MACPAC

Medicaid and CHIP Payment and Access Commission

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PUBLIC MEETING

Horizon Ballroom
Ronald Reagan Building and International Trade Center
1300 Pennsylvania Avenue, NW
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Thursday, February 20, 2014
8:44 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
RICHARD CHAMBERS
DONNA CHECKETT, MPA, MSW
ANDREA COHEN, JD
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TRISH RILEY, MS
SARA ROSENBAUM, JD
ROBIN SMITH

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S [8:44 a.m.]

CHAIR ROWLAND: Good morning. If we could please come to order, and we are pleased to start today with an update on our MACStats and on our continued efforts to provide ongoing data information about both the Medicaid and CHIP programs. So I am going to turn to Ben Finder to kick it off -- oh, to Molly McGinn-Shapiro.

MS. McGINN-SHAPIRO: Yes.

CHAIR ROWLAND: So it is the order that you are in. Okay.

Session 2: Review of March MACStats, New MACPAC Web Products

* MS. McGINN-SHAPIRO: Thank you. So just briefly, Ben and I would like to show you a couple of recent publications that we have posted online. You can find these new publications off of our main website, which is www.macpac.gov, and you just need to click on the "Other Publications" tab. So I'm going to show you where that is, and then hopefully it will bring that up. There we go.

And so you can find these new publications -- you know, the documents that we discussed -- both under these recently posted documents, and then also the documents that we're discussing will also -- are under "State Policies."

So I am going to start with the financial alignment initiative document, which is a series of tables that we've developed to make it easier for you to compare the design of the CMS financial alignment demonstration projects for individuals dually eligible for Medicaid and Medicare in those participating states. So let me pull that up for you.

And so this document, there are eight tables that provide an overview of the progress of the financial alignment initiative as it moves along. And so then this just provides an overview of what's in

those tables, and then as you scroll down, you'll see there will be several tables. And they review the key elements of the state financial alignment demonstration projects for states that have signed the memorandum of understanding with CMS, including the target population, the enrollment process, benefit design, payment policies, and other such details.

Information on these state demonstrations are primarily pulled from the publicly available information in a state's signed MOUs, and at the moment eight states have signed MOUs with CMS to implement the financial alignment demonstration project. These tables currently focus on the state projects that are testing the capitated model because they represent the trend towards increasing managed care for dually eligible enrollees that many states are now considering. So we plan to update these tables at a regular basis as new information becomes available, and so just that's where it is.

So I'll turn it over to Ben now.

* MR. FINDER: Thanks, Molly.

So I'm here to tell you about our Medicaid fee-for-service physician payment landscape. Again, it's on our website under "Other Publications." We have this premium spot here at the top, but you can find us forever at the bottom under "State Policies."

When you click on the file, there are two sorts of companion pieces that go with this. There is a pdf and an Excel file. And the Medicaid fee-for-service physician landscape is a document in which we have documented the methodology that states use to pay physicians and other professionals.

So when you click on the pdf, this is sort of the instruction manual for the Excel spreadsheet. You'll see at the top there's a little blurb that tells you why we did this. Then we get to the methodology of how we did it. And further down this page there's some information on how you can use the summary tables

and the state-specific tabs when you get into the actual Excel file.

So I'll now turn to the Excel file. It opens up on the summary tab. In the summary tab, you can see the fee schedule basis. So this is the information, and this is in Column B right here. This is how states set their fee-for-service physician payment policies. Some states use an RBRVS system, other states base theirs on the Medicare fee schedule, and some have their own independent methodologies to set their physician payments.

We also document whether or not they maintain separate fee schedules for different types of professionals and practitioners; any adjustments they might make, like a geographic adjustment or a site-of-service adjustment; and then further on the right there, there's information about incentive payments that states might make also for their physician payments.

So the summary table, like I said, documents a lot of that information for all the states and sort of categorizes it in easy-to-find fashion. If you're interested in more information on a particular state, you can look at the tabs at the bottom, which go by state, or you can click on the links on the left. I'll just go to Arizona, and here, this is the in-depth, detailed information that leads back to that summary page. In a lot of cases, this information is copied directly from the state plan amendment or the insurance regulation that states use to establish their payment methodology.

So in this document, we have left it in Excel so that you can play with it and manipulate it in ways that you find interesting. You can answer questions like how many states base their fee schedule off Medicare, how many states adjust based on site of service, or how many states maintain separate fee schedules for specialists.

We also recognize that these are constantly in flux, so we have included an e-mail address both in

the pdf instruction manual type thing and in the Excel file itself for people to submit feedback.

Thank you very much.

CHAIR ROWLAND: Okay. Any questions?

EXECUTIVE DIRECTOR SCHWARTZ: I just want to add that we're doing a series of these payment landscapes, so the hospital one we're finishing up on now, so in due course we'll post that as well. And then I think we will move on to nursing facilities after that.

CHAIR ROWLAND: Okay. It might also be useful to think about how emergency room visits are paid for and whether they are covered in managed care or what the policies are as a landscape, as a prelude to our next panel.

COMMISSIONER COHEN: Can I just ask, what's the -- how is it going to be updated and like sort of what's the thinking of the schedule for that? Is there sort of a date as of that it's --

EXECUTIVE DIRECTOR SCHWARTZ: Well, I mean, the date is on it that it went up, and I think we -- we know that parts of it are probably out of date already, and for the moment what we are doing is, as we hear of certain things, we can update it. We haven't come up with a plan for are we going to update this every year or not, because I don't think we have a sense yet of how much there is a change across 50 states. But, you know, you can be almost paralyzed by the fact that the minute you put it up, some aspects of it could be out of date. But nobody else has collected this information so we thought that it would be worth doing.

COMMISSIONER COHEN: Absolutely.

EXECUTIVE DIRECTOR SCHWARTZ: So it's a work in progress.

CHAIR ROWLAND: And the fortunate thing about having it on the web is if you learn of some

big change in one state or another, you could actually just update those pieces.

* MS. GRADY: Okay. Thanks. We seem to have a technical problem, but I'll go ahead and start. I'll shift gears from the web products to the March 2014 MACStats.

As in previous reports, the March 2014 MACStats provides national and state-level statistics on the Medicaid and CHIP programs, including enrollment and spending. One thing I want to point out here is that the figures that I'll present today are still subject to revision because we sometimes receive late-breaking updates from CMS because of updates or corrections to state-submitted data, so just that caveat. We really go down to the wire when it comes to the March report to provide the most recent information.

In addition to program enrollment and spending, we also have additional information that places the Medicaid and CHIP programs in context, so information on state budgets, national health expenditures, and information on other types of coverage compared to Medicaid and CHIP.

I won't go through each and every MACStats table, you're well familiar with them, but I'll just provide some key takeaways today.

The other thing this year is that we have some new tables with access-to-care measures that Anna Sommers described to you in detail in our December meeting, and I'll mention those at the end of the presentation.

With regard to Medicaid and CHIP spending, in fiscal year 2013, total Medicaid increase was about 6 percent for a total of $460 billion in spending this year. That's about $267 billion federal -- you have a typo in your printed slides; it should be 267 and not 257 -- and $193 billion state. Both of those numbers were growing at similar rates. Unlike in previous years where there had been a temporary increase in the federal match, we are back to normal matching rates, so we're looking at similar growth on the federal and state

sides.

Total CHIP spending was $13 billion in fiscal year 2013, and that was an 8 percent increase over fiscal year 2012. What I'll point out here is that spending for Medicaid expansion CHIP programs is what was driving the growth, and that's due in part, in large part to California moving most of their children from separate CHIP programs into Medicaid expansion. There were a handful of other states, though, that did an early expansion of the so-called stairstep children between 100 and 133 percent of poverty, moved those children from separate CHIP into Medicaid before the required time frame of 2014. So that was part of the reason for the increase in Medicaid expansion CHIP as well.

And then putting the Medicaid and CHIP spending in context, as we present every year, we look at Medicaid spending as a share of state-funded budgets, and that would include general funds, other state funds collected, like provider taxes and bond funds. And when you look just at the state-funded portion of state budgets, Medicaid was about 15 percent of state budgets in state fiscal year 2012.

The more common measure you'll see is Medicaid as a share of total budgets that includes the federal spending, and their Medicaid is a larger share. It's 24 percent of states' total budgets, including federal funds.

Just for some context, the share of state budgets that went to elementary, secondary, and higher education were 37 percent when you look at the state-funded portion and 30 percent when you look at the total state budget. So Medicaid is big, but not quite as big as education.

The other thing I'll point out about some context here is that Medicaid and CHIP as a share of national health expenditures was 15.5 percent in calendar year 2012, and that's projected to rise to about 17 percent over the next decade. There is an initial bump due to the increase associated with the Affordable

Care Act enrollment, but things sort of level out after that, and the CMS actuaries project that it will stay at about 17 percent through 2022.

Just for comparison purposes, Medicare is projected to rise from 20.5 percent of national health expenditures to 22.4 percent during that same time period.

I'll talk a little bit now about Medicaid and CHIP enrollment. Actual fiscal year 2011 data is available for less than 40 states on the CMS website right now. As you know, there's a considerable lag in the availability of Medicaid enrollment data, and this is fewer states than we've seen in the past at this time of the year. I think there's a lot going on at CMS and at the state level right now, so this is a little bit of a change from previous years.

From other sources, primarily the CMS Office of the Actuary, we know that the number of Medicaid enrollees was estimated to remain steady in fiscal year 2013. We do not have the latest CMS enrollment projections until the President's fiscal year 2015 budget comes out, hopefully on March 4th. We'll see if we can get those numbers into the March report. But if not, we'll make them available on our website. We're cutting it a bit close this year.

CHIP enrollment was steady in fiscal year 2013, again, with an increase in Medicaid expansion enrollment that was offset by a decrease in separate CHIP program enrollment.

CHAIR ROWLAND: Since the report is probably at the printer, can you request a little update internally?

MS. GRADY: Of enrollment? They're not able to share the information ahead of time this year. We've asked, and we'll -- I presume part of the reason is that the estimates themselves may not be final, given what's been happening with enrollment lately. But we'll get them as soon as we can.

With regard to Medicaid and CHIP eligibility levels, the big change this year is the shift to modified adjusted gross income counting rules and no asset test for most enrollees as of 2014. For most of their child and adult Medicaid populations, states had to go through a process of converting their old eligibility levels that included a variety of state-specific income counting rules and disregards, into new eligibility levels that reflect the MAGI rules for income counting that are uniform across states. And so we report those MAGI converted levels in MACStats this year.

In terms of changes in eligibility levels, for reasons other than MAGI, I'll just point out that there are -- there's still a maintenance-of-effort provision in place that prevents states from reducing eligibility for children through fiscal year 2019, so we don't see a change in that area.

There were a handful of states that reduced their previous eligibility levels for parents and other adults. The maintenance of effort for adults is over as of 2014, so states are allowed to do that. We're still confirming those recent changes with CMS, and the other thing I'll point out is just over half of states have opted for the adult expansion, and we'll have an indicator of that as well in the report.

As I mentioned, you heard from Anna Sommers in December about five new tables with access-to-care measures at the national level. That will be in the March 2014 MACStats. And those measures relate to provider availability, connection to the health care system, contact with health care professional, timeliness of care, and receipt of appropriate care. And all these concepts build on the framework for access to care that we've discussed in previous MACPAC reports. And the tables compare Medicaid and CHIP to other types of coverage, and that's the primary focus of these measures, is to look at Medicaid relative to other types of coverage. But we also have some comparison of Medicaid and CHIP subgroups to each other, particularly for adults with disabilities versus those who are not eligible on the basis of a disability.

And I'll stop there and take any questions you might have.

CHAIR ROWLAND: Thanks very much, April.

One of the things I think we really need to try and get a handle on -- and I know the data will be difficult to obtain -- is to answer this question about how many people are coming onto the Medicaid rolls because of the ACA versus coming on traditionally. There's lots of estimates out there that are not done as accurately as one would want because the data gaps and the reporting are very different. But I think that's a key issue for us to try and keep on top of so that we can help the Congress figure out what the impact of the Affordable Care Act has been.

Certainly when the states begin to submit for the 100 percent reimbursement, that gives us one number, but we also want to know more about the eligible but not enrolled and all of the other challenges that are out there in defining that number. But I think that's a very important thing for us to try to weigh in on and track.

Other comments?

COMMISSIONER GABOW: I've never been very good at math, so I have a question. It's on the Medicaid spending as a share of state-funded was 15 percent, so that's state money. And when you add the federal match, which is 60 percent or more, it only goes up 9 percent? That math doesn't seem to work out. But maybe I just don't -- maybe I'm confused about something.

MS. GRADY: I think it's partly because we're looking at the total state budget, so Medicaid is not the only thing that brings federal funds into the state budget. There are other programs as well. So the 9-point difference isn't just attributable to the impact of Medicaid. It's also the other programs.

COMMISSIONER GABOW: So you're adding all federal funds to the total state budget.

MS. GRADY: That's correct. That's correct.

COMMISSIONER GABOW: I think the way you often hear it presented -- or I've been in many discussions about this where just the federal piece of Medicaid is added, and then it's like, well, it's, you know, 25 percent or 28, or even more, percent of the budget. So I think that's a little -- maybe it's just confusing to me that you added the federal funds to the total state budget, all federal funds.

MS. GRADY: Of course, it does vary by state, which is sort of a joke at this point, but that is the average for all states. So it might be 28 in some, 26 in others, and so on.

CHAIR ROWLAND: But the way it's generally reported is that if you look at the state budget, what share is Medicaid, and that includes -- so it's a bigger pie than the state-funded only, or the state-funds-only budget, which is the one April is talking about. So I think the other problem is that they're not -- the percentages are being applied to a different base as well.

COMMISSIONER RILEY: On that, I think I missed -- the state-funded isn't just general fund, it includes the provider -- it's every state dollar?

MS. GRADY: It is, yes. And sometimes you see it only as a percent of the general fund, but in states where provider taxes -- I believe like Maine -- are a big part of the total, you need to add those to get apples to apples across states.

CHAIR ROWLAND: Okay. Thank you very much.

We are going to turn now to look at some of the eligibility and enrollment strategies that have especially been effective in reaching more children and to talk about Express Lane Eligibility and to talk about the great work that I know has gone on in the states to try and really put together the data to get more children enrolled, and I want to particularly welcome my old friend Ruth Kennedy, who seems to always

make sure Louisiana is at the top of this list, and so it's great to have you. Lisa Lee, great to have you, as well. And, of course, Alice, for the great work that NASHP has been doing on trying to further enrollment. I am going to turn to Moira to do the introductions, but I wanted to welcome the panel personally.

Session 3: Eligibility and Enrollment Strategies

* MS. FORBES: Sure. Thank you. Is this picking me up? So, states and the Federal Government have -- you cannot. I'll come sit in Sara's seat.

States and the Federal Government have, as we've discussed, several have increased insurance coverage through explicit coverage expansions that make additional persons eligible for Medicaid and CHIP and through policies that streamline eligibility, enrollment, and renewal processes, and help those who meet the eligibility criteria to complete the process and successfully enroll or retain coverage.

So, this -- we've had a lot of discussions about this. We have some things on the agenda today related to this. So, this is really to help provide some of the state-level perspective on this. Our speakers will provide an overview of state-level strategies to increase Medicaid and CHIP enrollment and retention.

And we've brought in three experts on these issues, as Diane said: Alice Weiss, from the National Academy for State Health Policy, who will discuss findings from multi-state research on successful approaches to increase enrollment and retention of eligible children; Ruth Kennedy, from Louisiana, who will discuss how Louisiana was able to increase retention and reduce administrative costs through Express Lane Eligibility and other strategies; and Lisa Lee from Kentucky, who will discuss a variety of strategies her state has used to achieve high enrollment rates in Medicaid and CHIP.

And so I'll ask Alice to go first, and then our state speakers, and then we'll have time for discussion. Thanks.

* MS. WEISS: Good morning and thank you for the opportunity to present today. My name is Alice Weiss and I'm a Program Director for the National Academy for State Health Policy. NASHP is a national nonprofit research organization whose mission is to promote excellence in state health policy. We work with state health officials across agencies and branches of government to provide research, convene and disseminate emerging and promising state practices to help states reform their health care systems.

As part of this work, NASHP served as the National Program Office for Maximizing Enrollment, a four-year Robert Wood Johnson Foundation initiative supporting state efforts to improve enrollment of eligible children into Medicaid and CHIP and to prepare eligibility systems for implementation of the Affordable Care Act. My testimony today draws on experience from this initiative, our work with CHIP directors, and other work NASHP has done to help states streamline eligibility enrollment systems in Medicaid, CHIP, and exchanges under the ACA.

