: I was particularly interested in Indiana.

MS. BUDERI: Indiana, it's like $4 to $8 for most things, and then I think inpatient, inpatient admission is $75, I believe.

COMMISSIONER SZILAGYI: Okay. So it's actually pretty substantial for a very poor family.

MS. BUDERI: Mm-hmm.

CHAIR ROSENBAUM: Yes.

COMMISSIONER SZILAGYI: I was going to mention a point as well. It's that there is a fair amount of evidence about the impact of cost sharing and premium, both for children and adults. I was trying to figure out what's unique here.

Did they do an estimate? If all the premiums and cost sharings were collected, what percentage of the total dollar, the total cost would that be? How much would that add? And this is apart from Kit's question about the added administrative cost of doing that. So how much does it actually save -- or could it save? Did they model that?

MS. BUDERI: They did not do that in the interim evaluation. They may be doing that in the final one.

COMMISSIONER THOMPSON: Well, can I just insert there, was that the objective of the waiver? I mean, every state has to describe what its objectives are. I don't know that Indiana's objectives were to collect money and use that as a budget offset. I think their more general idea was that this will change --

CHAIR ROSENBAUM: Behavior.

COMMISSIONER THOMPSON: -- behavior --

COMMISSIONER SZILAGYI: Behavior.

COMMISSIONER THOMPSON: -- utilization.

COMMISSIONER SZILAGYI: Sure. And there's good data from the early CHIP says that these CHIP families were happy to have some skin in the game, and they wanted -- they didn't want enormous premium, but they were very willing to do that, and so there's actually a fair -- large literature that families who can afford some are willing to have skin in the game.

There's also data that discretionary services tend to be more elastic for cost sharing, so preventive care or outpatient care or primary care tends to be more

sensitive to cost sharing.

And then ED is another area that is somewhat sensitive to cost sharing, depending on the population.

CHAIR ROSENBAUM: Although I would assume also in CHIP that the other takeaway from the family contribution experiences around CHIP -- and that raises the question of whether the thrust of 1115 is met if you are reevaluating the same points we've made.

I mean, one of the great takeaways of CHIP is that while a monthly enrollment fee may be a positive thing, when we've looked at the actuarial value of CHIP, we see that cost sharing is quite nominal once you're in the program.

So, I mean, I think it raises this question, which has been raised before, which is whether 1115 is an avenue in those situations where the issue is to allow a state to depart from the statute as opposed to develop new knowledge, and that really is the -- we don't have already.

Chuck.

COMMISSIONER MILLIGAN: Nice job, Kacey, and especially following the earlier discussion.

I have one question, going back to the premium

assistance part of this, where the findings were that it was more expensive than Medicaid and probably because of the provider fee structure underneath.

My question is what implications that might have to the budget neutrality part of these waivers if the federal spending was increased under the premium assistance models and whether there was jeopardy to compliance with the waiver by virtue of budget neutrality.

MS. BUDERI: Yeah. So the evaluations for Iowa -- and Arkansas, I'll look into that. Arkansas did exceed its budget neutrality cap for, I believe, the first year, but it's come down since then. And they attribute that to younger people -- fewer younger people than projected initially enrolling and then enrolling a little bit later.

COMMISSIONER MILLIGAN: So just to follow up, meaning on a per capita basis, it might be more expensive to do premium assistance, but that as the membership or the enrollment changed over time, it was inside of kind of the five-year overall global budget neutrality cap? Is that accurate?

MS. BUDERI: The per member per month for each month -- like the four quarters in 2014, it was over, I

believe, and then in 2015, for each quarter, it was under.

CHAIR ROSENBAUM: I have Brian, Sheldon, Stacey, Penny.

COMMISSIONER BURWELL: I am going to be fairly aspirational. So 1115s have been around for quite a while, and the theory of 1115s is to allow states to do things that aren't within the current statute and test new program design features and rigorously evaluate them, so that we would all learn of the impact of those on program outcomes and beneficiaries. I think that theory has largely been a failure over the last 20 -- I don't know of hardly any instance where some new 1115 program design feature has been identified as an improvement and other states have taken it.

But I don't want to lose that optimism. I think there's kind of a new wave of 1115s, and I see an opportunity for maybe MACPAC to do something about -- to really rigorously go over the results of these 1115 evaluations and try to pull together some type of synopsis of different new design features that states have implemented around healthy behavior incentives, copays, health savings account, and just summarize what these

evaluations have demonstrated. Nothing like that has ever been developed in the history of 1115s that I know of, and I think that we could make a contribution to the discussion.

Now, this is going to happen over the short term, and we're going to have to wait a fair amount of time to have these 1115s evolve. But I'm just kind of thinking of some kind of product where we could go with this at some point.

CHAIR ROSENBAUM: I think it's important to note -- I mean, it's a really important point, and I think it's important to note that what we have on our hands now -- there are a couple of us around the table who probably go a long ways back, one way or another, with 1115. So I go back to 1977 with 1115, and this round, this generation is quite unique, because it's in the context of a very specific program aim, which was to get the Medicaid expansions done in states that didn't embrace the expansion on their own and the tradeoffs that were made in statutory design, essentially, to achieve those expansions.

Penny, of course, is quite right that you can't use the statute. You can't invoke the statute unless there

is a demonstration capacity. The demonstration here really is can we demonstrate that under -- with enough altered rules, you can get certain states that otherwise would not do so to expand eligibility, as opposed to -- well, I mean, as opposed to -- for example, the great -- we've had three generational shifts as far as I'm concerned that have come from 1115. One is the movement to mandatory managed care, that really is based on the demonstrations that began in the '80s and went into the '90s.

A second was long-term services and supports that have their roots in actually early demonstrations, and the third --

COMMISSIONER BURWELL: [Speaking off microphone.]

CHAIR ROSENBAUM: No, no. No, I'm talking not about the 1915 stuff. I'm talking about 1115.

The third great generational piece was actually Medicaid eligibility, that first wave, that big wave in the '90s of the managed care demonstrations was typically paired demos with an eligibility expansion. Some of the eligibility expansions fell away ultimately.

So 1115 has a real history, I think, that has not been captured the way it should in moving the program into

places it wouldn't otherwise be.

The odd thing about this generation is that it's essentially figuring out an expedient way to bridge to where the program already went, you know, for people who didn't want to go there.

Yeah, Alan.

COMMISSIONER WEIL: So I have to put out a teaser and say we'll have a paper on one of these in May, but I haven't read it, so I can't tell you what's in it.

The dual role of having a vehicle, sort of a political safety valve, having a process by which states can do things that they wouldn't otherwise be able to do and the evaluative role, that tension has been around forever -- close to forever.

I think the question, going back to your questions for us, I would contrast the approach in the 1115 process with the approach of CMMI under the Affordable Care Act.

When it comes to wanting to get something done, the administration is certainly able. Administrations of both parties have over the years sent strong signals to states, "Please send us waivers to do X, and we will be

happy to get them. And here's a template." But that's really on the "We want to get something done" side.

On the evaluation side, if nothing changes, we are going to continue to have suboptimal evaluations of things that are really important, and not that the CMMI process is perfect by any stretch, but it has two elements that I think are missing in the Medicaid arena. One is they're funded. There's actually a pot of money to do this stuff, and the second is they're structured in that there will be a series of calls for submissions of things that entities want to do.

Now, it's easier to do a call for something that's going to happen in a hospital when there are thousands of potential applications. If there are only 50 potential applicants, it may be a little harder.

Again, not to romanticize the CMMI process at all, I think from the perspective of what we can offer -- I wouldn't go so far, Brian, as to say we haven't learned. I think we've learned a lot.

I, not so politely, turned to Penny and said a lot of what we've learned is that we've learned about things that don't work, and states do them anyway, or

states do things before we know whether or not they work because they want to do them. And you can't really -- the former, you might be a little queasy about, but the latter, you can't really criticize. Something seems like it might work. It's going to be five years until we know whether or not it does. We don't have five years to wait. So we're going to give it a try too.

So I think from a MACPAC sort of an institutional perspective, trying to figure out ways to improve the learning, not to try to quash the political safety valve role, because that's inherent in it, but to take the learning side of it and say as an evidence-based entity that's trying to provide guidance, what could be done that would give us a better foundation of evidence for advising Congress? I think focusing on that side is something where we -- whether we would succeed or not, I don't know, but I do think we could really make a contribution.

CHAIR ROSENBAUM: The other major difference with CMMI, of course, is that the Secretary has been given even more extraordinary powers to take the results of a demonstration and turn it into policy, and that is missing from 1115. In 1115, in theory, you're always in an

experimental phase, and it really falls to Congress to take the results from an experiment.

COMMISSIONER WEIL: And I'll just say NGA has at least a -- when I worked with them 20 years ago --

CHAIR ROSENBAUM: Right.

COMMISSIONER WEIL: -- has a longstanding policy that that should be part of the --

CHAIR ROSENBAUM: Right.

Sheldon.

COMMISSIONER RETCHIN: So I just wanted to ask, Kacey. Rather than focus on the value of the demonstration structure, but just going back to these four programs, on one slide, it says where you said -- by the way, this is really well done. On Slide 7, it says, "Overall, changes do not appear to have significantly altered beneficiary behavior," which surprises me as I read through -- and then specifically on the Indiana program, or did you mean to say altered beneficiary healthy behaviors or actually behaviors? Because it seems like there were some behavioral economics going on here with the reductions in ER visits and actually the continued ER, even more ER visits for sickness by those with power accounts in the HIP

Plus. So why would you say they didn't alter?

MS. BUDERI: I think I would say that there's no specific element of the waiver program that's unique to the waiver program that appears to be leading to specific changes in behavior.

EXECUTIVE DIRECTOR SCHWARTZ: I would say one of the evaluators for the Indiana program said to me, "I don't know why you would expect certain behavior changes because this is so complicated, I can't understand it."

So I think I also just want to put a point on the table. I was in a meeting with evaluators a couple months ago who -- and these were mostly evaluators who were working in state universities that were charged with doing some of these kinds of evaluations for these states and for other states. One of the things that they talked about, being very cognizant of the politics in their states, was the expansions would not have happened in their states without these elements in them, and that state legislators, while obviously are making tradeoffs all the time and trying to figure out how to use state funds in the best way possible, there's certain fixed views about how the world works, how Medicaid beneficiaries work, how the health care

system works, that even absent evidence or even if the evidence is contrary, those elements -- those perceptions are sort of -- are fixed. So some of them said, "We're not surprised we didn't find a result because I could have told you going in, we wouldn't find a result, but we wouldn't have the expansion unless their settlement had been part of it."

COMMISSIONER MILLIGAN: And I'm sorry. There's an important of sort of context I want to jump into this about, and I'm responding to a few comments.

We shouldn't forget that in Massachusetts, the expansion that happened that led to the ACA --

CHAIR ROSENBAUM: It was an 1115.

COMMISSIONER MILLIGAN: -- was an 1115, but I want to just -- I won't belabor this. I promise. Massachusetts had essentially a big safety net hospital fund that it wanted to keep doing forever more, and the George W. Bush administration said, "No. You have to convert that into coverage. We're not going to keep subsidizing uncompensated care," and that led Mitt Romney and Ted Kennedy to come together to retain funding, not so unlike accessing funding under the ACA, and it was an 1115

that did serve as a precursor to the ACA with modifications in the ACA.

But what we're talking about here in Kacey's presentation, many people would view in the same lens. This would be a precursor to the AHCA that we were just talking about.

So I'm much less pessimistic about the utility of 1115s to serve as an incubator of ideas, and I don't think that what led to the ACA out of Massachusetts and the state trying to retain its safety net funding and forced to convert it into coverage with subsidies and an employer mandate, individual mandate, is so different from this context.

CHAIR ROSENBAUM: And you can look at whether the demonstrations are expedient and whether we -- but we still have to deal with evaluation and what we learn, and the question is what we do with what we learn.

I have Stacey, Penny, Marsha.

COMMISSIONER LAMPKIN: I have a fairly small question that I'll ask offline in the interest of time. Thank you.

CHAIR ROSENBAUM: Oh, okay. Penny.

COMMISSIONER THOMPSON: Well, you are right. I mean, we could spend a lot of time on 1115s, and we haven't even talked about how you use them to create savings, and what you do with those savings.

I did want to just come back to this, which is very helpful, and I think people are very interested in these particular elements, and as Chuck is saying, we see these picked up in the proposal that we just were discussing. Just the one couple of points that I would make is that one of the issues that CMS has always struggled with, about this idea that if a state -- if enough states have done it, over a long enough period of time, whatever the evidence, one way or the other, like it should just be available for everybody.

And so one of the things that the federal government has said, through multiple administrations, is, well, it's the context. And an example of that is retro eligibility, which, you know, these waivers, at least in terms of giving a waiver of retro eligibility -- and there are tons of other waivers of retro that have been given out over the years -- was predicated on the idea that, well, there's a system that can take in and adjudicate an

application quickly and accurately, and so the lag between when I come in and apply and my invitation to engage in that process helps mitigate the need for retro eligibility.

So I do think that -- and, you know, some of this around NEMT, though, we see again some of that picked up in the legislation, is also relating to what's happening in the local transportation network, what can you say about what that looks like.

So I do think that it's important when we talk about these to talk about these as, again, kind of going back a little bit to what the state was coming in and say. Why do I want to waive this? What do I think this is going to mean for people? What is my theory of the case? And that's, then, what gets evaluated against going forward.

Just on Arkansas, when we say it's more expensive than other Medicaid, that would be true for almost all of the new adult population. Even under the traditional Medicaid expansions, the rates-paid plans were high, in comparison to traditional Medicaid population. So are we are making that -- is that adjustment being taken into account when we do the comparison?

MS. BUDERI: So in -- sorry, Arkansas --

COMMISSIONER THOMPSON: Arkansas.

MS. BUDERI: -- Arkansas' evaluation, it does discuss that and it has methodological details about how they dealt with that, but I think it comes back to the broader challenge of just, like, how we can't know what the rates would have been if they were in traditional Medicaid, because they never were.

COMMISSIONER THOMPSON: And traditional -- and their argument was -- traditional Medicaid could have never absorbed them

MS. BUDERI: yes, exactly.

COMMISSIONER THOMPSON: -- and provided adequate access --

MS. BUDERI: Exactly.

COMMISSIONER THOMPSON: -- without significant increases in those rates.

MS. BUDERI: Yeah, and they have a projection for what it would have been --

COMMISSIONER THOMPSON: Right.

MS. BUDERI: -- but obviously we can't know.

COMMISSIONER THOMPSON: And is that -- and that's part of what the federal evaluation is supposed to do,

right, in the sense that -- so, what you could do is you can compare what Arkansas looked like compared to other states, and that's part of what the federal evaluation is supposed to be doing, right, is looking across states at some of this?

MS. BUDERI: Right.

COMMISSIONER THOMPSON: And when in 2017 will we see that evaluation?

[Laughter.]

MS. BUDERI: I can get the exact date for you that it's due. I think it's in the materials. But it's in the summer, I believe.

COMMISSIONER THOMPSON: And who made that commitment of that date?

MS. BUDERI: It's just what's in the schedule.

COMMISSIONER THOMPSON: Okay.

MS. BUDERI: Yeah. Yeah.

COMMISSIONER THOMPSON: It's due to CMS. Okay.

MS. BUDERI: So we don't -- so it's when CMS will release it. We don't know when they will release it.

COMMISSIONER THOMPSON: Right. Okay.

CHAIR ROSENBAUM: Marsha, you get the last word.

VICE CHAIR GOLD: Oh, well, it picks up on that point. I've thought a lot about whether how you can make some of the learning on this more useful, and I think there are two points which are relevant to us.

One is that I think there's an under-appreciation to how valuable it is to stay, and for others to document what was done and implementation, so people can learn, replicate, and all the rest. And some of that just involves converting what you may be learning in evaluation into documents that are useful to someone else that get out in more real time, because that can be done. And I think we might want to think about that a little as just, you know, ways of encouraging getting states supported to be doing things and learning from another.

The other side is that there are some real conflicts between getting evaluation results of "impact." You know, what was the effect on use costs and people making this change? And it's hard sometimes to move that up. However, it gets complicated, and this is nonpartisan, because I've experienced it both in Democratic and Republican administrations. It takes a long time to get the report out of the bureaucracy once it gets in there,

and sometimes that's just bureaucratic clearance slowness. Sometimes it's -- when it's a hot issue, they just don't want to get it out, and as things get more politicized, that's been the case, and that was true under the last administration, and I suspect it will be true under this one. I think we have an important obligation -- these are federal funds.

We report to Congress -- to encourage the administrations to get reports out on a very timely basis once they're in. I mean, they do have a need to do some initial review and make sure that the contractor did their job, and the results are reasonable quality and well written, but after that, it really should get out, and I don't know if we can talk about tools or ways to get that, because it's a growing problem.

CHAIR ROSENBAUM: Thank you, Marsha. That's a great place to end. We are now running a full half-hour, almost, behind on our schedule, so we are going to have the last presentation of the day, Joanne, Kristal, and Nevena, on the issue of Medicaid's role in social programs. This will get a fraction of the time that this topic deserves, and if we can try and complete this session by about

quarter to five, so about 25 minutes, have our public comment period, and then we will adjourn a half hour over time. But it's been quite an afternoon, so --

POTENTIAL EFFECTS OF MEDICAID FINANCING REFORMS ON OTHER HEALTH AND SOCIAL PROGRAMS

* MS. JEE: Okay. So we'll speed through this.

So what we wanted to do this afternoon was talk about some of the downstream effects of Medicaid financing reforms on other health and social service programs that are not necessarily Medicaid themselves. So, of course, we have no way of predicting how states will actually respond to any of the reforms, but if we assume that the reforms will result in fewer resources for states and that they, in turn, have to make some tough choices, that's the premise of this presentation.

So what we wanted to do is go through some illustrative examples. So we have a little, tiny bit of background. We'll move through that very quickly. We'll also move very quickly through some of the previous work that we've done and then move on to the illustrative examples. And we had thought that we would sort of go through some of the background on each of the programs and

maybe we can skip over some of that and move on to the implications piece, just in the interest of time.

Okay. So we will talk about four specific programs today, and how they interact, and those programs are school-based services in Medicaid; substance abuse disorder treatment services, which you heard a lot about, so that might be a good one to sort of really move quickly through; services for individuals with developmental disabilities; and Older Americans Act-funded long-term services and supports. So that's our range of populations.

As you know, MACPAC has done a lot of work describing some of these programs -- not the ones that I just said; I'm sorry -- other programs and how they interact, and they're listed on this slide here. If you're interested in any more of that information I'll be sure to -- we can get that to you.

One other point is that much of the examination of Medicaid reform proposals has really focused on enrollment and federal savings, and less so on these downstream non-Medicaid effects. And so we thought it would be important to just sort of talk about that a little bit.

Okay. So this is the bottom-line slide, and, of course, the specific implications of Medicaid reforms really depend on the reform itself as well as the specific programs. But among the ones that we've looked at so far, the sort of key things that have emerged are that if there's downward pressure on states with Medicaid funds, programs might have to -- other programs might have to take on some of the responsibility for providing or financing the services that were previously paid for by Medicaid. Then programs, in turn, might shift some of their funding around to make up for some of the gaps that are created by Medicaid, which then, in turn, could create other service gaps. Programs might turn to serving fewer people, and they might experience other resource constraints, such as workforce reductions.

Okay. So Medicaid in schools. I won't go through all of the backgrounds, except to say that Medicaid does pay for services in schools, and particularly important are the services provided to children with disabilities who, under the Individuals with Disabilities Education Act, referred to as IDEA, are entitled to health-related services in school settings to enable their

educational achievements.

Okay. So we have learned that if Medicaid funding is constrained, schools could face constraints on their resources, which are used for things such as funding the salaries of personnel who provide these services in the schools, their ability to provide some of those services, and other outreach and coordination efforts that are on the slide here.

There was a recent survey conducted of school officials in which they were asked to talk about their concerns resulting from Medicaid reform, and they said that if Medicaid funds are reduced, that might hamper their ability to provide health services sort of broadly in the school, to eligible children, and that it could impede their ability to fulfill their mandates under IDEA. So if Medicaid funds are reduced, you know, the schools still have to meet all those mandates. They just have fewer federal funds with which to do that.

Okay. Substance abuse services. Here we're really focusing on the state substance abuse agencies, and they serve uninsured, underinsured, and some Medicaid enrollees. Particularly, they provide services that are

not covered by Medicaid, and that might be by choice of the state or that might be because they're not allowed too -- Medicaid is not allowed to cover them.

I think we'll sort of move on to the implications piece. So in thinking about the implications for Medicaid financing reform on state substance use disorder treatment efforts, there are a few things. States may reduce coverage of certain treatment services. Many of the services are optional. Or, if the essential health benefit requirement for the Medicaid expansion adult population is eliminated, as has been proposed in the legislation you all were just discussing, states could eliminate that coverage, which, in turn, would reduce access. And, of course, there's the effect of placing greater responsibility and pressure on these agencies for providing these services.

* MS. VARDAMAN: Next, I will briefly cover some systems that provide services to populations that use long-term service and supports for individuals with intellectual or developmental disabilities, and second, older adults.

So first, in terms of services for individuals with IDD, these are provided by state departments of disability services, which often partner with Medicaid in

order to administer home- and community-based services waivers. And so because of that, and the large proportion of home- and community-based waiver funding that is spent towards services for individuals with IDD, really, we're talking about these departments in the context of other programs or systems, but they really are very much intertwined with Medicaid. And these HCBS waivers cover a broad range of services to support individuals' long-term services support needs, as well as community integration, which may include things like supportive employment services.

So in terms of the implications of financing reform, again, this is really getting at waiver services. As Medicaid funding is reduced, states -- we don't know how states would respond under that scenario, but since HCBS is optional, they could reduce or eliminate certain HCBS, or they could reduce the number of waiver slots, which would lead to increased waiting lists, which are already a concern in a number of states.

In terms of state units on aging, these departments and agencies use federal, state, and local funds to support a broad range of community supports for

older adults. One source of funding is the Older Americans Act, which was recently reauthorized in 2016, which is a source of funding for community supports for individuals aged 60 and over. The Administration on Aging provides OAA funds to state units on aging, which then distribute them to area agencies on aging, which can directly provide services or fund local service providers. And although recipients of OAA services -- they're supposed to be targeted to individuals with the greatest needs, some of these individuals may have higher incomes than Medicaid eligibility thresholds, so it serves a broader population.

So, again, assuming that there would be some implications of financing reform that could constrain HCBS waiver services, those changes could put pressure on OAA services, as well as other services by provided by state units on aging, which may include things like home modification and homemaker services. And so any of these kinds of changes might then challenge state units on aging to utilize their other sources of funding to fill in some of the gaps that might be created by constraints on waivers.

So in terms of conclusions, the Commission might

want to use this time to discuss some of these illustrative examples of how Medicaid financing reform could affect other social and health programs, and speaking in more general terms, we talked earlier, Joanne mentioned that MACPAC has published a number of issue briefs and chapters on Medicaid's interactions with a number of programs, and staff could do addition work to focus on some additional programs and produce some additional publications. You could also use some of this time to talk about which areas might be of most high priority to the Commission.

CHAIR ROSENBAUM: Thank you. Can I just note that I think there's a critical difference here for us to bear in mind, as we're going through our priorities. There are certain program that, by statute, are built into the Medicaid statute and vice versa, child welfare, IDEA, where the interaction is not just the result of two programs working together. It is because it was contemplated that two programs would work together. And so as we think about where we want to spend time -- because a number of places where Medicaid affects other parts of health care delivery, you know, you might want to sort of -- I will be reading your stuff from afar so I won't be part of the

prioritization after today.

VICE CHAIR GOLD: So you can tell us everything to do.

CHAIR ROSENBAUM: Right. No. So, but I do think that this is an important issue to bear in mind.

Alan. And then we've got Peter, Kit, Toby, and Andy.

COMMISSIONER WEIL: I think this is really important work and I'm very excited you're doing it. I want to express a perspective, which is, this is -- this presentation is very program focused and it's perfect material for a governor to go to Congress and say, "If you pull this stick out of -- you know, out of the structure, things will fall."

I think, however, there is an entirely different narrative that needs to be told here, and I don't want to say "instead" but I want to say "as well," and the term "downstream" just immediately catches me. These are programs that, in the current health lingo, are addressing, in many respects, the social determinants of health, and they do at least two things. One is they provide services to Medicaid recipients that extend the service package, if

you will, of the core medical services of Medicaid to address other needs that people on Medicaid have. They also support programs that serve people who are not today eligible for Medicaid, but for those services might well have their health or other conditions deteriorate and make them eligible for Medicaid, or need much more expensive Medicaid services.

And I think whether we're talking about education, or aging programs, or almost any of these, I think it's very important when we think about this interaction that we not treat it as a one-way dollar flow from Medicaid out to all of these programs, that if we shut off the spigot they would all suffer, which is, in some sense, tautological. If they get less money from Medicaid, they'll have less money. I think the issue is, in addition to the statutory elements that Sara importantly points out, just from the perspective of families and meeting their needs, these are intertwined programs that together meet the needs of families in need, and it's the constellation that addresses the overall needs. And if we fail to meet some of the social needs, we will exacerbate the health burden, and that story, I feel, is not captured here.

CHAIR ROSENBAUM: Peter.

COMMISSIONER SZILAGYI: Yeah. Two points. To follow up on Alan's, an example of the intertwining. If you look at nurse home visitation programs, especially the evidence-based ones, some of the best ones may cost $1,000 per family, and they have been shown, both in the medium term and long term to reduce a lot of downstream health problems and costs. So that's outside of school but another example of the social determinants. But, you know -- and they are targeted toward the poor population, the high-risk population. So that's an example of the intertwining, and also an example of how -- do we want to look at an ROI within one year, or down the road?