In tracking the evolution of Medicaid and CHIP outreach and enrollment, it may be helpful to put these changes in their historical context. This morning, I'm going to offer a brief perspective on how Medicaid and CHIP programs' role in facilitating enrollment has shifted by starting from the beginning and offering a brief tour forward, looking at some major developments since Medicaid's inception.

From 1965 until the early 1990s, Medicaid had relatively simple eligibility requirements for states, designed to ensure that benefits were delivered efficiently and correctly. States were required to ensure that the enrollment process was accessible and to provide benefits to those determined eligible with reasonable promptness. States were also required to determine eligibility in a way that ensured administrative simplicity and was consistent with applicants' best interests, but there was little guidance on how to effect these goals. By contrast, Medicaid's limits on errors, which were defined as erroneous benefit payments, not erroneous

denials of coverage, were very specific. Also, for the first three decades of the program, Medicaid eligibility was linked to welfare eligibility, and often, one human service agency performed all eligibility determinations.

This focus on avoiding errors combined with Medicaid's link to welfare led many agencies to see the eligibility process as a method to prevent ineligible applicants from enrolling. Program integrity, not enrolling eligible applicants, was often the top priority for states.

The enactment of new strategies in the late 1980s and early 1990s, like the option to temporarily determine pregnant women presumptively eligible for coverage and outstation eligibility requirements, mandating states to provide access to eligibility at large hospitals and clinics that disproportionately serve low-income individuals, were significant changes and shifts in this approach, but they were isolated in their impact.

In 1996, welfare reform delinked Medicaid eligibility from welfare eligibility, creating the first major shockwave to state Medicaid eligibility processes. In the wake of this change, some states changed how health care eligibility was done and many saw a decline in enrollment among eligible low-income beneficiaries.

Then, in 1997, the state Children's Health Insurance Program, or SCHIP, was enacted. SCHIP created an incentive for states to make meaningful progress on providing health insurance coverage to uninsured low-income children. SCHIP's enactment in 1997 also marked a transition in states' evolution on enrollment. SCHIP's enhanced match rate gave states an incentive to enroll low-income children. SCHIP mandated that states screen all eligible children and enroll eligible children in Medicaid, creating a new pipeline for enrollment for previously uninsured children.

SCHIP's block grant approach also sparked state innovation. Many states created separate CHIP programs and agencies driven by a mission to find and enroll eligible children.

SCHIP also created new tools to fuel outreach and enrollment, including allowing states to spend up to ten percent of their block grant funds on outreach activities and creating a presumptive eligibility option for children.

While initially slow to adopt CHIP programs, within ten years of enactment, states had innovated new strategies to streamline enrollment, and the combined effect of all these factors combined with advocacy at the state and local and community levels resulted in a major decline in the uninsurance rate for low-income children, which has continued to today.

So, what were some of the strategies that helped prompt these changes? NASHP reviewed available literature in 2009 and identified a number of strategies that may have contributed to the growth in coverage. Some of these include marketing and outreach efforts that were targeted to a defined population; streamlining the application and renewal processes using a single streamlined application or renewal form for Medicaid and CHIP; simplifying eligibility documentation, including the use of available data a state already has; eliminating asset tests, which can be complex and require multiple documentations; eliminating the in-person interview, which was often burdensome for working parents; limiting or eliminating waiting periods for coverage; eliminating grace periods or implementing longer payout periods for premiums; and coordinating Medicaid and CHIP processes to smooth transitions between programs, including through electronic transfer of eligibility information.

A few years into CHIP implementation, researchers realized that states' efforts to enroll eligible children were being undermined when eligible children were unnecessarily disenrolled from coverage at

renewal because a form was not returned. In a seminal report on this issue, the Urban Institute identified that states needed to focus as much energy on retaining eligible children as they did on enrolling to avoid the "hole in the bucket" problem that was identified.

As a result, we saw an increasing number of states prioritizing streamlined renewal processes. Ruth Kennedy and her team in Louisiana were national leaders in this work. Some of the strategies that they and other states pioneered included using an administrative renewal process, including ex parte renewals or prepopulated forms that renew coverage with information the state already has without requiring as much action by the beneficiary; adopting 12-month continuous eligibility periods so children wouldn't churn off of coverage due to a temporary income change during the year; and creating 12-month renewal periods.

The CHIP Reauthorization Act of 2009 built on CHIP's foundation by adding three important tools to the mix. First, CHIPRA created performance bonuses to reward states that increased Medicaid enrollment of children above threshold levels if they also implemented five of eight enrollment and retention strategies. These strategies were drawn from a number of promising strategies already mentioned and included continuous eligibility, liberalizing asset requirements, eliminating in-person interviews, combining Medicaid and CHIP application and renewal forms, administrative renewal, presumptive eligibility, Express Lane Eligibility, which is another new tool created under CHIPRA, and premium assistance.

States were increasingly able to take advantage of these performance bonuses, and the bonuses, in turn, speeded adoption of a number of these strategies. By 2013, 23 states received a bonus, and states' adoption of simplification strategies became more widespread. Premium assistance was the strategy that was least likely to be taken up among states receiving bonuses.

A second tool in CHIPRA was the CHIPRA Outreach Grants, which were grants awarded to state, local, and community-based organizations to provide outreach and enrollment assistance with a special focus on vulnerable and underserved and Tribal populations. These grants created a foundation of support for outreach and enrollment work and honed strategies that many states are drawing on in the current outreach and enrollment efforts for the ACA.

The final major tool in CHIPRA was Express Lane Eligibility, a strategy states could use to expedite enrollment into coverage that allows Medicaid or CHIP agencies to borrow an eligibility finding from another program. While CHIPRA authorized Express Lane Eligibility, or ELE, for enrolling children, CMS has granted waivers to two states, Massachusetts and Alabama, to allow the use of ELE for adults.

As this chart notes, 12 states plus the U.S. Virgin Islands have been approved to use ELE, and all but one state has implemented, either for children, adults, or both.

As the Mathematica ELE evaluation report to Congress notes, states have varied in their implementation strategies, and so there is also great variation in how states have had -- what the impact of ELE has been in the states. States that have used ELE to automate enrollment and retention have seen dramatic results, both in terms of increasing enrollment and in savings to the state from administrative efficiencies.

In Alabama, ELE is now used for 43 percent of the state's monthly renewals. In 2011, South Carolina estimated that they experienced direct cost savings of one million dollars per year and reduced their timeframe for renewals from one-and-a-half months to 20 minutes for renewals for those participating in ELE, and that they had enrolled 65,000 children in the first year alone.

Another significant shift in state approaches to eligibility over the past decade has been prompted by

advances in technology. A growing number of states have been harnessing technology to streamline their enrollment, renewal, and business processes, and this chart is from a report that NASHP released in the past year highlighting the work of maximizing enrollment grantees in their efforts to implement technology and providing specific examples.

The chart highlights a number of innovations identified among the maximizing enrollment states, of which Louisiana was one. Some of the strategies noted here include the use of consumer-facing accounts, e-notices, and texts to improve communication with applicants and enrollees; using electronic databases to verify eligibility; and moving towards paperless processes with electronic case records and document management; and promoting a paperless task-based workflow and centralizing or reorganizing eligibility processes due to technology.

With the enactment of the ACA in 2010 and its implementation this year, many states are experiencing a sea change in enrollment processes. The ACA represents a number of major shifts in approaches for states, especially from their experience under Medicaid. States will need to shift in how they approach determinations, from determining whether an individual is eligible to which program they are eligible for. They need to change how they engage with their sister agencies, both at the state level and with their Federal partners, from a more siloed approach to a more coordinated approach. The documentation burden will shift from the individual to the state. The verification approach will shift from verify, then trust, to trust and verify in a post-eligibility environment.

I grew up in New Jersey. I do not know if any of you have driven in New Jersey on the New Jersey Garden State Parkway, but I like to analogize that change in how states will experience this and how individuals will experience this from moving from a parkway approach, where you have to stop and put the

coins in every few miles to go through to a streamlined approach with E-Z Pass on the superhighway.

Going forward, all Medicaid and CHIP programs, not just those expanding or choosing to host a marketplace, will have to, among other things, use a single streamlined application or alternative application approved by HHS; use electronic verification first to the greatest extent possible, including a Federal Data Service Hub, and only request paper documentation as a last resort; provide a seamless no-wrong-door approach to eligibility that enables an individual to apply once and be determined eligible for whichever insurance affordability program for which they are eligible; and provide individuals with assistance, as needed, to enroll in coverage; adopt a new set of eligibility standards for non-disabled, non-elderly populations that allow for eligibility to be determined based on taxed household income without requiring an interview, asset test, or applying disparate income standards or inclusions; adopt new eligibility simplification strategies, including presumptive eligibility for hospitals, administrative renewal processes, and 12-month renewal periods; and use technology to simplify the application process, including by allowing individuals the right to submit applications online, by phone, by mail, or in person, and allowing individuals the option to receive notices electronically.

While states are now in the midst of full implementation of these requirements, the impact of these changes will be felt immediately by applicants and enrollees and will have a lasting impact, catapulting decades-old paper-based systems forever into the digital age.

So, where are states now and what does the future hold? It is worth mentioning a few key ideas, and I can discuss others during the Q and A.

First, it's important to note that CMS's targeted enrollment strategies rolled out in May as temporary strategies to support state enrollment during the transition are having a significant impact already. Most

significant is CMS's strategy number three, which allows states to use SNAP or other program income in place of MAGI determination for adults. Six states are approved and a number of states, including Arkansas, West Virginia, and Oregon, have reported significant enrollment bumps. Arkansas used the strategy to target enrolment to adults and children and saw an increase of over 63,000 individuals as of November. Oregon enrolled 70,000 adults, and West Virginia enrolled more than 58,000 adults and children using this strategy.

Clearly, a major new frontier for the states is the need for increased coordination and collaboration with Federal agency partners. The first challenge both states are facing is with the technological hurdles of account transfers, but others will likely follow. Improving and strengthening methods for communication and problem solving will be critical for success. Renewals and transfers remain a core concern for states and Federal agencies looking ahead. It will be vital to the success of the enterprise that we don't re-create the hole in the bucket of disenrollments that states experienced with CHIP.

States now have access to more data and are reporting at a national level to CMS, which is groundbreaking. Still, many states are not likely yet using the data they are collecting to its fullest advantage to monitor and improve performance in enrollment and retention. More incentives and opportunities to train states are needed here.

In conclusion, I will note that, without a doubt, states have made a great evolution in their approach to outreach and enrollment in public programs over the past five decades. While the future state of enrollment work remains somewhat uncertain and fraught with some challenges at this time of transition, as you will hear from my colleagues from Louisiana and Kentucky, states' futures are also filled with promise and opportunity, only limited by states' imagination and interest in innovation.

Thank you. I look forward to the opportunity to answer questions.

CHAIR ROWLAND: Thank you very much.

Ruth.

Donna, did you have a question?

COMMISSIONER HENNING: I fully support the idea of the states becoming more technologically advanced and doing all this stuff electronically. It only makes sense, and it seems like, eventually, it would also make the reporting to the Federal Government much easier for them and being able to check on their progress and their performance and that kind of thing.

But my concern is from the consumer end. When you have people that don't have access to computers, that don't -- even if they had access to computers through their local library, don't have any knowledge of how to use them; it's making sure that those people don't drop through the cracks because those are the people that are most likely to need Medicaid and to need CHIP.

MS. WEISS: So, I think that's a great point, and I neglected to mention, in my haste to try to stay within the time frame, that one of the core issues that was addressed in our report was the value of remembering the need for human touch and that the technological pathway is not necessarily going to be the right pathway for all applicants or even most applicants, given the level of literacy and access to computers.

I actually just returned from a site visit in Arizona where we were reviewing their work on creating these local office kiosks and talking about the issues facing Tribal populations and populations without access to the Internet, let alone computer literacy.

So, I agree that this needs to remain a core concern and that the value and importance of human

assistance and engagement will not go away with the advent of more and more technology.

CHAIR ROWLAND: Thank you, Denise.

Ruth. Richard.

COMMISSIONER CHAMBERS: Thanks. Great presentation. On Slide 5, the one where you talked about the 1997 to 2009, and I think there were ten strategies around there, were they in any particular order, or was that just random, or is there any kind of information on which ones were more successful than others?

MS. WEISS: So, this is a challenge that we struggled with in establishing the maximizing enrollment program with the Robert Wood Johnson Foundation, and we did a review of the literature, and what we found is that it's really hard to isolate any particular strategy in terms of its impact, because, invariably, states were implementing these strategies all together.

COMMISSIONER CHAMBERS: Sure.

MS. WEISS: In very few cases can you sort of identify a single strategy and its impact because of the fact that there were so many things going on.

I will say that one thing that we have heard consistently from states is the value of focusing in on renewals, which I know Ruth will be talking about, because of the return on investment and the challenges that it can create for states in generating workload when you have a family that is eligible at renewal but becomes disembroiled, that it generates a lot of -- a significant volume of workload and that the cost of doing that initial enrollment is high enough to warrant states really investing more time and energy and effort on renewals, and I think that will continue to be an area that states will want to focus.

COMMISSIONER CHAMBERS: Okay. Thank you.

CHAIR ROWLAND: I will let Ruth now focus on that. Ruth.

* MS. KENNEDY: Good morning, everyone. I want to thank the Commission for the invitation to be here this morning and talk to you about the processes that we have put in place in Louisiana.

So, an overview of my remarks for today. First is just a summary of those enrollment and retention strategies and when those were put in place in Louisiana. Then, our experience with ex parte and administrative renewals as well as with Express Lane Eligibility. I'll focus most of my attention on that, because, as you will see from the timeline, we have all the other measures were in place in 1998. So, we spent -- and then I'm going to wrap up with some conclusions and observations from my 15 years in the trenches in Louisiana, working to increase enrollment of eligible people in Medicaid and CHIP.

So, the timeline here, the performance bonus, the eight measures that Alice previously alluded to, you can see that we had four of those five measures in place in 1998. And so we implemented our CHIP program, and it was a Medicaid expansion program, and so you've heard the saying that the rising tide lifts all boats. And so all of the improvements that we made with the implementation of CHIP, our children who were eligible for Medicaid in Louisiana benefitted from those, as well.

And so November of 1998, we began doing aggressive outreach and we were giving our undivided attention to identifying, informing, enrolling eligible children in Medicaid and CHIP.

In October and November, those first children of 1999, it came time for their annual renewal. Nothing had been done to simplify that process. And while we were enrolling children like gangbusters, when we got our enrollment counts in November -- for November 1st of 1999, we had had a net loss of 6,600 children. So, it was, like, you know, something is wrong here.

So, we began our decade of work, working to improve our renewal processes, and so that's what I'm

going to focus on. You'll see there that first arrow, that's my November 1999, where we had our little dip, and so, next slide, Alice.

That hole in the bucket that we identified, and there were a couple of things about it. Those renewal closures, the overwhelming majority of them -- it was a bigger problem in Medicaid than CHIP, as you might expect, because of the issues those folks have with literacy, et cetera. The majority of those were for what we came to call procedural reasons. It was not because the children were ineligible, but it was because they didn't complete a form and mail it back in. And so it far exceeded the number of eligible children. As I said, in one single month, we lost 6,600 children.

So, this is early 2000. And so while we're wondering, what are we going to do, we get correspondence from CMS, a State Medicaid Directors Letter that I refer to as a watershed event for us. This was a letter that told us that we needed to look at our policies and procedures and practices, and this is the first mention that I recall of ex parte renewals by CMS. And they told us to identify any unintended consequences about welfare reform that was put in place in 1996 that Alice alluded to. And so we actually put a moratorium on any closures at renewal until we had finished this review of our policies and procedures and practices. And so we began ex parte renewals for those children who were losing Supplemental Security Income eligibility in 2000.

But now we went full force into ex parte eligibility in July of 2001. At that point, we changed our policy to say that any child who was in an active Food Stamp case in Louisiana was eligible to have an ex parte renewal. For us, it was, in essence, "adjunctive eligibility." But there was still work that needed to be done by a Medicaid eligibility worker, to pull that data from the Food Stamp system and key it into the Medicaid system.

By May of 2003, 57 percent of all of our renewals were via this ex parte method, and it is the number -- ex parte renewals are the number one factor in Louisiana's large enrollment increases between 2001 and 2005. If you look back at the slide where you see that huge spike from that arrow up to Hurricane Katrina in August of 2005, it was ex parte renewals. So, now, ex parte renewals are a worker worked on every one of those cases and went and pulled information.

We then went to another level. Our definition in Louisiana of administrative renewal is that it is a process that is much more data-driven than an ex parte renewal, and at some point, you may have heard this type of renewal referred to as passive. But we would state that we believe that this is a mischaracterization. It is not passive. It is very much data-driven for us, identification of enrollees from data, from historical data of cases with a very, very low probability of change in their situation and in eligibility because of income.