The question I had about schools, I've worked with two large school systems, in Rochester, New York, which is the second-largest in New York State, and now at the L.A. Unified School District, which is the largest in the country -- 750,000 kids in the L.A. Unified School District. And I had no sense -- so I think this chapter is really good in general terms, in talking about the -- what happens if the Medicaid dollars go away. If 1 in 80 children are on the autism spectrum disorder, who is paying

for the special needs -- the special health and educational needs of those children?

But I have no sense for -- so one thing I do have a sense for, school nurses are disappearing. Schools have -- they're spending all their money on teachers and they're spending less and less money on what small health care-related dollars they have, or other things, especially urban -- large urban, poor schools, that take care of the Medicaid population. So there's little discretionary money left beyond pure education in the schools. I have no sense of the scale for how much Medicaid money, for example, goes into the L.A. Unified School District versus the $2 billion budget of the L.A. Unified School District, and it might be helpful for some illustrative examples to try to get a sense for how large the Medicaid dollar is related to the school, you know, services that are provided, because I personally don't have any sense.

CHAIR ROSENBAUM: The magnitude issue.

COMMISSIONER SZILAGYI: The magnitude issue.

CHAIR ROSENBAUM: Kit.

COMMISSIONER GORTON: So like Alan and Peter, I just want to raise maybe a couple of different ways to

frame these questions. The first, and sort of the easiest, most concrete one, is, I think it's important when we talk about home- and community-based services for ID/DD or any of the other waiver populations, those are services in lieu of stuff that is covered by Medicaid. So I do think it's important to remind people that if you decide not to fund services in the community, then you better go back and open up all the state institutions, because the people are going to have to be somewhere. Right? And we did the math and we know it's way cheaper -- not to mention better quality of life and more respectful, and all the other good stuff -- it's way cheaper to serve people in the community.

And so I think that basic construct needs to be illustrated where it applies. But it doesn't apply everywhere, and I think that one of the things I struggle with is, over the course of my career in Medicaid, the boundaries get fuzzier and they keep moving out. Right? So is Medicaid still what Title XIX envisioned as being a health care program -- a medical program, actually, because it was supposed to be medical services -- or does it have this broader mission?

And if it has the broader mission, then fine. We

need to do the developmental work instead of the policy framework, because we've gotten to a place where it's hard to draw a line around it and say, okay, this is what Medicaid is. And I believe that people like me, who tend to be somewhat fiscally conservative, say, "How do you build a fence around this thing? How do you get your arms around it and control it, because it seems to sort of leak and ooze out everywhere?"

And I think, to Peter's point, school nurses is a perfect example. So did we really intend that the Medicaid program was going to be the way the federal government subsidized school nurses in rural school districts across America? I don't think we set out to do that, but boy, we sure ended up there. And so, you know, transitional housing for homeless people with mental health -- you can make a case for all of these things.

I had somebody in my office a month and a half ago who led off with the line, "Food is medicine." And I said, "Stop right there. No, it's not." Right? So food is a good thing. I'm in favor of it. I'm in favor of feeding people. Housing is a good thing. Good transportation, good roads, good schools. But it isn't all

medical and it can't all be Medicaid.

And so I think what I and many people struggle with is where do you draw a line? How do you say, you know, we're not going to continue to -- you know, you have the school districts who are no longer meeting their IDEA responsibilities, providing the free and appropriate public education to the kids who are entitled to it, because what they do is they medicalize it all and the Medicaid agencies are paying for that. Now, maybe that's a good way to draw down federal funds. Maybe it's not.

And so I do think that it's important that we take an honest look at how Medicaid has become so much more -- and, you know, I'm not saying necessarily this is a bad thing, but I think we have to own it, and I think we have to acknowledge -- and this is a point that Peter makes frequently -- the oozing is not geographically equal. Some states and some localities have oozed a whole lot more than other states and other localities. And what that means is that hard-working families in all the states are dumping money into a pot, which is leaking more in some places than in other places. And so there's a fundamental economic justice issue there that needs to be addressed.

And so I do think this work is important, because what it can help us do is sort of frame the question, you know, is this what we want to spend Medicaid dollars on? And if this is what we want to spend Medicaid dollars on, then let's write the program that way and let's have all of the states spend the Medicaid dollars on those things, and let's fund it appropriately.

CHAIR ROSENBAUM: Toby and Andy, oh, and Chuck.

COMMISSIONER DOUGLAS: My points. I pass.

CHAIR ROSENBAUM: Andy.

COMMISSIONER COHEN: Great conversation and I think a great topic. Kit has raised some really tough and important issues about the way that our sort of program spending has evolved in this country, where entitlement programs, especially health care programs, have grown at a much greater rate than appropriated programs, and that mostly cover more social services and other kinds of things. And so as a somewhat natural result there is an oozing of the Medicaid line to fill in gaps that other programs can't cover. So that is a truth.

On the other hand, stopping that oozing, or pulling back that oozing doesn't solve the problem. It

leaves big gaps, in my view. So while I totally agree with you that we have to be honest about kind of what's going on and about, you know, one program filling gaps that maybe others more appropriately should cover, nonetheless, unless you better resource those programs, pulling back leaves gaps.

So in terms of where this takes, I think, MACPAC's work in this area, I would suggest a couple of things. I think one is it would be very helpful to go deeper on maybe one of the very largest programs, probably something around, you know, school-based, you know, IDEA services or something along those lines, and really just go -- try and go deeper and look at how these programs and funding interact in a few places, and I bet it is different and there is variation, and use that as maybe an example. But I also think the taking inventory is also very, very important, because I think it is not probably well-known, just the really great extent to which Medicaid has been used to fill very real gaps in our social service sort of safety net, and it's important to understand what a retrenchment would mean in those areas.

CHAIR ROSENBAUM: Chuck, and Norma will close us

out.

COMMISSIONER MILLIGAN: I guess the comment I would want to make, based on listening to the discussion, is that a lot of what happens with these programs is that they also support state and local workers and others who are administering these programs, whose salaries and benefits and all of that are cost-allocated as part of Medicaid admin. And so I hadn't really thought about it much until Peter and others kind of got us going, kind of all of the ways in which Medicaid is providing these social supports in one form or another.

I do think it's worth capturing, you know, in a little bit of the narrative, that the implications are also to the support system of state and local workers and others who are administering those social programs, because part of the administrative support is cost-allocated back through Medicaid too.

CHAIR ROSENBAUM: Norma.

COMMISSIONER ROGERS: The definition of Medicaid is that it is a health care program. Everyone knows that. It's supposed to provide long-term care for medical and custodial cost. How do you do that without taking social

determinants of health into consideration, in order to provide those services, Peter, that you said -- because the school nurses not being there? I mean, I don't know how you can do this program without considering the social determinants of health and taking care of all individuals. How do you take care of a patient medically if you don't know who that patient is throughout his whole holistic care? How do you do that? You can't. You have to take these things into consideration.

CHAIR ROSENBAUM: Well, and in truth, I mean, if you look back at the original statute, the definition of medical assistance went beyond, say, the conventional insurance of the time, and, of course, the history of Medicaid since 1965 has been pushing the outer boundaries of what is medical assistance, both through the expansion of the definition and through specific authorities, like the long-term services and supports authorities, which have authority to spend on things that a conventional insurer would not spend.

And, of course, just closing the loop on this morning's discussion, two of the most common exclusions that are very much -- we did a paper for Health Affairs, on

this, actually, a couple of years ago -- two of the most common exclusions found in traditional insurance, which are still very much part of insurance, even after the Affordable Care Act, are an educational and a social exclusion for children, leaving Medicaid, just like this discussion of the opioid situation, as the only third-party payer, typically, for services in schools. And, of course, CMS has a history of probably 30 years of writing guidance around the exclusions.

Anyway, it's a huge, huge issue. I mean, for my purpose, you can't spend enough time on this because it is the part of the Medicaid story that I think a lot of people just don't appreciate, both the effects on health programs and the importance of Medicaid to programs that are just as important to Medicaid as Medicaid is to them.

So thank you very much, and now we have time for public comment, and the audience has been extremely patient with us. We are way over on time and I don't know if there's any public comment -- commenter.

PUBLIC COMMENT

* [No response.]

CHAIR ROSENBAUM: Seeing none, we are adjourned

for the day.

* [Whereupon, at 4:46 p.m., the meeting was recessed, to reconvene at 10:00 a.m. on Friday, April 21, 2017.]

PUBLIC MEETING

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

Friday, April 21, 2017
10:03 a.m.

COMMISSIONERS PRESENT:

SARA ROSENBAUM, JD, Chair
MARSHA GOLD, ScD, Vice Chair
BRIAN BURWELL
SHARON L. CARTE, MHS
ANDREA COHEN, JD
GUSTAVO CRUZ, DMD, MPH
TOBY DOUGLAS, MPP, MPH
HERMAN GRAY, MD, MBA
LEANNA GEORGE
CHRISTOPHER GORTON, MD, MHSA
STACEY LAMPKIN, FSA, MAAA, MPA
NORMA MARTÍNEZ ROGERS, PhD, RN, FAAN
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
PETER SZILAGYI, MD, MPH
PENNY THOMPSON, MPA
ALAN WEIL, JD, MPP

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[10:03 a.m.]

CHAIR ROSENBAUM: All right. Good morning, everybody. Hi, Martha. Martha is taking us through MACPAC's analysis of mandatory and optional populations and benefits.

REVIEW OF JUNE REPORT CHAPTER: ANALYSIS OF MANDATORY/OPTIONAL POPULATIONS AND BENEFITS

* MS. HEBERLEIN: Hey, good morning. Nice way to start the day. So today I'm going to present the second part of our analysis on mandatory and optional populations and benefits. If you remember, back in March we had a scintillating conversation about the methods for this proposed analysis, so today I'm going to spend a little bit of time reviewing the congressional request and the methodology in far less detail, as well as some of the decisions we made since the last meeting, and then I'll present some of our preliminary results, and then open it up for discussion.

So to review, this analysis was requested by the chairman of our committees of jurisdiction in a letter dated January 11, 2017. The letter describes Medicaid as

an important safety net program that provides health coverage and long-term services and supports to the nation's most vulnerable patients, but it also notes that the growth in federal Medicaid expenditures is a major concern and may affect Medicaid's ability to meet the needs of these individuals.

The requesters want a better understanding of the optional groups and optional benefits that states are currently covering, and the resources associated with these, and specifically requested the analyses that are listed on this slide.

So I'm going to run through this fairly quickly because we had a long discussion in March. But to examine enrollment and spending on mandatory and optional populations and services, we are using fiscal year 2013 Medicaid Statistical Information System, or MSIS, and CMS-64 data. Because these data do not specifically identify individuals or services as mandatory or optional, we determined that status based upon a review of the statutory and regulatory citations in combination with MSIS data dictionary.

To classify individuals as mandatory or optional

we relied on their Medicaid Assistance Status/Basis of Eligibility, or MAS/BOE, and then to classify services we used MSIS type of service code.

For children, because early periodic screening diagnostic and treatment requirements limit the extent to which states may apply criteria other than medical necessity to covered benefits, almost all services for children, including those received through managed care, were considered mandatory.

So a few updates on our methods. While we had hoped to use the transformed MSIS or T-MSIS data to provide a sensitivity analysis of our assumptions related to some of the distributions of mandatory and optional enrollment, states are still in the process of submitting these data, and while we have received -- recently these data have been made available to us, we are still in the early stages of testing the completeness and validity of them, and so we were not able to use these data for this analysis.

And then in terms of managed care, we assumed that spending in managed care would mirror that in fee-for-service, and we did this at the group level, so adults, for example, at the state level. We also made some refinements

based on our discussion at the March meeting. So in states where the managed care penetration rate for a particular group exceeded 75 percent, the national distribution of mandatory and optional fee-for-service spending for that group was applied.

For most enrollees, all services received through managed care were assumed to be acute services, but in states where there was a large proportion of LTSS users in managed long-term services and supports, the proportion of fee-for-service spending used for the aged and blind and disabled groups included both acute and long-term services.

So moving on to the exciting part, starting with enrollment, our preliminary results showed that in 2013, about 71 percent of enrollees were mandatory and about 29 percent were optional. When breaking this down by group, the majority of mandatory enrollees were children, followed by non-disabled adults, people with disabilities, and people over the age of 65.

When looking at optional enrollment, non-disabled adults made up the largest share of optional enrollees, followed by children, and then similar proportions of people with disabilities and people over the age of 65.

The number of enrollees eligible under mandatory and optional pathways varied by eligibility group. So overall, about 46 percent of enrollees were children, and the vast majority of these children, about 86 percent, were mandatory. Non-disabled adults, including pregnant women and parents, represented about 30 percent of enrollees, and approximately 56 percent of these enrollees were optional. I do want to note that about 4.6 million of these 11.3 million optional adults were receiving family planning services only.

Fifteen percent of enrollees were people with disabilities. Almost 80 percent of these enrollees were mandatory. Approximately 10 percent of enrollees were people over the age of 65, and 68 percent were eligible under a mandatory pathway. And while not shown on this slide, there were approximately 10.7 million dually eligible enrollees in 2013, and of these, 70 percent were considered mandatory.

The distribution of mandatory and optional enrollment also varies by state, reflecting both state decisions to adopt optional pathways and the demographics of the state. For example, in Vermont, 35 percent of

enrollees were mandatory, compared to 96 percent in Nevada.

The number of enrollees in each group also differed by state. For example, Maine has the largest share of enrollees eligible on the basis of age, while West Virginia had the largest share of people eligible due to disability, and Commissioners, there are some state-level tables in the appendices of your chapter.

So moving on to spending, in fiscal year 2013, Medicaid spending totaled about $401 billion. Nationally, almost half of this spending was for mandatory populations receiving mandatory services, so the first line in this table. Approximately 21 percent of spending was for optional services for mandatory populations, and the remaining 31.5 percent of spending was for optional populations receiving either mandatory services or optional services.

Across the states, spending on mandatory and optional populations and services varied. For example, spending on mandatory populations receiving mandatory services ranged from a high of 74 percent in Arizona to a low of 27 percent in North Dakota. And like the variations seen in enrollment, these differences reflect state choices

and the demographic and health status of enrollees, as well as provider payments and geographic differences in the cost of care.

So looking at spending by enrollment group, spending on people with disabilities comprises the largest share of spending. This was followed by spending on those age 65 and older, children, and then adults. And spending for mandatory and optional enrollees in services varied by the different eligibility groups.

So, as I said before, almost all of spending on children, regardless of whether they were mandatory or optional enrollment, was mandatory as a result of EPSDT. There was about $530 million spent on optional services, and this was primarily home- and community-based waiver services.

Just over half of spending on adults was for those enrolled through a mandatory eligibility pathway, and spending for non-disabled adults was more likely to be for mandatory services than for optional services.

The majority of spending for people with disabilities was on those enrolled on a mandatory basis. However, when you look across the eligibility groups, it

was about evenly split between mandatory and optional services.

Approximately half of the spending for people eligible -- sorry -- people over the age of 65 enrolled on a mandatory basis, and then spending on the services was also similarly split between mandatory and optional, among the aged populations.

In terms of mandatory spending by type of service -- and I want to just note that this doesn't take into account the mandatory or optional enrollment status the individuals. It's just looking at the type of service. So the majority of spending on mandatory services was for acute services, such as inpatient hospital and physician services, over a third was for managed care, and about 17 percent was for long-term services and supports.

Again, spending varied depending on -- across -- depending upon the population you look at. So spending on mandatory services for non-disabled children and adults was about evenly split between acute services and managed care, with very little spent on LTSS. On the other hand, the majority of mandatory spending for people with disabilities was for acute services, and looking at the elderly

population, the majority of spending was for mandatory LTSS, so most likely nursing home facilities, and smaller amounts were spent on acute and managed care services.

In terms of optional services, the majority, or about 52 percent of optional spending was for long-term services and supports. Optional spending on LTSS was also the largest share of optional spending for people with disabilities, at about 57 percent, and for people age 65 and older, at about 64 percent. And while not shown on this graph, spending on fee-for-service prescription drugs accounted for just about 3 percent of optional spending.

So moving on to the discussion, overall, the results that we found mirror the earlier work that was done by the Kaiser Commission on Medicaid and the Uninsured, and the Urban Institute, that they found in 2007, about 70 percent of enrollees were mandatory. That study also found that about 40 percent of spending was for mandatory services for mandatory enrollees, which is somewhat lower than what we found in our study.

It is important to note that because these data represent 2013, which was the most recent year for complete data that we had, they don't reflect any of the changes

from the ACA. So this would include the Medicaid expansion to the new adult group. While post-ACA implementation from MSIS are not available, we did look at the CMS-64, which shows that as of June 2015, there are about 13.2 million enrollees in the new adult group, and spending for this group totaled about $18.4 billion.

While this population is technically mandatory under the statute, the Supreme Court ruling made them -- their coverage optional. And so considerable enrollment in this new adult group would likely add to the number of optional enrollees. But on the other hand, the ACA also resulted in increased enrollment among already eligible enrollees, and the available data cannot provide information on the distribution of mandatory and optional enrollment that may have resulted as a gain of these -- as a result of these enrollment gains. And, furthermore, we don't have the details on the utilization of services of the new adult group so we can't really look at whether their service use -- how it falls in terms of mandatory and optional services.

So, in summary, these findings show that almost half of total federal and state Medicaid spending is on

mandatory services for mandatory enrollees. Mandatory coverage of people and services reflect a set of decisions made by Congress over time regarding the core features of the program which must be provided by every state. A significant amount of spending, about one-third, is on optional enrollees, and the spending was about evenly split between mandatory and optional services.

Like many other aspects of the Medicaid program, states varied considerably in the optional populations they cover, the optional benefits they provide, and the amount of spending attributable to these. And these variations reflect both deliberate state choices, when considering the health needs of their residents, as well as the cost of paying for their care.

So with that I will close and I look forward to your discussion.

CHAIR ROSENBAUM: Thank you very much. So I have Brian, I have Alan, I have Kit, Sheldon.

COMMISSIONER BURWELL: Very good analysis. It kind of connected to the previous presentation. So we have some access to T-MSIS data. Is that correct? MACPAC does?

MS. HEBERLEIN: Yes.

COMMISSIONER BURWELL: Have we looked at all at the eligibility codes or the service codes in T-MSIS versus MSIS, and made any assessment of the degree to which T-MSIS would, you know, increase the accuracy of our ability to classify people and services appropriately?

MS. HEBERLEIN: So there is more granularity in the T-MSIS file, in terms of the eligibility pathways. So instead of MAS/BOE there's, I think, 75 eligibility pathways listed in T-MSIS. We did a crosswalk to basically match the T-MSIS codes with the MAS/BOE codes. The data, we have been given some preliminary VALIDS data to look at from a handful of states, and we did try to look at several quarters where there was some data reporting, and we just didn't feel like the data were, for lack of a better word, valid enough for us to use at this point. States are still reporting. There's a lot of quality back and forth, questions that they have. So we did look at it. We just didn't feel confident that we could use it for this analysis. But I think in the future, it could be used.

CHAIR ROSENBAUM: Thank you. Alan.

COMMISSIONER WEIL: This is great work. I want to go a layer below the surface here, and the question is

whether this belongs in this report, but I think it kind of has to. So the -- from my perspective, the primary motivation of the request has to do with concerns about whether optional, either populations or services are as high a priority as mandatory. And I think it's pretty clear that for many of the populations and for many of the services, there's no value judgment between mandatory and optional. It's an artifact of the history of the program, as you've noted.

The one group that stands out is the non-disabled adult group, and I am struck, as I look at the analysis, that there's not a lot about that group -- because it's an overview of mandatory/optional in populations, mandatory/optional -- there's not a lot of a focus on that group, and yet I think in terms of the origins of the request, that's where the focus is.

And so there was -- there is reference to family planning, you know, partial benefit populations. There's reference to five-year immigrants. There is reference to whether the services are mandatory or optional, although I'm not sure, to those who are asking this question, whether that's a key concern.

So, in general, I realize that going an entirely layer deeper on every optional versus mandatory population and category would make this too long for anyone to read, but it does seem to me that some more focused attention on what the eligibility pathways are for the non-disabled adults, and, therefore, what the service mix is, not just mandatory/optional, would not just be useful but would actually help those who asked for the analysis.

CHAIR ROSENBAUM: Yeah. I have to say I share -- I thought about that immediately, and, of course, where we are is that there's sort of -- you know, except for pregnancy and disability, there's no mandatory adults in the working age population because the state eligibility standards for mandatory adults are low, and so you have this huge group of people who are -- they would have been mandatory, you know, under the original statute, and have the status of an option today. And so developing more about them, I think, would be a useful thing.

I have Kit, Sheldon, and Marsha.

COMMISSIONER GORTON: The chapter appropriately observes that, in some cases, less expensive optional services have been put in place to serve people in more

appropriate ways, and they offset more expensive mandatory services. I think we've made that point. But that's one of the things. For as long as we're going to use this legacy framework of mandatory and optional, I think we need to point out to people that sometimes that's what you're doing. So home- and community-based services, optional; ICR/MR, mandatory. But people want to be served in the community, they want to live in the community. It's better quality of life. And so I think we just need to continue to repeat that. I think you've done that well.

Following up on what Alan and Sara were just talking about, I was thinking about arcing back to yesterday, Joanne and Kristal's presentation, where they have the -- everybody doesn't have the slides from yesterday but the four sort of scenarios, state substance abuse agencies and financing the individuals with ID/DD, implications for financing, that set of stuff from yesterday.

It seems to me that if we could, within those -- the scenarios that got presented -- so schools, substance abuse, ID/DD, aging, and maybe not all of them but maybe some of them -- particularly to Alan's point, the substance

abuse one, if we can look -- if we can do the mandatory versus optional kind of drill-down into that, then I think what we would find is that the people who use those services are largely "optional people," and the services themselves are largely "optional services." And we can infer, based on what we know about the expansion adults that they're heavy users of these services.

So, therefore, what we would expect, would be de-funding those optional people and optional services would be a massive step backwards in terms of substance abuse disorder intervention.

And so I just -- I agree with Alan. It's probably unwieldy to try and take the whole analysis down another level, but if you can maybe focus on some of those scenarios, it calls out this idea of, again, where we are using better, more appropriate, less expensive services and resources to give people higher-quality care, and in doing that, we use the flexibility that generations of wise people have built into this program to allow states to solve problems.

CHAIR ROSENBAUM: Sheldon.

COMMISSIONER RETCHIN: Just a quick question.

Maybe it's in the two cells with optional benefits, but how much do the pharmaceuticals distort the numbers and spending, if you were to take those out, or to show --

MS. HEBERLEIN: So the pharmacy is included in the acute care, and it's only fee-for-service spending. And some work that Chris did before showed like between 50 and 60 percent of pharmacy spending was in managed care. So that would be in the managed care part. And what we could pull out from the fee-for-service, about 3 percent -- it represented about 3 percent of optional spending. So it was small.

CHAIR ROSENBAUM: Marsha.

VICE CHAIR GOLD: Yeah, I've provided you some comments, and I think actually listening to the discussion, they're actually very in line with what other people were saying. And I think it's a matter of sort of humanizing this. I mean, it sort of reads a little bit -- less in the text than in the presentation, but, still, a little bit more like a mechanical exercise of sorting things into four boxes as opposed to talking about people who happen to be in various categories and have various needs. And I think that maybe some collapsing of some of the figures and

adding some text. So, for example, I see what was in the report as Figure 4 is really key, I mean especially if you add a total there, because it lets you talk about the fact that children are the dominant population in Medicaid and they actually are almost all mandatory. The non-disabled adults, I didn't pick up the fact that that was mainly family planning. You can talk about that it's pregnant women, and then that's your entree to talk about we didn't have the expansion population, but there, the people with disabilities, I don't know who those people are, but we know later that long-term-care services that are optional are a large share of their expenses. So that's key.

And if you can sort of talk about who the people are, then it will make it easier to relate it to the expenses. And I think you might need to combine, on 13 and 14, those -- I had trouble, mandatory spending by groups and then optional, and somehow you had to put it together. And I think rather than two figures, if you had a table that looked at it, because I think -- and I may not be right here, but I think you need to say essentially the kids, it's not -- it's really all mandatory. I think people with disabilities, it's -- at least a large share of

it is long-term services and supports. And you can get in some of Kit's comments here, too, and just make it real, because I think we had the point when we talked last time that this optional versus mandatory on benefits is an artifact of how benefits have been defined over time, and, you know, if you go to a nursing home, it's mandatory, but if you're in the community, it's not, and some other things. And I think that doesn't come through as much, and I think if you, you know, humanize it a bit more and get a little bit below, it shouldn't be too hard because you have most of the -- I think you know most of it. It would really help.

CHAIR ROSENBAUM: Great. Toby.

COMMISSIONER DOUGLAS: Just building on what Marsha's saying, on Slide 13, if you go to Slide 13, just a really important theme that I think needs to be pulled out between Slides 13 and 14 is this point that this is really -- optional services is really about the disabled and the aged. And, you know, any discussion around this artificial fact, these are services that are being used to serve our most vulnerable, whether it's, as Kit said, take them in the community or for benefits that are needed for a

population that isn't served in commercial or other parts of our health care system.

CHAIR ROSENBAUM: I think the sentiment being expressed is very much the same, which is helping Congress get below the graphs and see the story that -- you know, the word "optional" conjures up all kinds of things in people's heads, whether it's people or health care, and I think the more we can sort of help people understand what they're looking at, the better.

Penny.

COMMISSIONER THOMPSON: Yeah, great chapter, great work, great conversation. The other piece that just popped out at me that made me curious, and we're not really providing a lot of detail underneath that might be helpful to people, is you do recognize and talk about the variation, though, among the states. On the one hand, we're kind of talking about these thematic elements about some optional services substituting for mandatory services and so forth. And yet underneath of that, there still are quite significant variations in some of the states. And so I think sort of similarly as we talk about identifying some scenarios to kind of play this out so that people get a

feel for what's underneath of this, that it could be useful as well to pick a few different states that have like a really different look and mix and talk about what their programs actually look like underneath of that and maybe why they're pursuing some of those flexibilities in different ways.

CHAIR ROSENBAUM: Stacey.