And so, for example, a single-parent household is much less likely to have income over the limit than when there are two wage earners in the house. If a child is living with a caretaker relative whose income doesn't even count, well, that, of course, is at the top of the list for a candidate for an administrative renewal. And then another thing that we found from data is if your income had been below a certain amount, like $500 for three years, I mean, it was very unlikely that income would increase.

So, we actually worked on this. We developed our administrative renewal process using the PSDA, the Plan-Do-Study-Act model, extensive testing, including testing of whether, when we sent a letter saying, our information is that you continue to be eligible for Medicaid, if you have had changes, call us. And from testing, we learned that people will call and report changes.

The key tenet for our administrative renewals as well as ex partes is that if income for Medicaid and

CHIP is below the cap for that program, the precise amount does not need to be established. Now, this is not the case for cash assistance or for food stamps. In food stamps, for every $3 difference in your income, there's a $1 difference in your food stamp allotment; for cash assistance a dollar for dollar. So whenever you're using the same mindset to determine eligibility for Medicaid and CHIP that you're using for food stamps and cash assistance, there's a real disconnect, and people get adversely impacted by that, in my opinion.

Now, some of the things that we did, at the time they were -- you know, I felt like we were way out there on a limb. But I can tell you today that two PERM, payment error rate measurement, eligibility cycles is that Louisiana Medicaid, we have -- our error rate in eligibility is well below the national average, so it does not adversely impact the integrity of eligibility decisions.

And now on to Express Lane Eligibility. I first heard about Express Lane Eligibility during the CHIPRA -- or the CHIP extension legislation that was vetoed. You may still have been at the Senate then, Alice, working on that. But we saw that as something that we really needed to put in place in Louisiana, and I'll tell you why in a minute. But before CHIPRA, we actually had in 2007 put in statute in Louisiana this language that the Department of Health and Hospitals, upon enactment by Congress, we were hopeful, of legislation allowing the same, may utilize income determinations made by the food stamp program, WIC, or the National School Lunch Program to determine eligibility for Louisiana Medicaid or CHIP. So we had that authorization.

The next slide you will see is that our data showed that in Louisiana the highest number, highest percentage of uninsured children were those between 50 and 100 percent of poverty, not at the very lowest income but in that range. And so that leads to why we believe that Express Lane Eligibility is important for

Louisiana kids, that high percentage, of course, of uninsured children between 50 and 100 percent, and so the reasons for that are, we believe, literacy issues, and while we've done a lot to simplify enrollment, that's relative, and also, you know, behavioral health economics issues. And our families have complicated lives. In Louisiana, we do have different agencies who determine Medicaid eligibility and eligibility for food stamps, and so we've got the issue of parental priorities and just Maslow's hierarchy of needs: is someone more likely to go to the food assistance agency if a child isn't -- you know, doesn't have urgent health needs. And then we were quite confident that we would get some administrative savings out of this, and we're very concerned then, as we are now, about maximizing the reduction in churning. We believe that to improve quality we have to have continuous coverage. So the reduction in churning, not only does it impact administrative costs, but it is important for getting those quality improvements.

So why, when we already had Express Lane Eligibility and administrative renewals, would we be wanting to move to -- I'm sorry -- ex parte renewals and administrative renewals, would we be pursuing Express Lane Eligibility so aggressively? We believe it leads to an even further reduction in our administrative costs, and that has been proven; less need for any caseworker action, as in zero; reduces exposure to our eligibility errors, just to be very frank, because the way that the statute is written, Express Lane Eligibility cases are excluded from quality control and PERM reviews; and it further simplifies eligibility in Louisiana so that all children who are eligible for SNAP or eligible for Medicaid as well; and also at the time, the performance bonuses were based on Medicaid enrollment increase.

Now, I will tell you that by the time that the performance bonuses came into effect, we had already had the bulk of our children enrolled, and our performance bonuses were very modest because we had enrolled those children by 2005, if you go back and look at that chart. No regrets about that, though.

Simplification isn't simple or quick relative to Express Lane Eligibility, which may explain that map with the states that have adopted it, and even fewer states, if you look at the Mathematica report, are using Express Lane Eligibility to automatically enroll and renew children. So, I mean, it was a great deal of effort on our part, a heavy lift, and even though we had that statute come 2009, we had to do internal marketing, why it was important to still pursue this, because there was a $4 million fiscal note when we went before our joint legislative budget committee in November of 2009 while we were having reductions in other areas of the program because there would be an increase in enrollment.

So we got our approval, and we enrolled the first children in February of 2010, and now we do -- later that year, we used this totally automatic behind-the-scenes process to renew children who have an active SNAP case in Louisiana.

Now, if you look at this map, whenever I had the 6,600 children, the net loss, this pie chart would -- we would have had 100 percent paper forms for anybody that got renewed, 100 percent paper, and so this was our December 2013 numbers.

We will do an administrative renewal if we can before we do an express lane. That could be reversed, and our express lane would be much higher. But this is the radical change in how we -- how families are determined to be eligible at the point of the annual review.

So some factors that impact our ability to adopt and institutionalize these measures is strong executive support over the last 15 years for increasing enrollment of eligible children in Medicaid as well as CHIP; simplified and streamlining the application and renewal processes, and that includes the current Secretary of the Department of Health and Hospitals in Louisiana, Kathy Kliebert, who is in our audience today. And so we -- many of the changes that we made did not require legislative approval. We already had

12 months continuous eligibility in place in '98. That's an important prerequisite. And we had delinked, actually before welfare reform, Medicaid and cash assistance eligibility in Louisiana in 1992.

Totally paperless case records by 2005. Eligibility workers in Louisiana are state employees and not unionized. That does make a difference, I'm told. And, finally, our unwavering belief that while it was resource-intensive to do this, the juice would be worth the squeeze, and it absolutely is.

So some final thoughts. Express Lane Eligibility option for states beyond December is scheduled to sunset, and so it is very important for Louisiana that we be able to continue our Express Lane Eligibility. You know, the Hippocratic Oath, "First, do no harm." At least grandfather those of us who are already doing it.

Another thing is to further refine the definition of Express Lane Eligibility to be more than just a "lead file" if bonus payments are going to be tied to the adoption, because there's great variation based on that Mathematica report on how Express Lane Eligibility is operated.

Expand the option to include adults if you're serious about enrolling eligible people. And now here this is sometimes the elephant in the room: recognize that enrollment and cost are going to increase if you implement Express Lane Eligibility and use it to automatically enroll and renew children and/or adults.

And consider enhanced match to states for individuals who are automatically enrolled or re-enroll through ELE, or at least for the system changes that are needed. It requires system changes, extensive changes in systems to make things automatic. And that match is 50/50. It's not even 75/25 or -- you know, it's very -- it's not at all an incentive.

So with that, I'll conclude my remarks, and if anyone has questions, either today or follow-up, here is my contact information.

CHAIR ROWLAND: Thank you very much, Ruth.

And now we're going to turn to Lisa Lee, and then we'll have an opportunity for the panel to ask questions.

* MS. LEE: Good morning. Thank you for allowing me to be here and talk about some Kentucky-specific information. My presentation will focus on policy changes and how they can actually either hurt or help enrollment.

So this is just a picture of Kentucky and our demographics. We have 120 counties in our state. Of those, 98 counties are classified as rural counties. We have approximately a little over a million children under the age of 19 in Kentucky. Of those, almost half are under 200 percent of the federal poverty level and would qualify for Medicaid or CHIP. Our rate of uninsured children in Kentucky is 6.8 percent.

Our CHIP program is a combination program. We cover children up to 200 percent of the federal poverty level. Our Medicaid expansion program covers up to 150 percent. Our CHIP program also utilizes the Medicaid infrastructure, such as the provider network, the eligibility determination process, the claims processing system, and we find that this is a seamless process. Our children can easily move from Medicaid to CHIP and not see either a reduction in services or have to change their primary care provider.

Some of the policy amendments that we implemented in Kentucky that we feel had a significant impact on enrollment. In July of 1999, when we first implemented KCHIP, we implemented it with a mail-in application. Prior to that, children had to go or their families had to go to a local Department for Community Based Services office and conduct a face-to-face interview. So in 1999, we did a very simple, one-page, mail-in application. We did aggressive outreach across the state. And then in 2001, if you look at the 2001, '02, and '03, there were kind of some issues, concerns about budgetary impacts because some of

the CHIP allotments sometimes were unpredictable, so leaders were concerned mainly with budget, and we started implementing things that would slow the process down, for example, implementing the face-to-face interview for recertification in 2001. We kept the mail-in application until 2002, so we flipped that decision, and we implemented the face-to-face interview for children again. And then in August of 2003, we implemented some nominal co-payments mainly for pharmacy and non-emergency use of the ER.

And in November 2003, we implemented a $20 per month per family premium for children in the separate insurance program, those that were over 150 percent and up to 200 percent.

And then basically we did a little of nothing from 2003 to 2008, and then we had new leadership in 2008. Our current governor, Governor Steve Beshear, said he wanted to find and enroll every child that was eligible for KCHIP or Medicaid. So we simplified the enrollment process. We embarked on an aggressive outreach campaign. We went across the state with our new application, teaching everybody how to fill out this application, and enlisting the help of everybody that was just willing to talk to us.

And then in November of 2008, we also implemented a policy that would allow eligibility workers to reprocess recertifications when documentation wasn't received. We discovered that one of the number one reasons that children were disenrolling from the programs was failure to return information. So we implemented a process that would allow our workers to process any case that had been discontinued and documentation was received within 30 days of that discontinuance date.

And then in July of 2010, we eliminated our $20 per month per family premium, and, again, we found that individuals who were not paying their premium and were disenrolling from the program were actually those individuals who were right on the cusp, and they were coming back into the Medicaid program. So we eliminated that premium so that individuals wouldn't get discontinued for failure to pay the

premium.

So some of our enrollment. As you can see, I put -- we first implemented CHIP in 1998, and as you would expect, we had the huge increase in enrollment. And what we found during that time also that led to some budgetary concerns is for every child we were enrolling in CHIP, we were enrolling two in Medicaid. So you can look at the -- when we implemented the face-to-face interview at the initial application, our enrollment kind of leveled off, and you would kind of expect, you know, at some point you'd reach your saturation and it would level off anyway. But look at when we implemented the mail-in application. Even though we weren't doing aggressive outreach from 2003 to 2008, we were still seeing a slight increase in our enrollment. With our Medicaid application and our aggressive outreach, we feel it led to the big spike that you see in 2008. We do see a slight downward turn right now in 2013 with CHIP. But if you look at our Medicaid enrollment, you kind of see that same little spike when we implemented the mail-in application. And our Medicaid and child enrollment continues to increase.

I've highlighted some of the July -- from July 2009 on, you can see that we have had a huge spike in enrollment. In July of 2009, we saw the largest increase in enrollment since we had -- since the program was implemented. We believe that this is the direct result of the mail-in application and the aggressive outreach that we embarked upon.

So some of our outreach and performance measures. Kentucky has not been awarded an outreach grant, those that Alice had spoken about early in her presentation. In 2013, one of our advocacy organizations was granted an outreach grant, and then we have not received performance bonuses because we have only three of the required criteria, and that's the ones with the X and I've bolded. We only have those criteria, so we have never received a performance bonus.

So our outreach strategies, when we started developing and talking about outreach, we kind of looked at our history, and we knew that policy could impact outreach -- or could impact enrollment, so what we wanted to do is we wanted to build an outreach infrastructure that was sustainable with very limited funding or maybe no funding at all. So in addition to simplifying our application process, we trained community partners to help us with our enrollment, specifically our Family Resource and Youth Services Center. We call these our "frisky" workers. They're in almost every single school in the state, and they are phenomenal about helping us get our kids in, and sending them not only to Medicaid or CHIP but to other resources to help those kids increase their health.

Our local health departments and our Medicaid providers, we enlisted their help because if individuals came into their offices without health insurance and they helped them fill out the application, then those applications were [unintelligible]. It was a payer source. So our providers and our local health departments, again, were very key partners. Faith-based organizations and daycare centers. We tried to focus where the kids are, who can we get to help, who cares about our children.

We developed new outreach materials. Previously, we had -- we listed the federal poverty level on outreach materials, and it would say, "If you are under this, you may qualify." And knowing how complicated the eligibility and enrollment process was, and other factors that may determine, we just started focusing on uninsured children. "If your child does not have health insurance, please fill out this application." We started doing audio news releases. We attended the state fair and spoke to everybody there.

Our urban communication, we advertised on the mass transportation, on the buses. We wrapped the buses so the telephone number was there. And in the rural areas, we had to rely on our community

partners.

So in 2012 and 2013, very recently, the Kentucky Department for Medicaid Services expanded our population. We are part of Medicaid expansion. We also created our own state-based health exchange. The individual that is the executive director of the exchange was also a previous Medicaid deputy commissioner. She brought Medicaid into the room. We sat with Medicaid, our Department of Insurance, Health Benefits Exchange, and our Office of Health Policy. We had such huge collaboration building our Health Benefits Exchange. We had our local workers come in and help them with the online application to make it simple. We have an online eligibility enrollment process that we believe is pretty simple, and individuals can enroll in Medicaid and CHIP now either through the online application process, they can go to our local Department for Community Based Services office and have in-person assistance, or they can call a toll-free number and have help on the phone. We'll actually talk to them and fill out the application while they're on the phone.

Again, we began an aggressive outreach in conjunction with the Health Benefits Exchange. We relied on a lot of the strategies that CHIP had implemented in the past. And when I talk about the state fair, I have to show this. This was a gold mine in Kentucky. This is just a bag -- this is just -- it's a very nice bag, and each one of you shall have one outside waiting on you. But individuals would come to the state fair, and they would seek us out. They would say, "Do you have those really colorful bags?" And it would be a chance for us to say, "Oh, have you heard about Kynect? Let me tell you about Kynect. Do you have health insurance? Do you know somebody who doesn't have health insurance?" And we would build that relationship with these individuals, and it was funny that none of them associated Kynect with the Affordable Care Act. So it was kind of funny. But we made a lot of contacts. I forget how many

thousands of bags that we distributed. And I'm so proud when I go to Kentucky and I walk around, I see these bags all over the place. You see them in airports. It is just phenomenal, that it's just something so simple but people like it, and it has our toll-free number on it, so it's wonderful.

So, again, our message was quality health care for every Kentuckian. We didn't associate this with any sort of Medicaid program, any sort of social program. And like I said, even the individuals talking to us didn't associate it with the Affordable Care Act.

So just here's some of our success. Like I said, I wanted to spotlight 2008 because we increased the net number of children enrolled in Medicaid and CHIP by over 70,000 in a four-year period. And I've just listed some of the children that were coming into the program, so in 2007 we had an average of 450 new children per month. If you jump up to 2009 -- again, we implemented our simplification process in November of 2008, so in 2009, we had an average of 2,931 children entering our program per month.

Health Benefits Exchange has assisted us in enrolling over 181,000 individuals into the Medicaid program since -- as of January 2014. We have also enrolled over 3,000 -- almost 7,000 children in KCHIP through our Health Benefits Exchange.

So factors that led to our success, we definitely know that leadership has to take a role. Our program, CHIP and Medicaid, is to serve uninsured children and individuals who have some very challenging -- they have very challenging lives, and so leadership has to know that these programs are there to assist people. It's not there to put up roadblocks. We're not there to put up barriers to enrollment. Simplifying the enrollment process to allow those individuals to come into the program, and right now, like I said, we can either apply in person, online, or over the telephone. Our Health Benefits Exchange is hooked up with the federal hub, so we do check a lot of the information there. Individuals do not have to

supply information unless we get some information back that is in direct conflict with what they have reported. And we focus on uninsured rather than the poverty level. And so we believe that we have right now some of the -- we have some of the most challenging and some of the most rewarding days ahead of us in the Health Benefits Exchange and what it means for our uninsured.

So, again, some of the factors that led to our success were training our community partners. It's well and good for us to sit in a room and make all these decisions, but unless you engage the community and you get out and actually focus and talk with them, you're not going to be very successful.

So we believe definitely our health departments, our providers, and our schools -- I can't stress enough the importance of the schools and enrolling children in our program. And in our marketing, something so simple just as a little colorful bag that engages people, that they want to come, they want this information, and you talk to them, and it has just been -- so far I've been very proud of some of the things that we've done in Kentucky.

I'd be happy to answer any questions. This is my contact information.

CHAIR ROWLAND: Well, I thank all three of you very much.

I think this has really given us a lot of food for thought, and I'm going to open it up to the Commission members' discussion. I'll start with Robin.

COMMISSIONER SMITH: Hi. My comment basically is for Ruth.