COMMISSIONER LAMPKIN: So thanks. This has been quite an exercise, and I agree with what others have said with respect to how we're presenting for the primary audience here.

But for the researchers and other techies that also use our product, I really appreciate how careful you all have been with respect to the limitations and the methodology and all those details. There were just a couple of areas where I wondered -- I just wanted to raise the question about whether we should say a little bit more. One of them is around the role of pharmacy, and it somewhat relates to the time period that we're looking at. You know, how do we think about -- pharmacy is a big component of the optional on the acute side, right? And so how are we thinking about rebates? How is that different in the

managed care and in the fee-for-service analysis? And how is that different from the way it looks now where the Medicaid rebates apply to managed care pharmacies? So is there something to say there?

And then just a brief acknowledgment around the administrative component of managed care capitation rate being allocated on the underlying services seems appropriate. But thank you, really solid. Thank you.

CHAIR ROSENBAUM: Brian.

COMMISSIONER BURWELL: I have one technical question. So people who are in nursing homes, over 65, who are not receiving the personal needs allowance, so they're classified as non-cash, are considered optional in this analysis? Because often -- so I know when states classify nursing home recipients, it's only those who are receiving SSI cash versus non-cash.

MS. HEBERLEIN: Yeah, I can double-check, but I think they would be optional. But it also depends on how states coded them in, because there are different age -- and then there's some overlap in the pathways within the different MAS/BOEs. So it's not always clear to me how they're coding their aged populations.

COMMISSIONER BURWELL: Yeah, the kind of irony there is if they weren't in a nursing home, they would be cash recipients. So you don't really know if they're cash or non-cash and, therefore, mandatory of optional. If their income is above the SSI level, then they would be medically needy, and so forth. It's a fairly technical question, but it might be worth mentioning in the chapter around how you classify people.

CHAIR ROSENBAUM: Peter.

COMMISSIONER SZILAGYI: Yeah, very good job, and I really appreciate the discussion that's going around the table. At the risk of repeating what Kit and others have said, I am worried that if you only looked at the figures, you would misinterpret the message that was clearly written in the chapter. Is there any way to take what others have said and actually create a figure, a modeling figure? If this wasn't optional, what might happen, you know, so that the costs are transferred into mandatory costs? Is there any way to take from prior literature to kind of create a figure? Because of the concern of just interpreting from figures and saying this is the amount of money that could be potentially saved if we eliminated the optional. But

that's in reality not possible because the additional mandatory costs might be greater. I don't know that part of the literature well enough.

MS. HEBERLEIN: I'm not an actuary, and I don't think -- that's not something we can say with the existing data. I think we did try to talk about it a little bit, that if you take something away, then it might have to be provided somewhere else. And I can look into seeing if there is any more literature that sort of explains where those pressure points might be and where those shifts might end up. But I think that could also potentially be an area of future research --

COMMISSIONER SZILAGYI: Potentially future --

MS. HEBERLEIN: -- but not necessarily something -- we can't do it with the data we have here.

COMMISSIONER SZILAGYI: Yeah, not as a fact, but that would be a modeling exercise.

CHAIR ROSENBAUM: Any other questions?

[No response.]

CHAIR ROSENBAUM: Well, thank you.

And now for something completely different, Home and Community-Based Services, Network Adequacy Standards

and Managed Long-Term Services and Supports.

MANAGED LONG-TERM SERVICES AND SUPPORTS: NETWORK ADEQUACY FOR HOME AND COMMUNITY-BASED SERVICES

* MS. VARDAMAN: Good morning, Commissioners. Today I'm going to review some results from MACPAC-funded research on home and community-based services network adequacy standards in managed long-term services and supports programs.

I'll begin with an update on where state stand in terms of their adoption of managed LTSS. Then I'll review some background on HCBS network adequacy standards and federal requirements. I'll then move into some results of a review of MLTSS contracts and interviews with stakeholders that was conducted for MACPAC by Health Management Associates. And then I'll end with some concluding observations.

First, in terms of the status of state MLTSS adoption, as many of you are aware, states are increasingly using managed care arrangements to administer LTSS benefits. There are currently 22 states with active MLTSS programs, which is up from eight in 2004.

In addition, five states are in active

development. Some of these are very close to launching this year; others are earlier on in the planning process. An additional five states are considering MLTSS programs for the future.

It is important to note and for interpreting the contract review results later on that some states are operating more than one MLTSS program. For example, they may offer different programs for different populations, and so there will be more than 22 contracts that were reviewed.

In addition, some states have programs that are regional, others are statewide, and there's a wide number of other areas where states vary in terms of their MLTSS programs.

In 2014, MACPAC staff and a contractor conducted a series of site visits to states with both new and established MLTSS programs. We talked to a number of different stakeholders at that time, and among the areas that were discussed were issues around developing HCBS networks, which is one reason why we decided to pursue this work.

In terms of HCBS network adequacy standards, they do differ from standards that are used for acute care in

several important ways.

First, in terms of HCBS, providers are traveling to the beneficiary rather than the beneficiary traveling to them, which requires a different kind of standard.

Second, HCBS are provided frequently and may be needed for months, years, or decades, which is important to consider in building a network.

HCBS network adequacy standards are part of state and federal oversight of these programs and help to ensure that plans are contracted with enough providers to provide access to the services in the contract. They also help to determine whether new MLTSS programs or plans are ready to launch, and monitoring in an ongoing fashion can identify access issues as provider supply and beneficiary needs change over time.

In terms of federal requirements for HCBS network adequacy standards, MCOs must meet general requirements for Medicaid managed care as well as some specific requirements for MLTSS that are set by CMS. In April of 2016, CMS published the final Medicaid managed care rule. Among the provisions, it codified May 2013 guidance that the agency had released regarding elements of a successful MLTSS

program. In addition, the rule directed states to develop and implement standards, including standards other than time and distance for providers who travel to the beneficiary. However, the agency did not specify particular standards states must use and noted that states vary so widely across the types of services that are provided and that diversity as well as a lack of consensus on HCBS standards compared to acute-care standards led them to state that it was best for states to set these contract requirements at this time.

So beginning last year, we contracted with Health Management Associates to describe existing state HCBS network adequacy standards in order to understand the variation in how states have approached requirements for managed care organizations. As part of that work, HMA reviewed 33 contracts in 23 states, so, again, several states had more than one MLTSS program, and at least one of the contracts they reviewed was for a state that is launching its MLTSS program shortly.

HMA also conducted 12 interviews to understand how these standards have evolved as well as how they work on the ground. They interviewed Medicaid officials in four

states -- Minnesota, Tennessee, Texas, and Virginia -- as well as two managed care organizations, three provider organizations, and three beneficiary advocacy organizations to understand from a variety of perspectives how these standards are developed and how they've evolved.

In terms of the contract review, there were 44 types of contract standards that HMA identified in the 33 contracts that they reviewed. The most common were standards related to time and distance for both providers that traveled to the beneficiary as well as certain HCBS providers where beneficiaries are traveling to the provider, like an adult day health care center. Also another common one was related to continuity of care.

Other frequently used standards included requirements that plans monitor gaps in service, which I'll discuss in more detail in a moment; also that they contract with any willing provider, provide procedures for single-case arrangements, contract with a minimum number of providers or use fee-for-service rates.

Fourteen contracts required plans to monitor gaps in service. So in these cases, states were requiring that plans track, for example, the time between the

authorization of a service and when that service began, or the number of times where a service was missed, so, for example, a personal care services visit that may have been missed. States and plans may be using electronic visit verification systems to help support this activity, and states are often requiring backup contingency plans to address how the plan will deal with situations where a missed visit may have occurred.

In addition, three states required that plans submit annual network adequacy plans. These plans describe how the MCOs will monitor the timeliness of care, how they will address deficiencies, as well as describing their existing provider network. Some contracts had special considerations for rural areas. For example, in a case where a beneficiary may have to travel or the provider has to travel, there may have been different distances for rural versus urban settings. Also, states used most standards for all HCBS provider types, but there were certain standards that were tailored to specific provider types, so for example, personal care services.

In terms of the interviews, again, HMA spoke with a broad variety of stakeholders, and there was really a

great deal of consistency across stakeholders in the things that they felt were important as goals for HCBS network adequacy. Among those goals were ensuring that beneficiaries have opportunities for self-direction and meaningful choice of providers. They also stressed the importance of cultural competency of providers, that states and plans are measuring outcomes and quality-of-life issues, and also that the purpose is to help promote a high-quality-care network of providers.

Finally, stakeholders identified provider capacity as a limiting factor in developing HCBS networks, and plans and states also noted a number of ways that they're trying to deal with provider shortages. But this was an area that they noted contributed to issues like missed visits. That if, for example, in personal care settings, if an attendant cannot make an appointment, that agencies may have difficulty finding someone to back up that appointment. And that was some of the reasons underlying some of the problems that plans may have in delivering services.

There was broad support across stakeholders for using gaps in service reports to evaluate network adequacy

on an ongoing basis. States emphasize that as their programs have evolved, they are moving towards standards that reflect whether beneficiaries have access to the care that they need and have been authorized to receive through their care planning process.

Several stakeholders noted that something like requiring a minimum number of each provider type in a geographic region may be something that's easy to enforce. It might be needed from a readiness perspective, but in terms of ongoing monitoring, things like gaps in service reports were more useful in understanding ongoing access.

So, finally, I would say that stakeholders did not feel that compliance with the rules provisions on HCBS network adequacy would be a challenge. Again, CMS acknowledged that states are currently in the best position to make standards that address their unique circumstances, and so there really didn't seem to be an impetus for federal action at this time.

So I will end by saying that we are currently in the process of working with HMA to finalize the report. I have reviewed some of the key themes today, and in terms of additional work, the Commissioners may want to use this

time to discuss whether there's other areas of inquiry around HCBS network adequacy that you would be interested in the staff pursuing, or given the increasing role of MLTSS in delivering LTSS, if there's other areas and research questions around MLTSS that you would like to pursue.

And that --

CHAIR ROSENBAUM: So I want to ask you a question. Thank you so much. This is very helpful, and I want to ask a question that has been bothering me since you began the presentation. If you look at -- not your presentation, but the question that has been bothering me.

[Laughter.]

CHAIR ROSENBAUM: I don't want to scare you to death.

If you look at some of the highest profile documents thus far about areas of really significant policy tension in Medicaid, Secretary Price in his letter to the states with Administrator Verma raised this point. It was in the Republican governor's letter back to the House Speaker and the Senate majority leader. The issue of federal standards around network adequacy has been flagged,

and it's also been a constant issue if you read stories covering various meetings, whether on Capitol Hill or other places. And yet the results that you have here suggest that states, of course, face -- I mean, this is probably the greatest challenge in Medicaid, is designing delivery systems that are capable of doing what people need in terms of their covered benefits.

But you don't see widespread responses either saying the measure itself is inappropriate or these are hopeless struggles for us. I'm using your presentation to raise this issue, wondering whether anybody here -- you might have some insight just from this work, whether anybody has some insight as to why we seem to have sort of cognitive dissonance between the politics of network adequacy and the management and operation and administration of network adequacy, which is a hugely complex thing. And you mix in, stir into the mix, the fact that if you look at the rules themselves, the rules say you have to establish standards, and the standards have to have certain elements.

So I'm wondering if you have thoughts, Kristal, from your own work and whether other people might. Penny,

Marsha, Kit.

MS. VARDAMAN: I would just say that this is for HCBS network adequacy, and CMS has given states a great deal of flexibility here. I'm not sure how much that applies to other provider types.

COMMISSIONER THOMPSON: I'm just going to jump in on not making as good a point as you made, but on that point, which is when I read this, what it sounds like to me -- and it's a little bit of an echo to our earlier conversation a meeting ago or maybe two meetings ago on access standards, where people say the federal government says to the states, "You need to pay attention to this and kind of figure this out," and then in this case, the states say to plans, "You need to pay attention to this and figure this out."

There's a lot of words, but in the end, there isn't a lot of prescriptive requirements. There isn't even a coalescing around best practices. There's a lot of things kind of in here to me, because I think of the availability of service providers as one thing, the compliance with plans as kind of another thing.

So my initial comment was going to be, what do we

really have here? It just sort of feels again like back to the access conversation, that we all know that we want to provide an adequate network for people to get to, whether it's in fee-for-service, whether it's in managed care, whether it's in managed care acute services or long-term care services. But we still struggle with what does it really mean to do that, and how do we measure that?

That may be somewhat of the answer to your question, which is if nobody really knows, then maybe there's a question about how much the federal government should be substituting its judgment for states' decisions or reviewing what a state is doing if there are no clear standards by which somebody would judge that as adequate or not adequate.

CHAIR ROSENBAUM: It's the very absence.

COMMISSIONER THOMPSON: It's the very absence of clear standards --

CHAIR ROSENBAUM: The absence of standards.

COMMISSIONER THOMPSON: -- or even kind of a framework that is sort of like why am I sending this to you, and what are you going to tell me about it? And you're going to ask me a bunch of questions, but in the

end, that conversation isn't necessarily going to lead to anything productive.

CHAIR ROSENBAUM: Marsha.