I'm not one of the professionals. I'm a parent of an adopted child and foster children who have Medicaid provided for them, basically, because they're medically fragile or developmentally disabled.

I particularly like that you've taken the burden away from the parent for re-enrollment and put it on the administration.

And I also will say -- I'll preface this with it's one of my complaints about passive enrollment.

I got a letter last week, asking for -- South Carolina has not been particularly burdensome as far as extending my child's Medicaid. I have to say that up front.

But I did just get a letter, and it said I had 30 days to come up with some school documentation to prove he was in school in order to maintain his services that he gets because of being a special needs adopted child, and that includes his Medicaid.

And the letter was dated January 9th, but the postmark is February 7th, and so there was 30 days from January 9th. We had the ice storm. We had the holiday. I still have not been able to reach the person. I've e-mailed. I've called, and nobody has called me back.

It can be frustrating and scary to a parent, thinking, oh, no, you know, what do I do now?

And the documentation that I have to get is not your typical documentation. I can't just go get a report card for him because he has this huge IEP.

So I really do appreciate that you have taken that burden away from families and placed it -- I was going to ask you why they would maintain enrollment in food stamps and other programs like that but not stay enrolled in Medicaid, but you answered the question by saying it was a priority.

So I appreciate that. It's not something that I'm familiar with, not being a professional.

CHAIR ROWLAND: She is a professional. She's a professional great mom.

COMMISSIONER MOORE: Can I just interject and ask Lisa or Ruth to comment on continuation of eligibility for situations like this, with foster children or with special needs kids that have been adopted, and whether you've encountered those problems and how you might have addressed them?

Or, Alice may know of some ways, too.

MS. KENNEDY: In Louisiana, we actually -- as long as a child is in foster care or that status, they get Medicaid continuously, as long as they're in foster care. There is not a separate determination for someone in foster care.

MS. LEE: And Kentucky is the same. If you're in foster care, children continue to be enrolled.

And, as far as some of our special needs programs, we do have waiver programs that many of our children are enrolled in. And they do have a recertification period every year, but that is where we find most of our children.

MS. KENNEDY: And I would add that the simplifications that we have in place are not only for children in Louisiana, but they're for all of our Medicaid populations.

Some of the work we did for simplification around 2000, with children who were in home and community-based waivers, were involving the same information every year. And so, I mean, that was a catalyst for us to do simplifications for that population because it was just the same thing over and over and over, when we should know that this was not going to change in terms of certain factors.

COMMISSIONER SMITH: Can I just say real quickly -- I just wanted to clarify that this is a one-time deal. I have not been asked to do this over and over, but it just sort of goes to an example of how things can go so terribly wrong when you just send a parent a letter in the mail and expect them to answer back.

MS. WEISS: If I can add, I think the strategy that Ruth was mentioning, where Louisiana identified populations that were vulnerable populations with special needs who were likely to remain continuously eligible, Louisiana set an example for this. And our maximizing enrollment states came and visited Louisiana, heard about the strategy, and a number of them adopted this strategy.

I think Louisiana refers to it as administrative renewal.

We have sort of tried to coin this term, continuous renewal, for individuals who are on a fixed income, have a disability or are likely to be continuously eligible.

Where the state ends up going through a special renewal process, they send them a one-time notice. They let them know that they're likely to be continuously eligible -- let us know if you have a change in income. And then they basically don't even really touch those cases unless they hear from them, and they send them an annual notice -- you've been renewed.

So that's one thing.

The other thing that's worth mentioning is Alabama is implementing a process that's going to automatically transfer foster care children upon reaching the age of majority and transitioning to new adult eligibility, and so they have a process in place for that.

And then, finally, I was just going to mention to Ms. Smith that some states are implementing -- and I don't know whether or not South Carolina has this in place already, but some states are implementing customer-facing accounts that allow beneficiaries to get online very quickly, check the status of their benefits and receive notices electronically.

For example, in Utah, you would have received an electronic notice if you had signed up for e-alerts, and you would have gotten that information.

You would have known that you had to require documentation more quickly. It wouldn't have been relying on the vagaries of ice storms and mail and things like that, and it would have given you more of an opportunity to potentially electronically upload or communicate back with the state.

So that's something that, hopefully, is coming in more states.

COMMISSIONER SMITH: And then we have the issue of people who don't have -- you know.

MS. WEISS: Right.

COMMISSIONER SMITH: But, again, this did not come directly from Medicaid. It came from the Department of Social Services so that he could maintain his Medicaid status through his adoptive special needs status.

So I just want to clarify that also. I'm not blaming Medicaid.

CHAIR ROWLAND: Okay, Trish, then Sharon and then Andy.

COMMISSIONER RILEY: This has been great, and I haven't thought about that Plan-to-Study-Act and all the great stuff you did in Louisiana for a long time.

MS. KENNEDY: We learned that from you all.

COMMISSIONER RILEY: I remember that. I remember that. That was great work. I thought nobody would ever do it.

But, at the risk of being Debbie Downer --

[Laughter.]

COMMISSIONER RILEY: It shows we have divergence of opinions and backgrounds on the Commission because Robin brings the real story and I worry about things like the collision course of these great efforts, these extraordinary efforts, to do the right thing and get people involved and budgets.

And so I'm intrigued by the discussion about PERM.

And, Alice, it was great to have that sort of history of you all started thinking about error rates and that's what bound us up and we've moved into a different world.

Can you talk a little bit about how you budget for all this success and where the federal government

is today?

I know they're modeling and changing and thinking through the PERM. But, where are we on the error rate discussion?

MS. KENNEDY: You are familiar with PERM, the Payment Error Rate Measurement project. In our state, every three years, they do a review of both eligibility as well as claims -- managed care claims and fee-for-service claims. They post that information.

And so -- but I mean beyond that, Trish, I'm not -- that's all I know and that we hold our breath, you know, fearing the worst and hoping for the best.

MS. WEISS: So I have heard, although I'm not directly involved in the process, that CMS is updating their PERM process to try to take into account all of these changes, not only in the federal requirements but in state procedures, and ensuring that the PERM process is more faithful to those requirements. In the past, there have been some concerns raised by states where the state had an approved SPA that said that they were going to make these simplifications, and then they ended up getting dinged in the PERM process.

The other major change that we're going to be seeing with this administration's approach to payment error rates, as I understand it, is that we're going to be seeing a focus not only on ineligibility -- you know, sort of erroneous payments -- but also on tracking the extent to which states are doing well on enrolling those who are eligible.

And I think the performance measures that states are reporting now are the beginning of a longer process that will, hopefully, lead to a more coherent conversation about the federal investment in these programs and in these populations and ensuring that the dollars are being well spent, efficiently spent and

actually reaching those who are supposed to be eligible for coverage.

MS. KENNEDY: And what I would add to that is while we have made major simplifications, we've always been cognizant of the importance of the integrity and the accuracy of those eligibility decisions, and so we don't do anything that we think would compromise that.

And that is why even if the Express Lane Eligibility cases were included in the PERM sample, if the decision was made by the Louisiana Food Stamp Agency; I have a high level of confidence because they have that higher standard because of the need for precision.

So we have -- we are very confident because we use SNAP as the other agency that we're using.

So we don't believe that that is adversely impacting the accuracy of our eligibility.

CHAIR ROWLAND: Sharon.

COMMISSIONER CARTE: It's good to see so many colleagues, former colleagues, here today. And I can attest to Lisa's outreach. I already have my Kynet bag. So, as her neighbor and colleague.

CHAIR ROWLAND: We're all going to have them, I think.

COMMISSIONER CARTE: That's right.

One of the things that you've spoken to, or alluded to, is the delinking of welfare eligibility and now taking it to a different level that's behind this. But I know we've spoken about it at CHIP director meetings and some here at the Commission, that it requires really a whole changing of culture.

And, Alice, you mentioned the going from verify and trust to trust and verify.

Maybe all of you could speak to what helps to promote that.

I know, Lisa, you mentioned leadership.

But it is a major change, and it's one that, I think, states struggle with. So I'd be interested in

anything that you can shed light on there.

Also, I did want to mention the program integrity concerns, but I think that many states do, do their own PERM or other quality reviews to assure that error rates stay in line. So there are protections there. It's not like the door is thrown wide open for errors.

And, if you can speak to that a bit more.

MS. KENNEDY: Relative to the culture change -- that is, for the increase in enrollment of children in Louisiana -- that has been the gatekeepers are eligibility markers. And so it's very important that there be that organizational change and culture change at that level.

And one of the things that worked for us was to engage the workers themselves in here's the identification of the problem, you know, and how can we address this so that they had ownership in that process.

A concept that refer to is -- Lisa talks about marketing, the external marketing, but the first marketing has to be the internal marketing to those eligibility workers so that they understand what you're doing and why you're doing it and why it's important that children have health coverage.

And that makes a big difference, you know, when they understand that they are -- one of our goals in the Department of Health and Hospitals is to improve health outcomes, and they have a vital role in that because before someone can get access to care they have to be enrolled.

So, when -- that recognition is major, I believe, for eligibility workers in the culture change.

MS. LEE: Yeah, I'll just kind of add to what Ruth said.

I think as far as the cultural change goes, it is messaging, and one of the things that we talk about when we go out and talk to our community partners is that Kentucky ranks near the bottom in all of the

health indicators. I think we're maybe 44th overall. I mean, we're a very unhealthy state.

And it's not just our Medicaid and CHIP individuals that are bringing the health ranking down. It's us as a whole. It's the entire state. Until we start lifting everybody up and improving everybody's health, we're not going to be a healthy state.

So I think a lot of it has to do with messaging.

And, as far as program integrity, we still -- we mine our data. We look at claims. We make sure that all of their eligibility enrollment processes are followed.

Our PERM rates are similar to Louisiana's. We're below the national average on errors for eligibility. We expect that to continue, and we expect our Program Integrity Division to continue to utilize all the tools that they have to ensure that claims are processed appropriately.

We just went in to look at our claims. We have a fee schedule online with the rates and everything. And we actually did just a couple weeks ago a comparison of how our system is processing those claims, and we were so thrilled that less 1 percent of the claims processed inappropriately. So I think that's a good start.

MS. WEISS: So, if I can add, we actually looked at these factors in studying of the impact of change with our states, and we just released a report focusing on this, called Managing Program Change. That may be of interest.

And the primary author is in the audience, Maureen Hensley-Quinn, my colleague from NASHP.

But the key factors that we identified are among those that have already been mentioned, but I'll just list them out.

So, basically, we found universally that you couldn't underestimate the value of leadership and defining a vision for coverage, and that comes both from the top and from the capacity of mid-level agency

and division heads, to sort of articulate that change meaningfully and consistently and force it in everything that they're doing.

The involvement of workers, as Ruth suggested, has been critically important. Allowing workers to engage in, participate, provide ideas and take some ownership for the change that's happening is also important.

Training and transparency of the process was critically important in terms of how things were going to happen when change was happening, making sure everybody is on the same page as stages move forward.

And, reinforcing those changes in the policies.

We repeatedly tell a story of Louisiana's experience where they were moving from a culture of promoting case closures as doing the right thing by eligibility workers, to saying to workers, no, we really want you to try your hardest to renew these people, and we are not going to let you close a case unless you get approval from a manager, and actually make that a factor in performance reviews and reinforcing in policy manuals that they really, really mean it.

And I think that it's those sorts of initiatives and reinforcements that are going to be critical. It has to be organization-wide.

CHAIR ROWLAND: We have a lot of comments that people want to make. So I'm going to turn to Andy. Then I have Patty, Donna, Richard, Mark.

COMMISSIONER COHEN: I'm going to skip my turn because the issues around audits have been addressed. So thank you.

Although, Alice, remind me; I'm going to tell you I have another analogy on your E-Z Pass to add to your list for the future.

[Laughter.]

COMMISSIONER GABOW: Thank you. This was very interesting.

And I think your point that I believe -- I'm not sure -- maybe Ms. Kennedy made, that if we're really serious about coverage, whatever we can automate is really the way to go.

So, in that regard, I have a couple questions about whether you have information about the use of the WIC program and putting people in right then, or at birth when most births still occur in hospitals, and when you go into a hospital there's usually some screening for your income and payment method. What about automatic enrollment at the birth of a child, which of course is done in other informed societies?

And then, on that same group of automatic enrollment, could you discuss about automatic enrollment with income tax filing or earned income tax credit application -- all of which would seem like the more pathways that you can funnel into automatic enrollment the more successful we'll, obviously, be in getting everyone who should be enrolled.

So, if you could comment.

MS. WEISS: So, a couple of thoughts.

On your point about automatically enrolling newborns, I'm happy to report that there are a couple of states that are already doing this for Medicaid-eligible newborns. So, when the mother is Medicaid-eligible at birth, the newborn is automatically eligible for Medicaid.

In Oklahoma and Virginia, those states have adopted now statewide Medicaid eligibility automatically for the newborns upon birth, and it's automated so that the hospital enters in their information and automatically a number is generated for the baby before they leave the hospital.

So that's an innovation that we actually highlight in some of our reports, and that we're hoping that

other states may take up as they look for ways to make the process more streamlined.

But I don't see states having -- looking at automating enrollment, you know, at that point, but I will say that hospital presumptive eligibility potentially creates an opportunity for hospitals to be thinking along those lines. So there may be that going forward.

In terms of the use of WIC programs, I will say that I know we were looking at that as a strategy to see whether or not states might take it up. So far, we haven't seen too much. I haven't heard about too much penetration among states that are looking at programs to use for Express Lane Eligibility.

But it's definitely a new frontier and an area of data that I'm hopeful that more states can look at as they need to begin this fully automated process for both applications and renewals, and using all available data sources. So, probably stay tuned for some of that.

And then on the auto enrollment with tax information, I know that the Mathematica report highlights the experience of some states trying to use some tax data to inform the enrollment process. It's a more cumbersome process, it appears, in part because of the confidentiality requirements in the tax process.

I know that Utah has implemented -- for ELE, they use tax information to inform CHIP renewals for children, but I don't know that they've seen a significant number of families taking up that option because, again, the families have to opt in for it.

So I think that the use of tax information in the enrollment and retention process, though, will likely be a major issue for states going forward, and the use of tax preparers to support enrollment and those sorts of things, given the fact that eligibility is so much now, for the majority of the public, based on tax-based information.

COMMISSIONER CHECKETT: Well, thank you so much. I really enjoyed everyone's

presentation. It's really terrific to hear about all this innovation.

And I have a lot of questions, but I've limited myself.

And, Ruth, one thing that really caught my attention is when you said that Louisiana has an experience of people actually reporting a change in income because I think there's a lot of suspicion about that. So that's my first question, if you could just share more about that.

And then the second one, for whoever wants to answer this -- have you seen a decrease in the number of state employees that are required to do eligibility because of the work that you're doing, and is that seen as a good or bad thing?

And so I would appreciate your comments.

And, again, thank you so much for coming today.

MS. KENNEDY: We have actually had a decrease of a couple hundred employees doing Medicaid eligibility with the economic downturn, but we see it as really a good thing because we were able to -- a significantly fewer number of employees were able to produce the work and meet the timeliness requirements.

So we don't see it as a negative. We've been able to reduce administrative costs in the program without, we think, adverse impact on access to the program.

So that is -- we see it as a plus.

But probably -- I don't have the figure right now, Donna, but probably 200 fewer eligibility employees. We had 800-plus, and it's like just over 600 right now in Louisiana Medicaid.

COMMISSIONER CHECKETT: Thank you.

Okay, and then just the self-report, the people calling in on self-report.

MS. KENNEDY: And I think we thought the same thing. And while we were testing, you know, I mean probably our assumption was that we were not going to get reports, but we were really surprised by the number of people who -- because really, early in my career, I would hear people are basically honest, and I think it reaffirmed our belief in that -- that people are basically honest and will report changes if they have a way that we provide them to do that.

MS. LEE: I would just like to say Kentucky has not seen a decrease in our eligibility workers. When we implemented our mail-in application in 2008, we noticed that roughly 60 to 70 percent of those individuals were still going to the local office. So there are many individuals who want that personal touch or who need that.

So our workers have not decreased, and with our Medicaid expansion, it's just put a little bit more work on them. We haven't hired additional, but we also haven't decreased our staffing.

COMMISSIONER CHECKETT: Thank you so much.

MS. WEISS: So I'll just share from what we've seen from states.

States are generally reporting attrition in workers because of retirements and things like that, or because of in some cases they have layoffs or furloughs or freezes because of budget cuts. But, in general, the states that have saved money because of simplifications generally reinvest those resources in their process because the volume of cases has increased so much.

COMMISSIONER CHECKETT: Thank you.

COMMISSIONER CHAMBERS: Once again, thank you. Great presentations.