VICE CHAIR GOLD: Yeah. I thought I saw a discrepancy between what the standards were sort of -- I mean, you know, whatever they are, that says you should look at adequacy and what the interviews said. And the interviews had a lot more on-the-ground stuff.

I did a bunch of work a few years ago looking at financial alignment demonstrations and how you could tell if a Medicaid or Medicare plan knew how to treat some of the people who use these services and just a recognition of the diversity of different provider types that you need for different kinds of people who fall into these categories of needing these services. And regardless of whether it's a standard or whether it's just planning or discussion or oversight, a good plan will sort of know the people that it's serving and have the right mix of types of providers. And I don't know that the standards get at that.

Also, it seems to me that one of the biggest problems is sort of talking about what long-term care services supports versus doctor ratios or even hospital

ratios. Capacity is an enormous issue here that doesn't seem to come into the standards because if you have -- you might have a network that has X, but I know when we talk to plans, they say, "Well, if we're going to have -- if this means we're going to have to triple the number of people we have who give this service for this thing" -- and being able to serve a larger number of people, you may have the provider, but you don't have the capacity.

And Medicaid is a very -- a lot of these are very Medicaid-specific providers. I think they live through treating Medicaid because Medicaid is the only payer who really pays for a lot of these servicers, except for out of pocket.

So that flavor here, it's hard to get at what the right standards are, but I think the more important question is why the standards were there to begin with, which is sort of to try and make sure that there's the right capacity, some of which is under the control of a plan, some of which may not be.

And I'm not sure that -- I mean, one of the reasons no one is probably upset with the standards is that it doesn't really get at the key issues because it's really

hard to get at the key issues.

CHAIR ROSENBAUM: Oh, I was saying the opposite, though, that people are upset with the standards to such a degree that it's in the Price letter and the governor's letter, and what I can't put together in my head is that level of upset.

I think Penny's point may be the clue here, which is they're upset because of the philosophical issues around asking for performance on issues where, in fact, there are no standards that anybody really is willing to --

VICE CHAIR GOLD: I think it also may be just the numbers of groups that they have to report on.

CHAIR ROSENBAUM: Kit.

COMMISSIONER GORTON: So I think two thoughts. First, I think it's important that we recognize that when we start talking about home- and community-based services, particularly in some kind of managed care context, that that's a fundamental sea-change in terms of how things are organized.

We used the same words. Right? We call them "providers." Right? But when you're dealing with the acute care benefit, virtually all of the providers are

licensed facilities or licensed practitioners, and we have huge workflows in place in order to determine who's qualified to do stuff and who's not.

When you move into home- and community-based services, the pendulum shifts, and what you're dealing with predominantly is non-licensed providers and, in some cases, community resources. Right? So home modification construction companies, people who modify vans to be handicapped accessible, the pest control people, home-delivered meals, all of those things. Right?

And so when you start looking at that group of providers -- and they're providers now -- I think you encounter a variety of challenges, which I think, Kristal, it may be useful to go back and delve into in some way in a future piece of work and sort of array. And I think those issues fall in several buckets.

The first of them is workforce development around this capacity thing. If you have a personal care attendant, what constitutes being qualified? And I get that being culturally and linguistically capable is one thing, but does this person know how to safely lift somebody? Does this person know how to safely bathe

somebody? Does this person understand that the individual that they're supporting may have swallowing difficulties and has to be in a certain position and have a certain texture to their food and all that? So all of those competencies become critical in terms of the quality of care that's delivered, and then, of course, you have to build in enough redundancies, so that when that person goes on vacation or has a baby or gets sick themselves, that somebody else can step in and do that because people still need to be transferred, bathed, and fed.

So I think there's a lot of work around that. One of the things that I know states struggle with is these people, these providers don't often get paid a heck of a lot, and so there's a lot of churn through that. And so is the funding adequate to pay these paraprofessionals, for lack of a better term, adequately so that they can learn their craft, they can do it extraordinarily well, they can be dependable? So I think that's one bucket that needs to be looked into.

The second, in terms of the -- I'll call it the agency level because there's always an intermediary between whoever the payer is and the actual deliverer of care.

And, Marsha, I would just correct you slightly. These agencies, in fact, are accustomed to categorical funding. So they're used to getting paid some amount to serve a person for a year or some amount to serve a person, sometimes just to have the doors open and accept whoever comes in. And when we ask them to enter into a managed care environment and to be able to submit encounter data that we can put into T-MSIS, they're like, "Huh? We just want you to give us our grant check this month." Well, there is no grant check, and so the levels of accountability that providers -- these nontraditional providers' operational capacity to interact with the system as we've built it out -- is often very limited. They require huge amounts of technical assistance and hand-holding, and some of them just have a lot of trouble getting there.

And so I think that piece of it is important to the capacity building as well, because if you can't get paid for the work that you do for the 50 people you're supporting, you can't expand to support 500 people. So we need to think about operational infrastructure, business infrastructure for these agencies.

And then the last piece, just very quickly, is we're asking some of these agencies to repurpose themselves, sometimes in ways that they're comfortable with and sometimes in ways that they're not. So not only are these agencies often categorically funded, they often have what they historically think of as catchment areas, and we may be asking them to serve people in different geographic footprints. We're asking them to interdigitate with other programs, which they have not historically interdigitated with. We're asking them to simply think about this set of services in a whole new way. We're asking them to participate in an ecosystem, and then we're saying to them, "We know you're an area agency on aging, but by the way, we have these under-65 duals who we want to support. And can you do that? Can you do your stuff for them too?"

And this has been a problem in Massachusetts because the AAAs are about safe aging in place, whereas the centers for independent living are about getting people -- I mean, you don't want a 20-year-old in a wheelchair being safe. Right? Because -- you do, but you don't. Right? You have to afford them enough freedom and choice so that they can go out and live their lives, and that's not safe

aging in place.

So I think there are fundamental sort of cultural questions as people retool, and so asking the question do you have an agency that can do this, and we say yes or no. But does that agency have the competencies it needs?

CHAIR ROSENBAUM: So it's the question of access to what. Yeah.

I have Chuck, Brian, Norma.

COMMISSIONER MILLIGAN: This is a very interesting discussion. I almost don't want to talk and interrupt it.

So just a little disclosure first. The managed care organization I lead in New Mexico has MLTSS in it. It's a big state, a lot of rural and frontier, and in my health plan, we have 13,000 members who have plans of care that include HCBS and attendant care and those sorts of things. My network includes the people we're talking about, so that's a little context for a few of the comments.

I want to, I think, come back to some of the points, Sarah, how you got us started and Penny and Kit's comments.

I am going to identify four pieces of, I think, what's kind of underneath this. One is I think that this is a service type that the CMS uniquely doesn't have any other benchmark to understand. It's not part of Medicare. It's not part of what CCIIO does. There's no commercial equivalent, and so there aren't any other mechanisms by which -- within CMS, there are means of talking to peers or counterparts in other parts of the federal government.

So I think that there is a view that some would have that the federal government knows less about this than doctors and hospitals because there aren't even Medicare equivalents of any of this stuff. Partly to that point, how do you know if it isn't right, or how do you know what to mandate if -- I mean, it's almost like reporting in other ways. How are you going to know if it's adequate? And if you think it isn't adequate based on your oversight, what could you do to change it? So I think that's one dimension of this.

I think a second dimension of this is there's still for many an aftermath of a lot of concerns that are expressed by some of the local agencies around federal mandates, and it's come up in a few ways. One is some of

what has happened at the federal Department of Labor about overtime rules and payment paying for transportation.

Part of it is I think a lot of these agencies are now themselves subject to ACA employer mandates for coverage. So they've seen their cost of doing business go up, and I think that there's a kind of an undercurrent of pressure on the business model. Let me put it that way.

In my market, I am like I think what you described. The agencies aren't AAAs or CILs. It's really private-sector agencies, and many of them are multistate, the Adduses and Ambercares and others.

So I think I've identified a couple of things. One is I think there is no federal benchmarks in other programs. The second, I think there's some kind of legacy tension in several states about federal mandates around DOL rules or employer mandates that apply to these agencies, et cetera.

I want to identify a couple of others. One is piggybacking on what Kit said about this isn't physicians and hospitals. What that also means is there aren't licensure boards by which you can geomap providers. You don't have a way of saying there's, you know, 312 licensed

physicians in this county. There's no equivalent database. So it's hard to gauge capacity from other benchmarks, and it's a very, very fluid labor market. People come in and out all the time, and you don't need a license. So it's a very difficult way of evaluating capacity in the labor force, and it's very elastic with wages and so on.

The final comment I'll make, which is confounding all of this, I think, is self-directed models of care, which is a good thing, but it means people enter and exit the labor market and enter and exit the networks and capacity because there is a particular member they want to serve. There's a family member or a neighbor they want to take care of, and I don't know that we're ever going to have a good way of adequately saying that the capacity is sufficient or insufficient when many states and many health plans are moving in the direction of self-direction, who can then come in to employment relationship through an agency as their intermediary. But the exiting and entering of the labor market because of self-direction and the lack of a license and all of that makes this a very difficult service type to gauge capacity and access.

And I'll leave it there.

CHAIR ROSENBAUM: I've got to ask Leanna a question, and I'll come right over to Brian. So you are a user of these services for your family. In your own head, even if it's not a written-down part of your plan documents or whatever, do you have a sense as a consumer of sort of how you gauge your expectations when you feel as if you've waited too long for something, especially the kinds of services that Chuck and Kit are alluding to where it's not a doctor visit? It is something that is, in many ways, much more involved and organic to your ability to have your kids thriving at home. So it would be sort of an interesting check on how do you see what they're describing.

COMMISSIONER GEORGE: Yeah, a large part of the reason why Serenity, my daughter, is now in a group home was because even though we had the waiver for these services, we could not find the physical person to come to our home to provide these services. We might get one person once every two or three months that comes in to interview for the position. She comes for a day or two, realizes she's not able to do the job because she can't handle Serenity and the behavior, she's not properly

trained. And I'm not saying that they don't do any training. It's just that as far as how can you handle an individual with significant behavioral needs, with aggressive behaviors, you know, it's a challenge. And on top of that, low pay, they have their own mental health issues -- it seems like a lot of them did. And, I mean, to be perfectly honest. I talk to these people in my living room. But it just seems like -- you know, I hate to say -- these agencies, where we live is a very rural area. These people drive 30, 40 miles for maybe slightly more than minimum wage to work with my daughter, and they couldn't justify it, and, frankly, I wouldn't be able to justify it either myself to do this kind of work for what they're being paid, unless they're like my next-door neighbor.

But, generally speaking, the requirement was to have a high school diploma or a GED and be able to pass a criminal and drug background check, and that was it, to be able to get the job, and have transportation, obviously.

CHAIR ROSENBAUM: Yeah, the gap between the aspirational model and reality.

COMMISSIONER GEORGE: Yeah.

CHAIR ROSENBAUM: Brian.

COMMISSIONER BURWELL: So I am going to say many of the same things that other people have said, but I want to say it a little differently.

One is the concern that people who develop these standards for MLTSS are going to use a model that's not appropriate to the services being provided, either at the federal level or the state level. And I think we should make the point very strongly that, you know, an adequate provider network for people receiving home and community-based services is fundamentally different from a network for other types of Medicaid-covered services.

One, it's not about access in terms of people going somewhere. Most of the services are provided in the home. A lot of the services are self-directed services. The consumer picks their own provider, so, you know, that's part of the provider network.

Cultural competency is extremely important. You don't send somebody who can't speak Spanish into a home that's Spanish-speaking. A managed care plan has to have a set of providers that reflects the culture of the members that they serve. You can write that into standards. That's very important.

Backups are very important, backup plans. If people don't show up, people are stuck in bed all day long, you know, so it's not like, "Oh, I can't come today." It's like, "I can't come today, and this other person is coming, and is coming at the designated time." Backup plans are extremely important.

An extremely important person in the provision of these services is also the care manager, so care manager ratios, you know, some states, you know, it's like care managers have caseloads of a thousand people. I mean, that's ridiculous. So there's standards around that and around the training of the case manager.

There's been a lot of talk about the qualifications of the personal care attendants who come into their homes because they're not licensed, but there are some states that actually have -- you know, so it is on the plan's responsibility, they do have to be certified. And certification usually means that they go through some kind of training. The problem is the training is so often very minimal and is not specialized to reflect the needs of the population. But some states are developing, you know, different levels of training for personal care attendants

who meet -- who are going to provide services to people of different levels of acuity. And so the managed care plan should have a network of personal care attendants, again, available and competent to meet whatever needs their members have in the community, so they should know those needs and have a workforce that's appropriate.

Payment and all that other -- that's a big issue. People coming in, you know, retention, you know, but that's kind of separate from standards. Those are policy issues. But I think these are points that we should make in our chapter and just kind of acknowledge the differences for provider adequacy in this particular area.

CHAIR ROSENBAUM: I think it would be a major contribution and one, you know, especially an ongoing dialogue between MACPAC and the new administration, which is committed to sort of looking at the rules, to capture and express a lot of what has been said here, which I'm sure will not be new so much to CMS, but it is, you know, in the context of the discussions that are happening today, the differences between access to sort of very traditional acute-care services and access in this context.