Two comments. One is I can't help myself always from taking -- looking at things through a managed care lens since I run a managed care plan.

California has gotten religion with Express Lane Eligibility and is in the process of its food stamps program called CalFresh doing the Express Lane.

But on your very last slide, Alice, your very last bullet point talked about plan selection.

Just something to think about is California, as of the end of last year, is mandatory managed care in all 58 counties in the state. And so what happens in the Express Lane, because there has to be a selection process, is folks are being put into fee-for-service Medicaid for several months and then required then to go into plans.

It's just something to watch as to where any way of helping states with thinking through that because I don't think it's always the best, especially for people who are new into the Medicaid system, to go through several months of fee-for-service and then having to go into a managed care plan.

Certainly, from managed care -- and Donna and others would agree -- the quicker you get them into a coordinated and integrated system of care because that's where they're going to end up is good. So it's just one of those little disconnects and processes that certainly is worth keeping an eye on and is where states could be helped doing that.

The second one is more putting a Commission hat on. For those who have looked at Medicaid programs for decades and have seen the roller coaster, back to Trish's comment about budgets, the b-word, and have seen the roller coaster of states' efforts, even as you all have talked about over the last 10 years and how things have gone back and forth, for us, until some day, until the Medicaid program would be -- if it was ever -- federalized or turned into a single program, there's going to be state variability because of flexibility.

Any recommendations to us as commissioners as to what we do in making recommendations to

Congress of how we could smooth out from the federal side, as to smooth out the roller coaster, certainly would be -- I'm sure during tough times, tough budget times, to do a 100 percent federal match would keep programs in place.

But I've seen these types of eligibility simplifications, Express Lane used. During good times and bad times, they're pulled back. And so I'm just trying to think as to what you would say as to what we could do as making recommendations to Congress where it would help keep these programs in place if the ultimate agenda is to have as many eligible individuals enrolled in the program for as long as we can.

So it's sort of a long-winded statement, and I don't know if you have comments or a simple recommendation or a top recommendation of what we could do as a Commission.

MS. KENNEDY: Again, I had previously alluded to the administrative costs of implementing simplified strategies, particularly if they involve technology and IT system changes.

And I can't speak for any state other than Louisiana, but I know that in Louisiana that administrative costs are under the microscope much more that costs for services. And so, again, I think this is an opportunity for incentives.

Now, when I spoke of 100 percent FFP for certain populations, this is not without precedent. When we look at the Balancing Incentives Program, it's not unlimited. It's for a limited number of months. But there are some other areas that they are a precedent even if just for the administrative costs that you could put an incentive.

The mention of managed care triggered something that I think is important for relative to Express Lane Eligibility.

We were concerned going in whether or not we would enroll children under Express Lane Eligibility

who had never used the benefits, and then the next -- and so the Mathematica report has shown that while it's not quite to the level of the people who proactively apply, it is in the high 80s of the percent who use the benefits. But I believe that that is going to increase.

We implemented capitated managed care just recently in Louisiana -- risk-bearing managed care. And the health plans are able to do outreach to the members, and I believe to a much greater extent than we would have been able to do in the fee-for-service Medicaid program, which I am looking -- is going to increase that utilization of services when we look at that encounter data for children under managed care compared to fee-for-service, who were enrolled through Express Lane Eligibility.

MS. LEE: And I'd just like to say, in Kentucky, we also implemented managed care. We did it in a -- you know, it took us a long time to do it, three months. We did that on November 1st of 2011.

Our individuals on our eligibility and enrollment system now can actually choose their managed care organization. If they do not choose a managed care organization, we auto-assign them. So everyone who is eligible to be enrolled is in a managed care organization. They do not see a fee-for-service.

But, as far as recommendations, I think, like Ruth was talking, the cost of health care is the cost of health care. That's what's really driving this bus.

In Medicaid, we always hear that Medicaid is the absolute lowest payer of services. And I'll tell you; I've taken some of my EOBs to work, from my private health insurance company, and that's not always the case.

So we need to have something to compare. We have our Medicaid rates, and then you have your private insurance companies, but I know of no private insurance companies that list their rates for services.

So, unless you can kind of get some costs or prices that are comparable, I don't know how we can

always say Medicaid is the lowest payer and that providers won't participate because of the rates.

We have to know what is an acceptable rate and what is fair. How can we keep this program going if we're always told Medicaid is the lowest payer, but in Kentucky we're spending -- getting ready to hit $8 billion a year in this program?

So we just need something to compare the prices.

CHAIR ROWLAND: Okay, I have Mark, Norma, Sharon.

COMMISSIONER HOYT: Again, thanks for coming. It's always really helpful to us to hear about a couple of real-life examples.

I had a question about access. Both your states did a great job growing the covered kids population, let's say. Were there any issues with all these kids seeing a dentist, seeing primary care provider? Did you track use of the emergency department, anything like that? Did you have to do some fee increases to kind of stretch or grow your networks?

MS. KENNEDY: I will say that in that same period of time, 2001 to 2005 and beyond, is that we were increasing rates for children, you know, that there were increases. But while there were, as I believe would probably be the case in many states, there are certain rural areas -- most areas in Louisiana are very rural, and so -- but the -- but it would be an area where there is an access issue for people with commercial insurance as well as Medicaid. It's just as far as time and distance. So, I can't say that we had any greater utilization percentage-wise of emergency rooms by this population that we have data on, you know, that we have, because most pediatricians in Louisiana accept new patients with Medicaid, particularly in our urban areas. So, I don't -- I can't say that we had a real problem with access. For some specialty care, but then in Louisiana, that's the case with the commercially insured, as well.

MS. LEE: It's the same for Kentucky. We hear anecdotal information about areas where we have certain access issues, for example, in dental, but we monitor our network through geo mapping to ensure that all of our members have access to a primary care provider, hospitals, dentists, things like that. We do -- we haven't seen an increase in our dental utilization or our ER utilization thus far.

COMMISSIONER MARTÍNEZ ROGERS: Thank you for your presentations. Actually, Lisa answered the question when Donna asked her question, because it was similar to hers.

CHAIR ROWLAND: Sharon.

COMMISSIONER CARTE: Prior to ACA, children could not access CHIP if they were the dependents of state employees, and I know that not many states have taken up now the public employee option. But, Ruth, in your response to my question earlier, you know, you talked about the internal marketing to state workers that's necessary and I'd just like to hear your comments. I think we all know that in many states, there is a segment of our public workers' families who could avail themselves of CHIP coverage and possibly Medicaid if it were made available. So, it's hard to ask them to be marketing things to other people that they themselves are in need of taking advantage of.

MS. KENNEDY: I think Lisa and I did not experience that, Sharon, because with our Medicaid expansion CHIP programs is that the public employees were eligible, and many enrolled.

MS. LEE: And in Kentucky, when we first implemented CHIP, we didn't think that it was fair to have our state employees excluded just because they had access to coverage when they would actually be determining eligibility for individuals who made as much and maybe a little bit more as they did. So, Kentucky has always covered children of state employees. We did so with 100 percent state general funds until CHIPRA gave us the opportunity to submit a state plan and actually include those in CHIP, and

Kentucky was one of the first states to get our state plan improved for including children of state employees in our program.

CHAIR ROWLAND: Well, I'd like to ask you to think a little bit about what your experiences to date can inform us as we go forward looking at the ACA implementation issues and at some of the challenges there, if you have any recommendations for issues that this panel should take on, any recommendations. I heard Ruth raise the administrative match issues, which we talked about at our last meeting and, I think, will continue to be part of our work. But as a parting set of suggestions, if you have any suggestions to offer us about what we should be looking at, what some of the concerns you're seeing in trying to implement the coordination with the Federal exchanges and the coordination between the exchanges and Medicaid as ACA is implemented and the role there of Express Lane Eligibility.

MS. KENNEDY: I'll go first. Louisiana is not a Medicaid expansion state, but, of course, the changes brought about by ACA and the impact on Medicaid and CHIP eligibility, in my 33-plus-year career, I mean, nothing approaches this tidal wave of changes. And so day one was October 1, right, and the second day one was January 1. The reality here today, the 20th of February, is we're still on day one. There is much, much work to be done.

We will be getting data through the Federally Facilitated Marketplace, that data exchange, people determined by the marketplace as Medicaid-eligible. And Louisiana is one of the, I believe, 11 determination states versus an assessment state. It goes with our philosophy of eligibility, simplification, not asking people, again, to send you information or more information.

And we staffed for that model so that -- but our early experiences have been that the -- now, that is an area where I do have concerns about the integrity of the eligibility decision. The early cases we're getting,

you know, is pregnant people who are not pregnant, whether they're 54 and we call them and they say, "You know, you're right, I'm not pregnant," or whether we send them a letter and they -- you know, congratulations, you're enrolled in our pregnant woman program, and calling our customer service line and saying, "What? I'm not pregnant." We are getting eligibles through that transfer, "parents" who have no children.

And so, I mean, at this point, we're looking at those cases. But if we just imported that and said, yes, I mean, that is concerning. So, I mean, what we are -- I am committed and we are committed to doing is working with CMS to identify those unintended consequences in that data and in that information they're sending us, and so I believe that's something that we have to keep an ongoing look at, the progress of that and the integrity of those FFM Medicaid eligibility decisions that states are just going to be adding to their eligibility files.

COMMISSIONER MOORE: Ruth, a clarification. You said you were one of 11 states where the Federal decision would be a determination, or that was what -- is that --

MS. KENNEDY: There were two options that states had, Judy.

COMMISSIONER MOORE: Yes.

MS. KENNEDY: We could be a determination state, which means they make the determination, we -- and I want it to be just like Express Lane Eligibility. They make the determination and we put them on. They get the letter. You know, the other model is an assessment state where you get the data, but you do some more digging on your end --

COMMISSIONER MOORE: [Overlapping conversation.] -- go for an eligibility --

MS. KENNEDY: -- before you add them. It's not just saying -- my best analogy for a

determination state is, like, if they're eligible for SNAP, they're eligible for Louisiana Medicaid. So, if they're eligible for -- the FFM said they're eligible, we don't ask any more questions, whereas my understanding of the assessment is you still have this level where you look, and --

COMMISSIONER MOORE: But, my question is, so you are that determination -- you did choose to be that determination state --

MS. KENNEDY: Yes.

COMMISSIONER MOORE: -- but as you are looking behind or you're getting -- hearing from people --

MS. KENNEDY: At this point --

COMMISSIONER MOORE: -- you're finding some problems.

MS. KENNEDY: Yes. At this point, we're still not in production. We're still in testing. We have still not -- so, that is the -- but you may have recalled the letter the Friday after Thanksgiving about the Expanded Flat File. So, we're using the Expanded Flat File and looking at that, you know, and trying to see -- to sort this out. Many, many issues that I don't think anyone contemplated. Twins, that is an issue. Someone -- there are just all kinds of nuances that were not foreseen.

CHAIR ROWLAND: Thank you.

Lisa.

MS. LEE: I think we have some really challenging times right now, but I think we have some of the best opportunities we've had in a long time. I've worked for Medicaid and CHIP for 14 years, and I think the one thing that was missing in all those years was some sort of transition to other insurance. So, some of the most difficult calls that I saw on were with families who made -- maybe they got a $25 increase in their

pay, kicked them out of the CHIP program. They had a child who was asthmatic. They would forego that raise to stay in CHIP. Now, I think we have an opportunity to transition some of these individuals from either Medicaid or CHIP into the exchange. It's a great opportunity, and I think that CHIP serves as a vital stepping stone, not only as just to transition those kids as far as payments are concerned, but also services. Some of the services in CHIP, for example, we use -- we do use some of the EPSDT benefits in our CHIP program. So, I think we have some opportunities to help families transition and I would like to see CHIP stay as a vital stepping stone for those families.

CHAIR ROWLAND: All right. Well, thank you very much. I mean, what we are really looking at is how to make these programs work better, and especially to work better not only for the beneficiaries, but also for those who have to administer them. You've given us a lot of great information and your experiences will really help inform our continued discussion. As anyone who's come to several of our meetings would know, that we have many champions of simplicity and improved value and efficiency in the program, and those are our goals and you've given us a lot of guidance on how to pursue that in the future, so thank you very much.

Now, we'll take a brief break and then return for our next panel.

[Recess.]

CHAIR ROWLAND: If we could please reconvene so that we can continue our discussion.

We're very pleased to welcome this panel to look at ED, emergency department use and the issues around Medicaid use of emergency departments. We started a discussion of this at our last meeting. The Commission members said they'd like to hear more about this following some of the reporting on the Oregon Health Experiment.

So I'm going to ask Anna Sommers to introduce the panel, and then I'm going to be very pleased to have our panel present to us.

Session 4: Use of the Emergency Department by MEDICAID Enrollees

* DR. SOMMERS: Sure. Thank you, Diane.

The use of emergency departments by Medicaid enrollees has been a longstanding concern, both from the perspective of costs and quality of care. Medicaid enrollees are estimated to have a visit rate that is almost twice as high as the privately insured. The high rate of ED use is attributable to some combination of effects from primary care, high illness burden and disability, and enrollee preference in the Medicaid population. But the role that each factor plays is not easily quantified.

We know from research that patients with greater after-hours access to primary care practices report lower ED use and less unmet medical need, regardless of insurance coverage, and that Medicaid enrollees who report a greater number of barriers to accessing primary care are more likely to report ED use. But we also know that non-urgent visits account for only a small share of all ED visits.

Recent press coverage about the latest study from the Oregon Health Insurance Experiment has raised questions about whether those newly eligible for Medicaid due to the Patient Protection and Affordable Care Act will result in significant increases in ED use among Medicaid enrollees, presumably for two main reasons: the inability of primary care to accommodate new patients and the high pent-up demand for services among the newly insured.

So we've organized this panel in response to your request for further briefing on the topic. First you'll hear from Dr. Arthur Kellermann, dean of the F. Edward Hebert School of Medicine at the Uniformed Services University of the Health Sciences in Maryland. Dr. Kellermann's presentation will draw

from work he conducted with his former colleagues from RAND on the evolving role of emergency departments in the U.S. And the purpose of this presentation is to take a system perspective and explore changes in the delivery of health care that may be contributing to increased use of emergency departments across populations.

Then next you'll hear from Dr. Stacey McMorrow, who is a senior research associate in the Health Policy Center of the Urban Institute. Dr. McMorrow will review for you the evidence related to ED use from recent health insurance expansions and discuss how the experience of Medicaid's new adult population might differ. The purpose of this presentation is simply to support discussion of all of the factors contributing to changes in ED use after insurance expansions.

Finally, you'll hear from Dr. Maria Raven, assistant professor of emergency medicine at the University of California at San Francisco School of Medicine. Dr. Raven will highlight findings from a nationwide scan and literature review of programs aimed to reduce ED use among Medicaid enrollees and the uninsured served by safety net providers. This project was conducted by Dr. Raven and her colleagues at the California Medicaid Research Institute on behalf of MACPAC.

So the order will be Dr. Kellermann, Stacey McMorrow, and Maria Raven, so I'll turn it over to Arthur.

* DR. KELLERMANN: Thank you. I'd like to begin with a disclaimer. Six months ago, I became dean of America's medical school at the Uniformed Services University of the Health Sciences, so I am now an employee of the Department of Defense, and I just want to make it very clear, as everyone who has served in the federal government, I am not here to speak on behalf of the feds or the DOD or even my university. I'm here as an emergency physician who practiced on the front lines in public hospitals for 25

years and has done research on this topic for almost all of that period of time. So I'm here representing myself and my work, and particularly this report from the RAND Corporation. I brought a few extra copies. I have very few left. I could not think of a more worthy group than you, so those copies are available should you want them.

The first question is: Is non-urgent emergency Department use the problem? Certainly you would think so if you pick up a newspaper or talk to an elected official. But, in fact, if you look at the numbers -- and we should be driven by numbers -- emergency department use consumes maybe 2 to, at most, 6 percent of spending. And that 6 percent number comes if you factor in all the work done for the most complicated patients who are being admitted to the hospital, the most expensive group.

If you use a study done by RAND that came up with the expansive definition that if urgent care centers and retail clinics were ubiquitously available 24 hours a day and everybody got to them who might go to them, you could maybe peel off a quarter of those visits. They would be the least sick quarter, so not as costly as the average. So do the math. You are down to one-half, maybe 1 percent of health care spending at the very best optimization we could hope for. That's not to say that's unimportant in a $2.8 trillion health care system, but it is almost certainly less than 1 percent.

The real issue in America is access to acute care, and as Stephen Pitts and colleagues showed in Health Affairs a few years ago, Americans today go past their doctor's office more than half the time when they have an acute-care problem. That's insured as well as uninsured, and Medicaid is no exception. And, in fact, billings data show that the main reason that patients end up in emergency departments with what he termed "primary care treatable or preventable problems" was lack of access to primary care. This is not a push problem, as in push them out the door of the ER. It is a pull problem. We need to find ways to pull

and keep them in primary care as much as possible.

But the major focus of my remarks is let's look where the real money is: hospitalization. This is a typical chart -- you can find these pretty much anywhere -- of aggregate health care spending in the U.S. Nearly a third is inpatient care, the biggest single source of spending; doctors and nurses, number two; pharmaceuticals, typically number three. But over 30 percent of health care spending is hospitalization.

Guess what? Half of all hospital admissions in America today get in the door through the emergency department. That is, you know, two-thirds of all non-elective patients, meaning relatively urgent, but over 50 percent, and for certain groups it's even higher. So they are a major portal of entry for hospital admissions.

And, remarkably, in this RAND study we looked simply from 2003 to 2009, and over that period of time, while hospital admission growth was somewhat less than total population growth, all of the growth in inpatient admissions in America could be attributed to growth of admissions through emergency departments. Compared to 2003, American hospitals admitted 1.6 million fewer inpatients from doctors' offices in 2009. But that was offset by 2.7 million more inpatient admissions through emergency departments. And this growth in admissions is across the board in all payer groups, including the uninsured. Everybody is more likely today to be admitted through the emergency department than a decade ago. This is a national trend, every region, every payer group.

The second issue is the use of emergency departments is changing as primary care evolves and we see docs moving more into "I'm an outpatient doc" or "I'm a hospitalist." Primary care physicians today are locked into the tyranny of the 15-minute visit. They have got to churn and burn. They've got to see 25, 30 patients a day to meet their quotas, et cetera. So if they get a phone call from somebody saying, "I'm having

burning abdominal pain," or "I'm a little short of breath," or "I've got this odd squeezing sensation when Metro broke down for the 937th time and I had to walk up the escalator," they're much more likely to say, instead of "No problem, I'll work you in at 2:00," they're much more likely to say, "You know, why don't you go to the ER. They'll fix this, sort this out, and give me a call later." And, in fact, in our study we not only showed this quantitatively. We did focus groups with primary care docs and emergency physicians, and this sense of either deflection or a partnered utilization, you've got the diagnostic technology, you have access to consultants, you're engineered for no notice walk-ins. Emergency departments are really working more hand in glove with primary care as their quick turnaround diagnostic center, as well as, "Gosh, George, you look like you know what, but I'm busy. Instead of writing up your admission orders, I'm going to send you to the ER. They'll get your workup started and get the requisite studies done and get your admission orders done. I'll see you tomorrow morning."

And why do I say that? Look back again at the numbers: fewer admissions coming from doctors' offices, many more from emergency departments.

Which leads to my third and final thought, which is: Is this simply a vacuum cleaner for inpatient admissions, or might we be seeing something else? It depends. But, very importantly, let's look at a very important group of patients, which are those who have potentially preventable admissions, what AHRQ has called for many years "prevention quality indicators" or "ambulatory care-sensitive conditions" -- diabetes, heart failure, high blood pressure, UTI, or bacterial pneumonia, where if you got prompt outpatient care or asthma, you could probably be managed and not end up in the ER, much less in the hospital.

That has been one of the success stories in American medicine recently. While we've seen this overall growth in hospital admissions, between 2000 and 2009 PQI admissions were flat. That's remarkable.

And when AHRQ looked at these numbers, they celebrated: Primary care is working, we're doing a better job of managing these folks and keeping them out of the hospital.

Well, maybe that's true, but maybe there's a bit more to the story. In fact, if you look at the numbers, non-elective admissions from doctors' offices fell 30 percent for PQI admissions. But was that because they were keeping these folks healthier or because they were sending their not-so-healthy PQI patients to the emergency department who was then either admitting or working on them aggressively, tuning them up, to use the vernacular, and sending them home?

And, in fact, when you look at emergency departments, their growth of PQI admissions was 13 percent, but that was about half the overall growth of non-elective admissions. That suggests but does not prove that emergency departments might have been playing a moderating effect in the percentage or number of patients getting in the door with ambulatory care-sensitive or preventable admissions.

So to get a little better handle on this, we did an admittedly rough comparison. We took six PQI conditions and matched them up against CCS diagnoses, because as you might be stunningly unsurprised to know that we code outpatient visits differently with different diagnostic codes than inpatient admissions. So we tried to line these up the best we could to see whether or not what was happening in the emergency department was driven by more people coming in the door with the diagnosis or we were changing our threshold for admission.

In four out of these six categories, hospital admissions grew somewhat faster than total visits, which is not necessarily surprising if you think of this phenomenon that docs are sending their sicker people to the ER rather than admitting them directly.

In one notable exception, diseases of the heart, emergency department visits grew by 5 percent but

admissions fell by 6 percent. And I think that's pretty clearly attributable to the rapid growth of chest pain centers and clinical decision units in emergency departments. The old idea of admitting somebody to rule out a heart attack, we almost never do that in emergency departments anymore. We do a CDU admission in the ED. They never see an inpatient bed.

We also saw a distinction in hypertensive visits. Much of a great increase in hypertensive visits to emergency departments, a much slower growth of hospital admissions.

Here are the implications of this study. First, efforts to reduce non-emergent use should focus on strengthening access to primary care and particularly access to acute care for relatively minor or modest problems rather than asking emergency departments to turn these people away. You're more likely to see them coming back a day or two later a lot sicker and possibly needing admission at that point.

Second, policymakers, including MACPAC, should pay closer attention to the role emergency departments play in facilitating or reducing inpatient admissions.

And, finally, this idea, this growing use of emergency departments as diagnostic centers, another role, warrants a closer look. It may be a very inefficient use of resources, but it might be a very efficient way to get to the bottom of complicated problems quickly and avoid preventable admissions.

So the bottom line is the ERs today are a growing portal for inpatient admissions, the gatekeeper for up to half of all inpatient care. They are helping primary care docs by performing complex workups and handling after-hours demand; may -- repeat, may -- be playing a useful role in preventing hospitalizations; and non-urgent use is being driven by lack of alternatives and referral of patients to hospital emergency departments from their primary care docs.

Thanks very much.

CHAIR ROWLAND: Thank you.

* DR. McMORROW: Thank you. So before I get started, I wanted to acknowledge that this presentation was developed in collaboration with Sharon Long, my colleague at the Urban Institute. Sharon's located in Minnesota, so for today you're stuck with me.

By way of a little bit of background, and similar to what Dr. Kellermann said, proponents of health reform sometimes claim that expanding insurance coverage will improve access to care in the community and thereby reduce unnecessary ED use. And this is based on this widespread perception that a non-trivial share of ED use is unnecessary or avoidable, and while that share is hard to quantify, the belief and its associated arguments led to quite a stir when findings from the highly regarded Oregon Health Insurance Experiment came out finding that ED use actually increased following the expansion of Medicaid coverage to an uninsured population. So this has naturally led to many questions about what this means for the Medicaid expansions under the ACA.

So today I'm going to talk a little bit about what this and other research evidence can tell us about what to expect for states expanding Medicaid under the ACA and, maybe more importantly, what it can't tell us.

So there has been a great deal of research on the effects of Medicaid on utilization, including ED use, but some of the strongest study designs and most relevant evidence come from the most recent expansions in Oregon and Massachusetts. And the short story here on this evidence is that the effect of expanding coverage on emergency department use is mixed, and it's mixed both across states and it's mixed within states.

So it's important to note that prior to the Oregon study that brought such attention to this issue of

ED use, the first study released by the Oregon study team found no effects of the expansion on any ED use or on the number of ED visits. And then subsequently the more recent study is the one that found that Medicaid coverage increased ED use across a wide range of conditions.

And there has been similar mixed results as a result of the Massachusetts health reforms from 2006. My colleague Sharon Long has been tracking the effects of Massachusetts health reform over time, and the earlier results found no effect of health reform on ED use. But four years later, by 2010, the Massachusetts reforms were shown to result in declines in ED use. And there have been subsequent studies from other authors using different data and other study designs that have shown evidence that the Massachusetts reforms reduced admissions out of the ED, reduced reliance on the ED as a usual source of care, and reduce non-urgent ED use. So on the whole, their results are fairly mixed on what expanding insurance coverage affects on ED use.

So in order to consider what these results mean for the ACA, it's important to understand what drives these different results. There's two broad categories of drivers of the mixed results, and the first is differences in the study designs themselves. So, for example, different data sources can play a very important role in the results that come out of these studies. The Oregon study that found the increase in ED use as a result of the insurance expansion was based on hospital discharge data in Portland area hospitals. The study that found no effects on ED use was based on self-reported survey data that was across the entire population.

And there's a number of other data issues that can play a significant role in affecting the results, which include the mode of survey administration. Oregon's study also found different results that varied somewhat across in-person versus mail surveys and that varied whether or not the survey look back period

was ED visits in the past six months or ED visits in the past year. Again, geographic representativeness can play a role, though one study focused only on Portland area hospitals, the other study was across the entire state. And just the measure of outcome, whether you're looking at the number of visits or the number of people who had a visit, can play a role in the findings.

Another critical issue is the length of the post-intervention period, and we can see this very clearly in the Massachusetts results. In Massachusetts, early results from 2007, 2008, and 2009 found no effects of the expansion on ED use. By 2010, you started to see that the expansion was leading to a decline.

And, finally, there's a number of differences in some of the more technical, methodological issues that can drive the different results. These include the identification strategies, comparison groups that are chosen, and whether or not the results report on the effects of the eligibility expansion or the health reform as a whole versus the effects of gaining coverage specifically on ED use. And all of these factors can play a role in the findings.

Now, the other set of factors that can affect the findings are differences in the policy setting itself, and these are incredibly important. The population targeted by the expansion will clearly affect the patterns of care that are observed both before and after an insurance expansion, and it's really important to remember, particularly when comparing Massachusetts and Oregon, that the Massachusetts reforms were comprehensive reforms aimed at getting universal coverage and affected nearly all adults with low and moderate incomes up to 300 percent of the poverty level, as opposed to the study in Oregon and the expansion in Oregon, which was targeted specifically at previously uninsured individuals who were living below the poverty level, who specifically applied to the lottery to obtain coverage. So these are very different populations who likely had very different care patterns before and then, therefore, had very

different care patterns afterwards.

Another critical driver of the effects of the expansion is the health system context that the intervention enters into, and that includes safety net availability prior to the expansion; it includes primary care capacity prior to the expansion; and it includes the community care patterns that people are using prior to the expansions.

One really important key contextual issue in the Massachusetts study is that there was an uncompensated care pool in Massachusetts that paid for hospital expenses for low-income, uninsured individuals prior to reform. So newly covered individuals in Massachusetts did not see a drop in the cost of ED care when they gained coverage. They were already receiving ED care for free under this uncompensated care pool, so they did not see a change in their cost of going to the ED when they gained coverage. They did see a change in the cost of obtaining primary care. Whereas, in Oregon people would have seen declines in both the cost of ED care and primary care, and so that can be a very important driver of the different results in these two expansions.

So in order to think about what this means for the ACA, we really need to consider what drives ED use when the costs of the ED and primary care are similar for patients. And, fortunately, we can draw on a great deal of research evidence for the existing Medicaid population, which finds that ED use -- and Anna already mentioned most of these factors. ED use is high for individuals that have significant health problems. It's high for individuals that have limited access to primary care providers and after-hours care. And it's high for those who have preferences for ED care, and those preferences kind of focus around being a more convenient and high-quality place that people can obtain care. And there's been reports of that in the literature that this is how some people feel about obtaining care in the emergency department.

So as a result, we would expect higher ED use under reform in states that have sicker expansion populations, in states that have limited access to care in the community, and those that have few care options for the uninsured prior to reform, and where preferences may be high.

So while I can't say exactly who will enroll and where they live, we do have some evidence on the composition of the potential expansion population. We know, for instance, that they tend to be young. More than half are under 35 and more than half are male. More than half are also white, but racial and ethnic compositions vary substantially across states. And as most of us know, four out of five are childless adults. But maybe most importantly for the issue of ED use is the fact -- what we know about health status. And they appear to be relatively healthy compared to current Medicaid enrollees. Evidence on this population, which is basically just looking at the uninsured population below 138 percent of the poverty level, these individuals are less likely to report fair or poor physical or mental health than existing Medicaid enrollees, and they're less likely to be obese and report chronic conditions than existing Medicaid enrollees. So that may bode well for a lower reliance on the ED for a source of primary care.

Unfortunately, the other factors that are likely to drive ED use, including primary care capacity and safety net capacity and the individual preferences, are much harder to measure and much more likely to vary both across and within states. So the bottom line, unsatisfying as it may be, is that prior expansions of coverage have had mixed effects on ED use due in part to their target populations and the health system context into which they occurred. And the same is likely to be true under the ACA.

Thank you.

CHAIR ROWLAND: Stacey, in any of the studies you looked at, did you see as another factor the ability to get specialty care through the ED as opposed to being able to access that through perhaps a clinic

in the community?

DR. McMORROW: Yeah, I think that plays in in the preference argument, the fact that you can go in and get a full workup, you can get all of the tests that you need. You can potentially see a specialist, and you can have kind of a one-stop shop for the care that you need. And so that really does come in in the preferences.

CHAIR ROWLAND: But it may also reflect the lower participation rate among some specialties in the Medicaid program.

DR. McMORROW: True.

CHAIR ROWLAND: Okay. Maria?

* DR. RAVEN: Thanks for having me here today, and I'm here to talk about some work done on behalf of MACPAC by CAMRI, the California Medicaid Research Institute, about Emergency Department Visit Reduction Programs.

So, the question that we aimed to answer was what is the scope of Emergency Department Visit Reduction Programs and what is known about their effectiveness, and to answer this question, we first conducted a national environmental scan. We then conducted a literature review for the purpose of rating the quality of the studies and programs that we identified. And then we finally conducted an effectiveness evaluation, which I'll talk about in a little bit more detail.

So, first, the environmental scan. One thing we found is there's quite a bit of activity in this area nationwide and some of it has actually been funded by CMS in the form of Emergency Department Diversion Programs, ERD grants that were implemented in 20 different states. And the purpose of our scan was to create a typology of Emergency Department Visit Reduction Programs that Medicaid programs

could use as a guide to improve their understanding of the current nationwide activity in this area.

We found two main categories of Visit Reduction Programs, and some of these have been alluded to. The first were programs designed to target high-risk populations, and these people are high utilizers of the health care system, often not just the emergency department, but other areas of the system, as well, who are medically and also socially complicated. They are a small population, representing a relatively small percentage overall, but they make a disproportionate share of emergency department visits and also account for quite a disproportionate share of costs to Medicaid and other payers.

Then we found programs that were aimed at reducing so-called low-acuity emergency department visits, and these have also been alluded to. These programs target visits for conditions that, in theory, could be safely managed in non-emergency department settings.

Here are some results of our scan, and what this does is shows you the different program categories that we identified, and it lets you show sort of where the most activity nationwide was. So, for low-acuity visits -- and, actually, this should be the high-risk populations, so that is a typo. So pretend that says high-risk populations. The main activity was under intensive case management; health and social services navigation and care coordination; acute disease management and education; and permanent supportive housing for chronically homeless individuals.

And, next, for low-acuity visits, most of the activity was concentrated in programs that aim to link patients to primary care and coordinate that care, to alternative site expansion. An example of this would be expanded primary care hours or urgent care centers, emergency department diversion. And this would be when patients are triaged based on some predefined criteria, either before they get to the emergency department to an alternative site or after the time of triage to an alternative site, and, of course, without

violating EMTALA.

So, in the literature review, 91 of the 197 programs we identified qualified for the literature review, and the reason all the programs did not qualify is because many of the accompanying evaluations simply didn't have enough information for us to rate their quality. An example of this might be a program that would report a certain percentage of emergency department visit reductions but had no information about how those numbers were arrived at.

Of the programs we reviewed, 32 were rated as high to moderate quality, and 19 of these were targeted at high-risk populations while 13 were targeted at low-acuity emergency department visits, and the majority were rated as low to very low quality.

And of note to MACPAC is the fact that only 13 of the programs that qualified for our literature review had any financial data reported whatsoever.

In our literature review -- in our effectiveness evaluation, we -- the header for this should be "The Effectiveness Evaluation." I apologize. This is the first time I'm seeing this set of slides. We identified 32 high- and moderate-quality studies, and these studies were evaluated based on the following criteria. We looked at the impact on not just emergency department use, but also on other health services use, because when a program is attempting to reduce emergency department use, it's very likely that that program is going to have an impact on services used in other areas of the health care delivery system. Cost effectiveness -- and I use this term loosely -- as I mentioned earlier, only 13 programs reported any financial data whatsoever and none reported enough data for us to perform an actual cost effectiveness evaluation.