Norma and Sharon, then close us out.

COMMISSIONER MARTÍNEZ ROGERS: Well, one positive thing about Texas, in the great state of Texas --

[Laughter.]

CHAIR ROSENBAUM: I don't know if we can handle [off microphone].

COMMISSIONER MARTÍNEZ ROGERS: We do have a certification program for promotoras and community health workers. If they are going to get paid in the community and work in the community, they must be certified. But it's like Brian said: To what extent is the training? It is minimal training, but it is training, a certification. It's against the law in the state of Texas to work as a community health worker or promotora -- who are culturally sensitive because they're from the community where they live. It's against the law to get paid for that service if you're not certified.

CHAIR ROSENBAUM: Sharon.

COMMISSIONER CARTE: Well, just listening to Kit talk about competencies and Brian's point to training and also availability of personnel -- and since I've been dealing with my own family issues of trying to support somebody in the community and at home as long as possible -

- it just seems like managed care entities would have a common interest in getting bodies together to identify competency. I mean, almost all states, I believe, you know, certify nursing assistants for nursing facilities, and I don't know what would really hold us back from trying to create a national certification for people who are dealing with home, and also to have a basic level as well as additional training that they could get for dealing with certain populations, whether or not it's autistic children or elderly adults or whatever. You know, it's one of those things where you kind of look to the private sector for innovation.

COMMISSIONER GORTON: So I think the private sector would be interested in that. It's trying to fit it into the program design. And I'm not sure that there's a return on investment for the private sector that would justify a huge investment, and I don't know that we would -- we, our plan, would certainly be willing to participate in such a thing, but our margins are not such that we could afford to underwrite it. I think it goes back to my original comment about we need workforce development. We need to give these -- if we want to limit the churn, then

we need to give these people a career path. And I do think some sort of progressive certification, particularly if it were on a -- at least at a state level, but if it were on a national level, where you pass this course and, you know, you get a basic certification, you want to do children, you know, if we could do that, then you'll have people say this is what I want to spend my time working doing, and they can invest a little bit in themselves, which I don't think is a bad thing, gain some skills, go out, and provide these services. That's the only way we're going to be able to deal with the boomers retiring, quite honestly, let alone everybody else who wants to stay in the community.

We talked about IDEA yesterday. We have a whole generation of families now who delightfully have never confronted the need to have to institutionalize their children with disabilities because the school districts and the states have done a pretty good job keeping the kids in the community. Those families are now getting older, and so their adult dependents with disabilities are going to need more care than the families themselves can provide. If you look at the urgent waiting list people, they are usually aging parents taking care of people with

disabilities at home. They've been doing it without government assistance for years, and we're going to have to figure out how we wrap services around them, not to disrupt what they have now, but to be able to support them, because these caregivers are eventually going to pass on.

CHAIR ROSENBAUM: Thank you. A really good discussion, and thank you, Kristal.

And now we arrive at the final segment of the morning. Ben, Rob, and Kacey, an Update on MACPAC Work on Value-Based Payment.

UPDATE ON MACPAC WORK ON VALUE-BASED PAYMENT AND DELIVERY SYSTEM REFORM

* MR. NELB: Great. Good morning. So for the last session of today, Ben and I are going to just give you a quick update on our work on value-based payments and delivery system reform.

The goal of this session is just to preview some of MACPAC's work underway in this area and get your feedback on some of the areas that are of most interest to you. I'll begin with a brief background on the current state of federal and state delivery system reform efforts and review some of the highlights of MACPAC's work to date.

Then I'll turn it over to Ben to highlight some of our upcoming work on delivery system reform incentive payment programs, known as DSRIP.

In the interest of time, I'm just going to give some brief highlights, but I just wanted to highlight for you and for the audience that more complete information about each of these studies is available on our website, and the DSRIP work was also in our June 2015 report to Congress.

Okay. So, first, some background. As you know, states and the federal government are pursuing a wide range of activities under this broad header of delivery system reform, and, in general, these efforts are trying to change the way that care is delivered, particularly at the provider level, in order to improve quality and reduce costs.

Some of the most common Medicaid delivery system reform activities being pursued by states right now include patient-centered medical homes, or PCMH, which aim to improve enrollees' access to primary care services, care coordination, and case management; accountable care organizations, or ACOs, which are provider-based

organizations that assume clinical and financial risk for a defined set of -- or an attributed patient population and assume financial responsibility usually through a shared savings or a shared risk arrangement; and DSRIP programs, which Ben will talk about more, waiver programs that direct supplemental incentive payments to eligible providers implementing a range of delivery system reform projects.

Almost all state Medicaid programs are implementing at least one payment or delivery system reform activity, and you have more information about the particular initiatives states are doing in your materials.

In addition to the state efforts underway, there's a number of federal efforts to support and encourage these types of activities through a variety of mechanisms, including grants from the CMS Innovation Center, federal waivers through Section 1115, and technical assistance through the new Medicaid Innovation Accelerator Program.

In addition, I also wanted to highlight that Congress in the recent Medicare and CHIP Reauthorization Act, known as MACRA, added some federal Medicare incentives for providers to participate in new payment models.

There's a lot of changes that MACRA made on the Medicare side, but for today's purposes, it's just worth highlighting in terms of Medicaid that, beginning in 2019, MACRA will provide incentives for providers that are participating in all-payer payment models, which include Medicaid. However, at this point it's still unclear exactly which Medicaid models will qualify for these incentives.

So given the growing interest in delivery system reform, the Commission has engaged in a number of projects over the years to better understand these efforts. One of our first studies in the area was a broad look at various payment policies that states were using. Between 2013 and 2015, we worked with SHADAC to visit seven states that were implementing a range of value-based payment policies listed here. These include some additional payments to PCMHs for care coordination activities, episode-based payments that incentivize providers to control the costs of care for particular services such a maternity care or particular knee replacements or other surgeries, and then global payment models which incentivize providers to manage the total cost of care for their Medicaid patients.

In general, the study found that states were able to implement most of these payment reforms under existing Medicaid authorities. However, states did note some challenges making the up-front investments needed in data analytics and other infrastructure needed to support their activities.

In 2014 and 2015, we did another study that took a more focused look at safety net providers operating at accountable care organizations in Medicaid. We visited with seven providers in five states, including hospital-based ACOs and ACOs that were led by federally qualified health centers.

Unlike in Medicare, there is no common definition of ACOs in Medicaid, and so identifying the safety net ACOs was a bit of a challenge. Many of the ACOs that we did visit were still in the early stages of development, and at the time few providers were accepting downside risk for the total cost of care for Medicaid patients, so they were still in the startup kind of shared saving phases.

In general, providers reported that forming ACOs required considerable investments in data analytics and other infrastructure, and the safety net providers in

particular that we were talking with reported challenges in accessing the capital needed to make those investments.

In addition, some of the hospital-based ACOs that we spoke with noted some additional challenges in transitioning to these new payment models, particularly if they were still receiving some payments based on fee-for-service, which tends to incentivize hospitals to keep beds full; whereas, the new ACO payment models were trying to incentivized reduced hospital use.

Now I'll turn it over to Ben to talk about our work with DSRIP.

* MR. FINDER: Thanks, Rob. And before I dive into this, I wanted to describe again for you just what DSRIP programs, or delivery system reform incentive payment programs, are. These are programs that direct supplemental incentive payments to eligible providers who undertake delivery system transformation projects. Payments are made to providers based on meeting or achieving certain milestones. The milestones tend to include planning or project implementation milestones, and later on in the waivers, they tend to include reporting and outcome improvement milestones.

They tend to be structured such that payments are tied to planning and reporting milestones in the first few years of the waiver and health or quality improvement measures in later years.

DSRIP programs must be authorized through Section 1115 demonstrations because states are not otherwise permitted to make supplemental payments to providers under managed care.

Back to our work, between 2014 and 2015, we spoke with officials in seven states, including site visits to Texas, California, and New Jersey. And during our review we found that early DSRIP programs, like those in California and Texas, used Section 1115 demonstrations to preserve supplemental payments when they were transitioning to managed care. At the same time, we found that newer DSRIP programs, which at the time included the one implemented in New York, were not directly related to prior supplemental payments, and these were more explicitly focused on delivery system reform goals.

We highlighted key themes that emerged from this work in the chapter of the June 2015 report to Congress, as Rob mentioned, and that chapter as well as the contractor's

report serve as a great primer on the origin and design of DSRIP programs.

In general, states reported that financing, implementing, and evaluating DSRIP programs was challenging. Also, states and providers expressed concern about the sustainability of DSRIP programs.

In the June 2015 chapter, the Commission expressed its interest in continuing to monitor DSRIP programs, and although 2015 doesn't seem that long ago, DSRIP policy has evolved since then. Five additional states have approved DSRIP or DSRIP-like waivers, two states have extended their programs, and two states have received approval for renewal of programs for an additional five-year term.

In the new waiver approvals and renewals, CMS and states have made some key policy changes. For example, newly approved DSRIP programs do not have a relationship to prior supplemental payments and have more explicit delivery system transformation goals. We've contracted with NASHP again to better understand these developments and how they're playing out on the ground. This work will conclude this summer, and we plan to present the final results at a

future meeting this fall. But until then, we have sort of a teaser for you today.

We found that while many older DSRIP programs were financed by public -- by providers, rather, making use of IGTs through public hospitals, for example, most new DSRIP programs are financed indirectly by the federal government through designated state health programs, or DSHP funding. DSHP demonstrations are also authorized under Section 1115 waiver authority, and they allow states to drawn down federal matching funds for state spending on state-funded programs that relate to the health of Medicaid or CHIP enrollees or other low-income populations. By allowing federal Medicaid funding for previously state-funded programs, DSHP frees up state funding to finance the non-federal share of DSRIPs.

We've also found that DSRIPs are increasingly standardized, but the waiver approval process remains complicated and lengthy.

Newer DSRIP programs appear to include less post-approval negotiation between CMS and the state. For example, instead of requiring CMS to approve specific DSRIP projects, newer DSRIP programs require states to contract

with an independent assessor to evaluate DSRIP projects and make recommendations to the state.

We've also found that states and CMS are exploring opportunities to sustain DSRIP through managed care, but this model is still in the early stages of development.

In new DSRIP programs, CMS has encouraged states to develop plans that would sustain their DSRIP through managed care. Conversations between state officials and managed care contractors about how to achieve this goal are underway, and tend to focus on how and to what extent Medicaid MCOs should adopt alternative payment models.

To date, most interviewees reported that Medicaid managed care use of alternative payment models was still in the concept stage. They expressed a desire to shift towards APMs but were less clear about the means or how to do it.

We've also sought to better understand how states and CMS are measuring the success of their DSRIP, including questions around how they are being evaluated. So that is an exciting cliffhanger for which we will end this meeting on.

[Laughter.]

MR. FINDER: Let's turn to the last slide. We wanted to use this session, as Rob mentioned, to preview some of our preliminary findings and to jump-start a conversation that can be continued at future meetings. We are looking forward to your feedback and we've highlighted some questions to get you started on that conversation.

For example, what role should Medicaid play at both the state and federal level in financing delivery system reform? How should Medicaid delivery system reform efforts align with other payers? How should delivery system reform efforts align with managed care? Are there changes to Medicaid payment policies needed to support the development of value-based payments? And how should delivery system reform efforts be evaluated?

Thank you, and we look forward to your feedback.

CHAIR ROSENBAUM: Can you provide an example of a state expenditure on a health activity that would not normally qualify for federal contributions but does under this special 1115 demo authority?

MR. NELB: Sure. So GAO recently did a report reviewing some of these different DSHP expenditures, as

they're known.

CHAIR ROSENBAUM: D-S-H-P?

MR. NELB: Yeah. It's another fun acronym in Medicaid. Just when you think you know them all, here's another one.

So, one, it was expenditures for some medical education, for example, with Rhode Island and developing a protocol to identify training of patients at their state medical schools, of doctors that may go to work for Medicaid patients.

Other examples include some state programs for various public health initiatives that are not otherwise funded by Medicaid and --

CHAIR ROSENBAUM: [Off microphone.] Like lead abatement.

MR. NELB: Lead abatement.

CHAIR ROSENBAUM: Uh-huh.

MR. NELB: Yes.

CHAIR ROSENBAUM: So it doesn't have to be patient-based.

MR. NELB: Exactly. Yeah. And there's usually a process that's done to figure out the share of some of

those expenditures that are attributed to low-income patients, and then that portion would get matched through DSHP.

MR. FINDER: There are also subject to negotiation between CMS and the states. I think that's the process that Rob's --

CHAIR ROSENBAUM: And, typically, inside of DSHP negotiation, or it can be separate and apart from it?

MR. NELB: Right. So DSHPs had been used before DSRIP in some other state demonstrations.

CHAIR ROSENBAUM: Yeah. The famous Rhode Island example of almost 20 years ago now, essentially where Rhode Island was able to use funds -- some expenditures and funds, sort of a variation on the theme -- to abate lead. So --

MR. NELB: Yeah.

CHAIR ROSENBAUM: -- work it backwards and have DSHP.