CHAIR ROWLAND: Maria, can I ask for a quick clarification.

DR. RAVEN: Sure.

CHAIR ROWLAND: You're talking about the quality of the studies as opposed to the quality of the programs, is that correct?

DR. RAVEN: Well, yeah. I mean, there -- to some extent --

CHAIR ROWLAND: When you say, 32 high- and moderate-quality studies --

DR. RAVEN: These were evaluations of programs, and so when we went through and rated the programs, 32 of the programs, based on the evaluations, were rated as high- to moderate-quality, and this was based in part on the quality of the study design.

CHAIR ROWLAND: Okay.

DR. RAVEN: Yeah. So, and then, finally, we looked at quality, which focused on unintended consequences. So, for example, maybe a program reduced emergency department visits but increased hospitalizations or morbidity and mortality. We also looked at whether programs reported on patient and provider outcomes and health outcomes.

So, in terms of the effectiveness evaluation, for high-risk populations, many programs did report reductions in emergency department use. But, based on the criteria that we used to evaluate their effectiveness, we didn't find a lot of evidence to support effectiveness based on program cost, quality, and overall health services use.

Permanent supportive housing and intensive case management seem like two program areas that are the most promising. And, just as an example -- again, this is a small number of programs that reported any financial data -- but some of the annual per person savings from ED visit reductions that were reported ranged from $4 per person, per year to $704 per person, per year. Generally, most of the reductions were in the $100 to $200 per person, per year range, and it should be noted that these numbers associated with ED

visit reductions will not be sufficient to cover program costs. One of our key findings was that savings from these types of programs will come not from emergency department visits, but from savings related to reduced hospitalizations and other more costly areas, like long-term nursing care.

In terms of the effectiveness of the low-acuity Emergency Department Visit Programs and their evaluations, we, again, did not find much evidence to support the effectiveness of primary care or alternative site expansion or patient education. One example of this is in the area of studies designed to reduce emergency department visits made by pediatric patients for asthma. It's a pretty decent body of literature. The studies are pretty well designed. And almost to a one, none of these studies were able to show that they could reduce emergency department visits in that population.

Copays, we know, are an area of interest to Medicaid programs. Most of the research within the Medicaid population has been, again, within the Oregon Health Plan. And in those studies, copays were $50 or more, and those copays were shown to reduce both necessary and unnecessary emergency department use within Medicaid. Right now, it remains unclear whether or not there is a, quote-unquote, "safe" copayment level for Medicaid beneficiaries, and so those were our findings.

And then there was a lack of data regarding retail clinics and health technology and information sharing, although we recognize those are very sort of hot topics in the media right now.

So, getting to the limitations of the literature we reviewed, and this is sort of to your point, most of the programs did not have comparison groups. So, they would measure emergency department use before and after program implementation, and this is a problem, especially when you're looking at visits for high-utilizer populations because of the phenomenon of regression to the mean. And so you don't know if the reductions you are seeing are due to your program or they would have occurred naturally with no

intervention.

There was a general lack of data regarding impact on other health services use, so many programs just simply did not look at primary care or hospitalizations as a part of their outcomes. There are, as I mentioned, no or incomplete capture of program costs and savings.

And another phenomenon we saw quite frequently was that programs rarely assessed the impact of emergency department use outside of their individual study or program emergency department. And in densely populated areas with multiple emergency departments, it's very important to capture ED use across the entire community, rather than at just one emergency department, or you're going to lose a lot of visits that might otherwise be occurring.

Finally, few studies focused entirely on the Medicaid population. Many studies had a certain percentage of Medicaid beneficiaries as enrollees, but one of the things that this prevented was a lot of sort of reliable data on costs because there were so many payers involved in the mix in terms of the enrollees from the programs.

So, challenges in implementing Emergency Department Visit Reduction Programs in Medicaid are as follows. First, there really isn't any off-the-shelf formula for success that we can recommend at this time. Successful high-risk programs can be very costly, and so these start-up and ongoing costs have to be accounted for.

Primary care, as has been mentioned, is key for these low-acuity programs, but there is limited capacity, and I think it's also worth noting that whether or not expanded primary care -- and by this, I would mean primary care either after hours or on weekends or with more auxiliary services -- can be provided at low or equivalent cost as an emergency department visit, I think is an open question.

I think it's also important to note that there isn't a current method that is identified to safely identify non-urgent emergency department visits at the time of triage, so that group of visits is a very challenging thing to identify prospectively.

In addition, some of the programs reported issues of staff burnout and also difficulty recruiting participating providers.

And I just wanted to acknowledge our research team. Thank you.

CHAIR ROWLAND: Oh, thank you all very much.

David gets to start.

VICE CHAIR SUNDWALL: I don't know where to begin. This has been fascinating. Hi, Art.

I don't think I've ever had a panel where I feel like you've totally -- what's the word -- iconoclastic. I just had all these assumptions that I think everyone else has had that this is such a big problem, so costly, inappropriate use, and so this has been very, very interesting, but it raises lots of questions.

Art, I need you to repeat for me what you said at the beginning, that, in fact, this is one or two percent of overall health care costs. Is that emergency rooms in general?

DR. KELLERMANN: Depending on who you talk to, the advocates for emergency departments, American College of Emergency Physicians, pushes the number two percent. There is one paper in the literature that estimates six percent, but they reached in and counted the emergency department costs for the very complex resuscitation patients, et cetera, who end up getting admitted. So, it's somewhere, probably, between two and six percent.

But, if you then say, okay, of that amount of health spending, what could we theoretically peel out of the emergency department and be seen elsewhere, probably the most optimistic estimate there would be 20,

25 percent, and more likely it's around 12 percent --

VICE CHAIR SUNDWALL: Twenty-five percent of --

DR. KELLERMANN: -- of the two to six percent.

VICE CHAIR SUNDWALL: Okay. That's the --

DR. KELLERMANN: So, when you do that math, you end up with a really pretty small amount of the total population. Now, a half-percent of American health care spending is a whole lot of money, and we should never fall trap to, you know, it's only one percent. That's several billion.

VICE CHAIR SUNDWALL: Yeah.

DR. KELLERMANN: But, the real money is in inpatient admissions, and that's where I -- if I leave you all with one thought, it's go where the money is and how do emergency -- you know, emergency departments, we know from "60 Minutes" on one hand to very empirical health services research, they can either be vacuum cleaners for admissions or they can set up an iron door for admissions, depending on the hospital's management, the strategy of the administration, and whether or not the patient has a source of payment, and that's 50 percent of all inpatient admissions today.

VICE CHAIR SUNDWALL: Well, there are just two little other points I wanted to make. I mean, we -- I used to be responsible for the Medicaid program when I was the head of the Health Department. I didn't run the Medicaid program, but it was a great topic for discussion, and the legislature, everybody wrings their hands over this, and we had a program that, I think, was effective, and I wish I could give you the details. I don't know where you would rank it in your quality measure, but there was a simple program funded to call those who had had more than two ER visits within a set amount of time, and by darn, it worked, the patient education. They've documented the decreased frequency of these return visits, and we

have what are called frequent flyers, these people that show up, and it's generally the ones with a lot of social problems or the alcoholics or drug abusers that keep coming back for more.

But how can it not be more expensive when to walk through the door is, what, $1,200, $800 or $1,200? It's just an outrageous amount of money to get care there for things that are not urgent or emergent.

DR. KELLERMANN: There, I think the key is to differentiate charges from actual reimbursement.

VICE CHAIR SUNDWALL: Okay.

DR. KELLERMANN: We'll charge an arm and a leg, but may not get nearly that much. But, I think your point is very well taken. If there's a strategy that's going to work, it's to pull people into primary care, not ask the ER to push them into the night and just go figure something else out.

VICE CHAIR SUNDWALL: Right.

DR. KELLERMANN: And, I think, in general, those strategies that give people an option, an alternative, they'll take it. What we've seen for 20 years is any time you empirically look at this, about why these, quote-unquote, "non-urgents" are there, they've tried. They were turned away. Their doc told them to come. They didn't have -- nobody was open. People wanted a copay. And this is a 20-year -- we keep getting one answer, but policy makers keep driving a different construct. It's the old Washington slogan, "Don't confuse me with the facts."

VICE CHAIR SUNDWALL: Okay. That's fascinating. Thank you.

CHAIR ROWLAND: Andy.

COMMISSIONER COHEN: What a great topic and great panel. You provided so much information, and actually, my questions are sort of going to go into sort of tangential things, so I'm going to

ask to muddy the waters even more. But, thank you so much for your presentation.

So, I have two questions, if I'm allowed to. The first one is, and I'm not sure who is the right -- who among you might be able to shed some light on this, but I think there is a lot of discussion about how emergency room use is very expensive, and I'm always left a little bit confused on the question of, like, exactly to whom, and then sort of, furthermore, what does it take to reduce the cost?

So, of course, I understand that insurers and Medicaid programs and others pay more for an emergency room visit, sort of under almost any methodology, than they pay for a primary care visit. So, of course, it costs the payer more, but presumably that's because the cost to the hospital that has the emergency room is also more, and that's because it's more intensively staffed and more equipment and all those sorts of things.

And, I guess, one of my questions is what does it take to reduce that cost? In other words, with hospitals, we understand that, like, if you reduce the number of beds or something like that, then the hospital's costs go down, but empty beds don't reduce costs for a hospital. What is the -- or not very much. What's the sort of, like, analogy for an emergency room? In other words, if an emergency room gets 100 patients a day and it starts getting 80 patients a day, is there a savings? Is there a savings to the provider, and, obviously, to some extent, there's a savings to the payer if the 20 people are going to primary care and being well-served in primary care. But, I first wanted to have that basic question. Can anybody address that?

DR. RAVEN: Okay. I think I understand your question.

[Laughter.]

DR. RAVEN: Well, I mean, I think -- no, I think it's an important question. So, first off, Medicaid

reimbursements for an emergency department visit, I mean, I've done work on this in a couple different states and what I've seen, they range anywhere from kind of like the mid-$100s to around $300 per visit for a patient that's treated and released from the emergency department. So, you can contrast that any way you'd like to a primary care visit, either to a regular clinic or to a Federally Qualified Health Center, which has slightly higher reimbursements.

In terms of overhead costs, it's going to vary a lot from hospital to hospital, and I think a lot of hospitals aren't very transparent about what their actual costs are, and I think many hospitals don't know what their operating costs are, to be completely honest. I can tell you that there's been some work done on the marginal cost of an emergency department visit, and since we are staffed 24/7, the marginal cost of an extra person coming in for a sore throat or a urinary tract infection in the middle of the night probably isn't that high, to who? Probably to the hospital, since everybody's already there. To the payer, it's going to be the same as any other visit.

I think the question is, can we provide alternative sources of care to these patients that have all the services that they may require at an equal or lower cost, and because we don't have a great way at the time of triage to say, this person is sick, this person isn't, I just think it's hard to say. I think it remains an open question.

And I don't know that, for example, primary care providers who went to medical school knowing that they would come out working nine-to-five are going to be willing for the same cost to serve after hours and on weekends, whereas in emergency departments, we're sort of already there.

So, in a way, as Art was sort of alluding to, for some things, it may -- and again, may -- be a relatively efficient place to provide care, but I think that there would also be people that would dispute that, and I just

think it's an interesting topic.

So, I don't know if that answered --

DR. KELLERMANN: I'll give you two quick points. From the RAND study, if you average emergency department costs across the board, really sick people, not so sick, it's $900. The average inpatient admission is ten times as much. So that's one fact.

The second issue is that, as we've said, the real issue is kind of what are the marginal costs involved. If we want to reduce the costs of emergency department care, a great place to start is let's stop doing a whole lot of unnecessary testing and treatment, and that's a national doctor problem across the board. You know, in my career, we went from occasionally CT-ing a patient with abdominal pain to CT-ing almost every patient with abdominal pain, and we have no data to show that we're actually improving any outcomes with all those scans. But we're certainly irradiating a lot of Americans. That would be an example where we are doing the same thing, but far more intensively. We're doing more radiographs, more blood work, more ultrasounds, et cetera, without demonstrably better outcomes. That's a challenge for the American health care system and we've all got to man up, lady up, and get that done better. I threw that lady up part in --

[Laughter.]

COMMISSIONER ROSENBAUM: So, most Medicaid beneficiaries are going to be in some form of managed care arrangement, and I'm wondering, from either the Medicaid agency purchasing side of things or the managed care organization side of things, whether your studies tell you if there are certain management or performance metrics that might be advisable to recommend that the Secretary essentially encourage, based on what you all know.

DR. KELLERMANN: I was just going to say, Sara, that we looked at this in the RAND study as

best we could, which was not very well. The limited data we've got on managed care Medicare to date does not indicate a signal strong enough for us to say it's really making a difference. It may. We just don't have adequate numbers of data and data points yet to make that assessment.

A lot of doctors feel intuitively it's making a difference. If you've got a case manager who says, "We'll see them tomorrow, it's okay, I know they're fragile, their daughter will look after them tonight, we'll get them in," that it should make a difference, but we couldn't see, when we broke in the handful of states where we could look at it and compared fee-for-service Medicare to managed care Medicare, we saw no difference in utilization rates, but that's a very preliminary look.

DR. RAVEN: I think, from my experience with managed Medicaid, there aren't a lot of Medicaid managed care or Medicaid health plans currently that are doing the same amount of case management that occurred in Medicare managed care. But, I think, more and more, Medicaid managed care is looking into this area and realizing that with all of the mandatory SPD, seniors and persons with disability enrollment, and the like coming into Medicaid coverage and Medicaid managed care coverage that that sort of care coordination is more necessary. And so my impression is that many of the managed care programs are looking into providing these services.

CHAIR ROWLAND: Okay. Burt.

COMMISSIONER EDELSTEIN: Thanks very much. With regard to the Medicaid beneficiary population, the underlying assumption in all of our discussion so far has been that there's coverage for the services that are being treated in the emergency department, which is not true for adult dental services. So, reflecting on both your clinical and your policy experience, could you comment on the issue of presentations of acute oral problems in the ED?

DR. RAVEN: Umm, I think that's a great question and such an important area. We see so many non-acute dental issues because people simply don't have coverage. And, actually, in the studies that we reviewed, a couple of the very, very innovative studies were financed by -- or funded by the American Dental Association, and they were some of -- they were interestingly effective in accomplishing what they set out to do by providing either pro bono dental services or immediate referral to an oral and maxillofacial surgeon, or OMFS, from the emergency department, and I think those were great interventions. I think they may be hard to replicate, depending on the community, but the idea that we need more dental providers and coverage for these individuals that don't have it is huge.

DR. KELLERMANN: I have to -- I saw thousands, over the course of my career, patients -- dental abscesses, just, you know, really awful cases, usually with days or weeks of not being able to get care and then ending up at the ER, typically at two o'clock in the morning. If we didn't have an oral surgery service, I don't know what I would have done.

But for those who are kind of the policy wonks around the table, I would simply remind you of Deamonte Driver, the young boy in Maryland who literally died of a toothache that ultimately became a brain abscess and was covered, theoretically, by Medicaid in Maryland, but did not have adequate access to dental care.

COMMISSIONER RILEY: I always have to be the Debbie Downer. It does strike me, though, that while the dental issues are profound -- and I'm sitting next to Burt -- we also have to be careful to make sure that we can figure out how much of it is drug-seeking behavior and how much of it is real dental need, and I think, for all the data, we have to look at that.

But my question for you, I was struck with --

COMMISSIONER EDELSTEIN: Do you want to let me comment on that?

COMMISSIONER RILEY: It's just a -- they can --

COMMISSIONER EDELSTEIN: There's no question that a toothache is a good excuse for seeking drugs, but I think that we poked a hole in one balloon today, thinking that ER costs are way out of bounds and that they're accounting for disproportionate costs. I think we can poke a hole in that one, too, that the vast majority of clinical presentations are people who have been suffering significantly for some time. And I think it just gets to the fundamental issue that we have a failure of coverage. If we had coverage, then there wouldn't be these spotty, ADA-sponsored, few and far between local programs of people doing good, but there would be recognition that oral health care is essential and that there would be coverage for essential oral health services.

COMMISSIONER RILEY: I agree with that. All I know is we did a study in Maine of ED use and it showed oral health as a major issue, and we had our heads handed to us by ED doctors who said, "Don't forget, that's not all it was." So, I'm simply speaking from experience.