MR. NELB: With different things, yeah. But it's been a development in some recent DSRIPs as a way to finance it and, I think, in some ways, address some of these issues identified with the first set of DSRIPs,

where, when they're financed by providers there's a need to sort of return some of the funding to the providers, whereas if it's more federally financed, the states are -- you know, have a little more ability to direct it where they – need it.

MR. FINDER: Flexibility to expand the population or the group of eligible providers who can undertake some of these demonstration projects.

MR. NELB: Yeah.

CHAIR ROSENBAUM: Questions. Alan.

COMMISSIONER WEIL: Not so much questions but trying to -- the first thing I'll say is, I think it's too early for a lot of "should" questions to be answered, so I'm just going to frame it that way.

I think this is such a huge issue, and I'm really glad we're in it, and I'm just going to start by saying I think it's a little too early to even know what we should be doing. So, tentatively, I think, to me, the key questions are alignment between what Medicaid is doing and what other payers are doing, particularly alignment, or lack thereof, in outcomes being measured, how they're being measured. That just -- you know, these are questions that

come way before these questions. You know, like, what -- and it's why, I mean, I was involved in the first look at the DSRIP stuff, and I've been really interested in it for a long time. You know, what's the language being spoken? What do Medicaid programs think that a transformed system ought to be achieving that's different from paying, you know, claims? This is so early for many of these organizations.

So I think the descriptive work, which has been terrific -- I actually think we're going to be at the descriptive place for quite a while. So before we try to do more.

The other item that just jumps out at me is the -- you know, I can't say it in a neutral way -- the discordance between these efforts and what we talked about yesterday, about the policy discussion about the future of the Medicaid program. And when I think about how every other payer approaches delivery system reform, it's through investment, it's through experimentation, it's through, you know, systematic processes of engagement with the stakeholders, and if we're going to change how much the federal government is paying states for Medicaid, and we

want the states to do things other than just cut eligibility and benefits, then we need an environment where states and providers and patients are supported in efforts to reorganize delivery system, and I didn't see any of that yesterday.

So -- I mean, I -- so at this stage of the discussion, I'm interested sort of in the what's going on, and the resource question, both in the status quo, because we know there's a lot of challenge to the funding mechanisms, even under the current Medicaid program, and also the question of how that relates to resources, should there be a change in financing.

CHAIR ROSENBAUM: And I would just add to that, that it is, in my view, what 1115 is really designed to foster -- in other words, an innovation in the way things happen for people on Medicaid, as opposed to a very important mechanism for circumnavigating, you know, the political crisis du jour. I mean, this really goes to the heart of the use of demonstration authority. It is the most cutting edge, you know, potentially the most -- the thing that comes closest to what Wilbur Cohen had in mind, if he could have imagined delivery system reform, you know.

So it's incredibly important.

Brian. Penny.

COMMISSIONER BURWELL: So this is a huge and complex area and my idea is to divide this work into two major parts. To me, the DSRIP and the DSHP, or whatever that other thing is, is one bucket, and it has to do with redirecting supplemental payments to states and attaching some conditions to those payments rather than just throwing money. So in order to get -- if we want to see some delivery system reform done, however measured, and I think we need to get about what the -- you know, what are those milestones really things, and are they, you know, represent significant reforms.

The second is value-based payment in Medicaid. That's an entirely different thing, and I'm involved in that in the IAP program, and that's much more focused around patient level quality metrics and tying patients to providers based on outcomes measured -- you know, those quality metrics. That's a huge shift going on, and, you know, like governors have gotten this thing, "oh, value-based payments, you know, pay for value," and it's like out of control a little bit. They're like, "Oh, yeah, I want,

you know, like 80 percent of all Medicaid payments to be value-based payments in, you know, three years."

That's not -- it has to be a very thoughtful process. There's got to be data. You know, you've got to pick the metrics. You've got to have the data to develop the measures. You have to bring the providers along. I'm a little concerned about that. But I think in that body of work we've really got to get down to, well, what metrics are states selecting and what are the specific financial incentives that are being tied to those metrics? We've really got to get down to the nitty-gritty of those initiatives.

So I see these things as two fundamentally different areas, and I don't know if we want to split that -- split them up in our work.

CHAIR ROSENBAUM: Penny and then Chuck.

COMMISSIONER THOMPSON: Brian, I was going to make very much the same point, which is I think differently about investment and the provider -- and especially safety net providers on which Medicaid relies, and what kind of investment needs to be made, for what kinds of purposes, for what kinds of timeline, with what kinds of conditions.

And then how Medicaid, which is in the business of paying people -- paying plans or paying providers -- ought to pay people. Like, are there improvements on that payment? I do think, on that side of the equation, you know, this all-encompassing term is not -- doesn't do justice to kind of the innumerable variations underneath. You know, there are -- you know, there's everything from, I'm giving you a little bump, to, do a little extra care coordination. I'm giving you a little bump to report a little quality data, to, you know -- which are still volume-based activities and episodes or bundles, which can also still be volume-based activities, to more global approaches. And I just think that when we talk about this we should be -- we should resist the label, because I think it isn't very indicative of anything.

But I do think the distinction between how do I pay people, and what am I paying for, and the question of do I have to invest in my health delivery system for that health delivery system to be successful under those models, are kind of two different questions. And I think one, obviously, Medicaid needs to be thinking about how to pay people. They're in the business of doing that. They've

got to figure that out. The question of whether and how Medicaid makes investments, and where other payers should come into play in helping to promote those investments.

And, you know, to be clear, DSHPs, while they've existed a long time, and they can be very interesting to take a look at, and kind of reflect back on a little bit of our leakage in social determinants conversation from yesterday, you know, the idea that you've got some new DSRIPs coming out of DSHPs, as opposed to IGTs, is a reflection of the fact that some states had IGTs to offer up and other states didn't. And so you had states that were like, "Well, I want to be in the DSRIP business and I've got to find a source of funding."

And so, you know, the exercise is, to be clear, it's, you know, here are all the, like, health programs on funding through the state. Here are all the programs that I think possibly could be something that is supporting a Medicaid objective. What CMS would you buy-off on, in terms of allowing to be bought into through a CNOM authority, a cost not otherwise matchable authority?

So it would be better, I think, if we had a more forthright and up-front way that was equitable among all

states, that allowed for the proper kinds of investments to be made in the safety net, to be able to not only serve and support Medicaid but also to be able to serve and support other payers, because I also think that some of this is where does the end come, in terms of if you invest in something, you kind of have an idea about what you would consider to be the success of that investment, and that investment is not in perpetuity. And so I think that that conversation deserves some space amongst us.

CHAIR ROSENBAUM: Great. So I have Chuck, Andy, Stacey, and Toby, and then we are closed out, done with business.

COMMISSIONER MILLIGAN: With all the acronyms I was tempted to yell "bingo" at some point in there.

[Laughter.]

COMMISSIONER MILLIGAN: I want to align myself with a lot of the comments, and I think it's too early, as Alan said. I like Brian's framework about how to divide, honestly.

What I wanted to suggest, in terms of an analytic approach going forward, is to think about how we will know, in particular, whether some of the non-medical things

produce health outcomes effectively. And so I want to build that out a little bit.

A lot of these value-based models are really intended, I think, to drive not just the connectivity to social determinants and housing and those sorts of things, but also member engagement, coming in for preventive screening, how to use community health workers, and other forms of non-medical, non-licensed folks to kind of get engagement from members, do good prevention, et cetera, et cetera.

And so I think the question presented, in some ways, is, are those effective at producing health outcomes and how will we know? I mean, are HEDIS measures the right measures? You know, the fact that somebody is coming in for preventive screening or doing prenatal care, unscheduled, et cetera, et cetera.

When you start unpacking that you get into other questions, like, what do the encounter data look like to justify the expenditure? Is it cost effective? If we're not paying for medical services but we're paying for other things that reduce the rate of growth over time, how will we know if it's cost effective for Medicaid?

And I think -- I'm going to kind of go up maybe to the 40,000-foot level for a second. I think the bigger -- the biggest skepticism of DSRIP and all these kinds of things, and value-based contracting in general, in other ways, I think the biggest skepticism is that Medicaid financing is really being used for more global public health purposes, not focused on Medicaid beneficiaries, accessing needed medical services for Medicaid beneficiaries, and that they're all, you know, permutations of supplemental funding, whether it's to a safety net provider or to a state to advance some public health initiative that is kind of outside the mission and purpose of Medicaid financing.

And so I think the more we can build an analytic framework to focus on outcomes for Medicaid beneficiaries and whether some of these substitute services or substitute approaches produce good health outcomes in a cost-effective way, I think that's, to me, the analytic framework I would like to see us pursue.

CHAIR ROSENBAUM: Andy.

COMMISSIONER COHEN: Thanks. I will be quick because most of the, I think, critical comments have been

made already. I just want to weigh in on a couple.

So I agree that this is like essential work. This is the future and Medicaid can't be left behind. So I think that it is really important that not only is CMS permitting these kinds of initiatives but is encouraging initiatives in states that are really ready to do the kind of engagement and very probably hands-on process that is required to help move a delivery system along. But this is really critical work and it's especially critical just to make sure, again, that we don't end up with like a really bifurcated system where commercial -- you know, providers that work with commercial payers and Medicare have done investments to be integrated and to be looking at outcomes and Medicaid safety net providers are left in a low-paid fee-for-service model. So I think it's really essential.

I also just want to reiterate the point that Alan made about the importance, also, of aligning measures with other payers. Medicaid straddles -- depending on the market, and the markets are so local -- Medicaid sometimes is primarily relying on a safety net of providers that really mostly serve Medicaid beneficiaries, in some cases, and in other cases Medicaid is just another payer and the

providers are providers who get payments from many sources. So it is really critical that our federal policies sort of recognize that and align with other payers whenever possible, while acknowledging differences in both the needs and characteristics of Medicaid patients when it's relevant.

So I just think sort of keeping in mind alignment with other payers where it makes sense is really an essential point, and I think it'll leave it there but just encourage you to keep going there and agree, also, with Alan. This is the point where, really, this is monitoring and looking for issues more than you can really be evaluating anything at this point.

CHAIR ROSENBAUM: Stacey.

COMMISSIONER LAMPKIN: Just an idea, if it's not something you've already taken up. Is there any value to us gathering information from the Health Care Payment Learning Action Network, which, as I understand it, is an HHS-sponsored but privately administered, rapid cycle learning exercise around value-based purchasing across different payer types and stakeholders? You know, they would be, I think, seeing, with two years in now, what's

happening, what the challenges are on the commercial side versus Medicaid versus Medicare, and perhaps be able to help us see a little insight about some peculiar -- or, I don't mean peculiar -- specific challenges that Medicaid may have that are different from other payers. It may help us think about it from a different angle.

COMMISSIONER DOUGLAS: So one just nuance on the questions. I think we definitely need to incorporate in the managed care regulation and just as you think of DSRIP but going in, given the supplemental payment rules, that needs to be factored into it. I would definitely agree with Alan that we're way too early on on this as well, to go more than just continue to watch, rather than do detailed analysis.

The one area -- and I don't know if I'm just not following everyone -- is I don't see the DSRIP and value-based as different. I think you've got to connect the two together because DSRIP, the whole point was that it was a bringing into the stability of the long-term managed care system, and obviously I'm not wearing my California hat here, because it would be the arguments. But stepping back, it gets to this question, long-term, of do you really

need -- you know, when is enough for DSRIP, and, at the same time, you're having to continually push on a managed care system that they should be driving quality, which means, then, the plans have to figure out how to work with the delivery system to drive them to build the infrastructure. So then it gets to questions of, are we doing this twice?

So I just think that you can't separate them, and as we look this through, you have to see what's going on in managed care, with all the managed care rules around quality, all the procurement requirements around quality, which pressure the delivery system -- for the plan to invest in the delivery system to get the performance they want, and then outside you're having DSRIP doing the same.

So I don't -- it's all -- we've got to watch this. There's no evaluation, but I wouldn't watch it in two different silos.

CHAIR ROSENBAUM: Thank you very much. Peter.

COMMISSIONER SZILAGYI: One last comment, not on reform. But I just want to acknowledge the five departing members of the Commission: Herman, Sharon, Norma, Andy, and our illustrious Chair, Sara. Your commitment, your

dedication, your collaborative work has been absolutely amazing, and your passion for vulnerable people in this country is absolutely stellar. So we want to thank you for your service to this country.

[Applause.]

CHAIR ROSENBAUM: Thank you, and I have got to say, I was sitting here listening to this discussion, and thinking, I don't know how you guys feel but how much I'll miss MACPAC. You know, seven years is a long time thinking about all the other things to do, like go to the Caribbean or whatever. But this discussion, and actually the discussion over the whole morning, was particularly wonderful, and there is nowhere else you get this kind of discussion. So go forth.

And now it's time for public comment. Do we have any public comments? I don't even think we have a microphone there. Oh, do we?

PUBLIC COMMENT

* [No response.]

CHAIR ROSENBAUM: No public comments. We are adjourned.

* [Whereupon, at 11:50 a.m. the Public Meeting was

adjourned.]