But, my question, even though I agree that oral health is a huge need, is the fewer admissions from doctors' offices and more -- I'm thinking about the incentives and the changing face of hospitals and that more is moving outpatient, less inpatient, and sort of the incentive issues. It's been over the same decade that hospitals have owned and taken over physician practices. So, how much do you think is actually a change in doctor behavior and how much -- do the studies take that into account, how much may have been the change in where physicians are housed? And how many of them are owned by hospitals or managed by --

DR. KELLERMANN: I just don't know that we know. I suspect it's not the major driver. I do

think that we're seeing physicians diverge into hospital docs and outpatient docs. But the idea of -- you know, it's just so much easier -- the focus group data, they didn't say, "Well, it's because I work for a health system now and they told me to do X." It's just so much easier to send the patient to the emergency department, or if they even call in, "Don't come to me, just go to the ER and they'll phone me."

One of the things that really surprised me was that a lot of the folks that we talked to said, "I don't even make the admission decision anymore. It's made by the ER doc and the hospitalist." I'll often find out that my patient is in the hospital on the second inpatient day when they finally call me and wonder when I'm going to come see them. And so there is this growing dichotomy in the physician practice community.

And, again, I think we have to get away -- if we can figure out how to break this 15-minute visit tyranny so that people can actually manage patients in their clinic, that would be a big win. But it's everybody's trying to run the meter as fast as they can, and if they can't make much money, they're trying to make it up in volume, and that's not a good way to do health care or to help the country.

COMMISSIONER GABOW: I may get cut off because I have four, maybe five --

[Laughter.]

DR. KELLERMANN: We've been dreading you down on this end of the table. We know you know what you're talking about.

COMMISSIONER GABOW: No, no. Actually, the first question I have is a clarification in the paper that we were given from Sharon Long that's in Health Affairs about the Massachusetts experience. Maybe I'm reading the data wrong, but the text says that the national average is 20 percent, and they were at 35 at the start. So even with their improvement, they're still significantly above the national average. So there's something weird about that.

VICE CHAIR SUNDWALL: Both [off microphone].

DR. McMORROW: For visits.

COMMISSIONER GABOW: For visits per non-elderly adults.

DR. McMORROW: Do you want me to take that now, or do you want to do the rest of --

CHAIR ROWLAND: You can [off microphone].

DR. McMORROW: Okay. Yes, that's exactly right, and that's, you know, part of what I was trying to get at with the context of the two studies. Because Massachusetts had a comprehensive source of care coverage basically for emergency department hospital care for the uninsured prior to reform, they had a high level of ED use. And so, yes, it came down, but it's still not necessarily low. But it came down as a result of the reforms, but it wasn't necessarily -- it's necessarily at a very low level, and it has a lot to do with that fact that they were covered before, and those gaining coverage didn't see a drop in the cost of ED care.

COMMISSIONER GABOW: And the fact that they had a long history of coverage really suggests that, in fact, coverage doesn't reduce ED visits, because Massachusetts, as you said, had good coverage for a very long period before --

DR. McMORROW: Right. I mean, the fact is we know that coverage increases utilization in general of all services, that if you pay less for a service, you're going to use more of it. And that's true in the ED as well as anywhere else.

CHAIR ROWLAND: It's also true with the Oregon study, that overall service use increased, not just the ED use.

COMMISSIONER GABOW: The next question I have is what is -- not that we like to learn from other countries in America, but what is the data regarding ED use in other countries that generally have a

better system and after-hours coverage? And what do we know about what influences that difference?

DR. KELLERMANN: It's a global problem. There's a terrible problem with high rates of emergency department use in Canada, in Australia, in the United Kingdom, in Germany. There is some evidence in, for example, the Netherlands where they actually -- primary care docs do provide access. They panel with one another, and there's somebody out there until 9, 10, 11 o'clock at night. They haven't been able to make a bit of difference. It really seems to be after-hours access for acute care makes the difference, if it's convenient and accessible.

Look, imagine if we got to the point where we actually could provide very close proximate care, and it seems to me looking at the kind of gadgets Sara Rosenbaum has, if you put a primary care technician using one of those, you could make a huge impact on primary care and access. But we have to start thinking in 21st century terms instead of 20th century terms if we're going to get there.

COMMISSIONER GABOW: While she's talking, I'm going to slip in my next one.

[Laughter.]

COMMISSIONER GABOW: My next one is actually a comment from Denver Health's experience using advice nurse lines, which for this population is actually quite attractive because it doesn't involve transportation and it doesn't involve co-pays. And we did a study where we had an advice nurse line, then we called the patient back to ask them what they actually did, because we advised them, you know, maybe you don't have to go to the ED, we can get you an appointment, et cetera. Then because these patients are captive in the safety net, we looked at what they actually did do. And the advice nurse line actually worked extremely well because we even gave out prescriptions on the line, which is an important part of an ED visit for non-urgent things.

So I think that this is a very low tech but very useful thing, and while commercial patients may not use advice nurse lines very much -- I think that's the data -- certainly patients who have challenges with transportation and co-pay, this is an attractive point. So I just think it's something to think about.

My last comment is that it really is bizarre in my mind, if you drive around Denver, half the bulletin boards -- the billboards are, "Our wait time is 3 minutes. We have a pediatric ED; we have a geriatric ED. Come visit us."

VICE CHAIR SUNDWALL: And we're nice [off microphone].

COMMISSIONER GABOW: I mean, I wonder -- I know we don't like to do things like this in this country, but why are we letting people advertise to come in -- to make attractive something that we actually don't want them to do? I mean, could we prohibit that?

DR. KELLERMANN: I'll defer to the attorney on the First Amendment, but I'm a Southerner, I got to tell you one short story with a policy angle to it.

Several years back, I gave a talk in Atlanta to a community group about the high cost of health care, and an elderly gentleman came up to me and said, "I know one group of patients you don't see in the Grady ER." I said, "What's that, sir?" And he says, "Diabetics." And I almost fell out laughing. And I said, "I'm sorry. What makes you think that?" And he says, "Because I ran the endocrine clinic at Grady for 30 years, and I told my residents and doctors, `If one of our patients ever ends up in the ER with out-of-control diabetes, you failed.' And they stay on top of it. We had very few of our clinic patients ever in the ER." And all I could say was, "Sir, you're only 95. Would you please come back?"

The moral of the story is when we get smart and really figure out a reasonable way to capitate primary care in this country and incentivize and reward them for having low rates of emergency department

use for preventable or ambulatory care-treatable conditions and low rates of admissions for PQIs, then we align incentives and rewards in a way that will allow primary care to really thrive and do what it ought to do as opposed to 15-minute, you know, drop a charge kind of fee-for-service the way we are today.

COMMISSIONER CHAMBERS: I'd like to thank the panelists. Great information. I think, you know, for me the biggest takeaway from what I do on a day-to-day basis is there's no off-the-shelf formula for success, having spent the last ten years of trying to solve this problem, running Medicaid-focused plans and trying everything on your list is, you know, educating patients about health insurance and about primary care, previously uninsured, is about doing alternative site expansions, trying to get FQHCs to have weekend and night hours, and with limited success, urgent care center contracts, limited success, different times; nurse advice line that Patty talked about; retail clinics; trying everything.

We've implemented a care transitions program where a lot of it is telephonic, but we've actually put nurses in ERs to work with ER docs who we hear oftentimes are at that critical point where, you know, should I admit somebody, back to what you said, Mr. Kellermann -- or Dr. Kellermann. Excuse me. The inpatient admission is a critical thing, and the doc in the middle of the night is, "I'm not so sure about this patient. Should I admit him or not?" You know, unless they can feel comfortable that if they send them back out into the night, they're going to get an appointment the next day, can we arrange all of that?

We have a community connectors program, non-clinicians who visit the people the next day. "Did you get the doctor? How about if I take you to the doctor?"

So all of these interventions, but, like, there's no definitive information as to what is absolutely working, and oftentimes it's because plans, managed care plans are trying -- it's the shotgun approach. Let's try everything, and let's just hope that as we look at the numbers there's better outcomes and reduced costs.

But it's a very complex issue that has many, many components to it that we just have to keep working. So that was more of a statement than question.

DR. KELLERMANN: I take your point that, again, focusing on the impact on inpatient utilization, because it's so much more expensive, is really -- it's a paradigm shift from where we are now. We're focusing on the least expensive, lowest acuity, but they're public and they're aggravating, and we ought to be able to fix that. But I really think we need to -- how do we do a better job of keeping Medicaid patients at least healthy enough that they don't get hospitalized and you don't get those big inpatient bills.

COMMISSIONER CHAMBERS: And I know you meant this, but it's inappropriately -- and I wouldn't say inappropriately admitted. It's just that it was admitted because folks weren't sure. Like with the Medicare observation day issue and Medicaid, at least in the state of California has no observation day in the state Medicaid program. And so, you know, somebody gets admitted, and it's, you know, 2,500, 4,000 per diem.

DR. KELLERMANN: I would point the committee to a JAMA study done by Brent Asplin a few years ago where they actually used faux patients to see if they could get an urgent follow-up appointment following an emergency -- you know, for bilobar pneumonia or things of that sort. And what they found was that even if you had insurance, this patient, they had trouble getting follow-up within a week. But Medicaid patients, if the same caller said they had Medicaid or were uninsured, two-thirds of the time they couldn't get follow-up within a week for a very serious health condition, and Medicaid did not in that particular instance provide better access within that week than being uninsured.

So a lot of this our docs are not that thrilled to be getting at the reimbursement rates, and so they end up rolling back into the emergency department.

COMMISSIONER CHAMBERS: And to some degree, as more of Medicaid moves to managed care, particularly with complex patients, like we have, you know, the entire Medicaid population enrolled in managed care in California now, it's the incentive on the -- you know, you put the plan at risk, and our incentive is to find solutions to get that access. It doesn't matter what we have to pay. You know, we're on the phone with a doc if we have to do a letter of agreement just to get that quick appointment, and you pay 200 percent of Medicare to get that admission to the doctor's office, but it's cheaper than, you know, the $3,000, $4,000 per diem that they end up.

COMMISSIONER HENNING: Dr. Kellermann, several times you've mentioned the tyranny of the 15-minute visit, which I deal with every day. And it kept coming back to me that we keep doing the same thing in American medicine and expecting a different result, and that maybe it's time to really look at group care, especially for chronic conditions like diabetes, like hypertension, like even pregnant women, where it's been shown to reduce pre-term births and that kind of thing. The time has come, really, to start taking these people that don't really need full head-to-toe exams. They need a dietician. They need, you know, people to talk to them about what's the best thing to eat. They need people to show them how to use their glucometer. They need, you know, other things than 15 minutes necessarily even with a physician. You know, they need an assortment of services, but that care could be provided ten people at a time. Those 15 minutes could be an hour with 10 people, and you would end up getting reimbursed basically the same, but the people in that one hour would be getting so much more benefit from that hour of time rather than spending 45 minutes in my waiting room and 15 minutes with me, of which 10 minutes is me typing on the computer.

So I really think that we really need to start looking at different ways of providing care that make

more sense.

DR. KELLERMANN: I couldn't agree with you more. Memphis was mentioned earlier. I was the EMS director in Memphis for seven years. I took care of the out-of-hospital emergency care needs for an entire city by myself. I just had 250 firefighters helping me. So, again, using different providers, different mixes, practicing at the top of the license but also task shifting the kinds of things you're talking about. We're efficient in so many other sectors of the U.S. economy, and yet in health care we're wildly inefficient, and it's often bound to traditional ways of reimbursement that lock us into traditional ways of thinking.

DR. RAVEN: Just talking about in efficiencies, I think it's worth mentioning as well that I think some of the inefficiencies are also created by just a lack of data sharing. So, for example, when patients go to more than one emergency department or get admitted to a hospital that their primary care physician is not affiliated with, they often never find out unless the health plan happens to phone them. And I think that a future focus should be how can we better integrate data systems across hospitals the way, as Dr. Kellermann mentioned, a lot of the other sectors of our economy have been able to do, and I think that would go a long way as well in better coordinating care and letting disparate providers know what's going on with the same patient and not duplicating work and tests and costs.

COMMISSIONER SMITH: This is all so interesting to me. My son was in a medically fragile children's program through MUSC Children's Hospital, and he was a frequent flier. He's very medically complex. And because they received the bundled payment once he went into that program, and everybody was there, the dietician was there, the OT, the PT, and they actually literally worked together with the pediatrician right there, they worked very aggressively to actually address his medical status and changed it. And that changed his need to go to the ER and hospitalizations. He didn't go to the ER once in the three

years. And we were frequent fliers before that. And he only had one admission to the hospital, and that was to actually do an airway reconstruction; whereas, before, the doctor he'd been seeing prior was lasering him every three months and putting him in the PICU for a day or two days, and then a hospital room for another two or three days. And so they actually changed his health status, and that changed -- and it wasn't just him. It was the National Association of Children's Hospitals did a study, a case study I believe on it, or report, and it was across the board. And it changed their lives. It didn't just change, you know, the cost of health care and going to the ER and all. It just changed everything that they were able to do, and most of the children were actually adopted.

CHAIR ROWLAND: Robin always reminds us that it's about changing the lives and improving the health, which is why we're so glad to have her.

COMMISSIONER SMITH: I think we're leaning back towards that type -- people are looking at that now again, so it's very exciting.

COMMISSIONER MARTÍNEZ ROGERS: I have two comments. I'm going to go to something that Denise was saying in terms of the benefits to the patient, to the consumer, and that is -- I'm a psychiatric clinical nurse specialist, and that is why, I think, in mental health we went to group therapy, because it's a benefit of the patients, and if you could do a proposal like that, perhaps somebody could fund you at least to do that, to check it out and see if it's really helpful.

I want to address the fact about you all keep mentioning the primary care providers, and that sometimes they refer the patient to the ER. And I wonder, because in our facilities in San Antonio, a lot of the hospitals have hospitalist, and so the primary care physician doesn't see the patient anyway. And I wonder how that affects the continuity of care, because it's just like Robin was saying, or somebody

mentioned, I think Maria, that sometimes the physician doesn't even know -- the primary care physician doesn't even know that the patient is in the hospital, or if the doctor did refer the patient to the ER and they use a hospitalist, then what happens? That happened to my oldest son, and he ended up with a hospitalist, and I had to demand that they call the primary care physician. I mean literally demand it, because they wanted to use a hospitalist and I didn't want them to.

DR. RAVEN: Yeah, unfortunately I think that's sort of the reality of where our further specialization in medicine is going, and I think what happens -- and I've had this happen with family members of mine, too, where they come out of the hospital and their entire medicine list has been changed or altered and you're not quite sure why, and when you actually talk to the person, the reasons weren't always there. And then the primary care physician doesn't find out about it until they go for their follow-up, which is sometimes two weeks later, and then they've had another -- I mean, the stories go on and on.

And so I think that it is a consequence of exactly what you're talking about. We specialize so much, and hospital medicine is now so different than outpatient medicine. And I think a lot of outpatient physicians don't necessarily feel comfortable, and rightfully so, with a lot of the things that they may have felt more comfortable with in the past when they were actually following a patient from their office and then caring for them in the hospital. That doesn't really happen anymore.

DR. KELLERMANN: Fragmentation of care is wasteful, it's aggravating, and all too often it's dangerous. And a lot of what we're doing in American health care today is increasing fragmentation rather than reducing it.

COMMISSIONER COHEN: Thank you so much. I want to follow up on a theme that's, you know, emerging, which is, you know, that emergency room visits are one thing to look at, but really it's the

real cost -- one real cost drive that's more significant is the relationship between the emergency room visit and an admission. And you've mentioned, Dr. Kellermann, that there's big variation among hospitals I think currently and potentially in terms of the role of the ER doc in being a vacuum for admissions, a gatekeeper for admissions, and that today, as I understand it, it's very dependent on hospital policies which can be very tight. And, again, I've heard this anecdotally, and I'm curious to hear your reaction to it. You know, there are hospitals that are fairly clear or explicit about expectations about the kinds of -- you know, numbers of admissions or proportions of admissions from people coming into the emergency room. And I presume that's not universal. I don't know if it's common. But some discussion about that, and whether or not there are public policies that could possibly address that problem. There's great discretion. You've already mentioned some good reasons for that discretion, and not every patient with the same condition is the same in terms of what they're going home to, what their potential for future follow-up is, but what's a potential sort of public policy that could address what might be some inappropriate vacuuming?

DR. KELLERMANN: I think this actually follows nicely on the last comment. You know, we have to get health care providers better connected, information sharing, accountability, managing the patient to the benefit of the patient and their family, not to the benefit of my practice income or your practice income.

You know, I know we're running short on time. I want to leave you with a factoid, which you can follow up from a Health Affairs study that Steve Pitts did a few years back. Today 4 percent of America's doctors are emergency physicians -- 4 percent. They provide 11 percent of all outpatient encounters in the United States, 28 percent of all acute-care visits. Germane to this panel, half of all acute-care visits to Medicaid and CHIP beneficiaries for outpatient care. And as I stated earlier today, they're the portals of

entry for half of all hospital admissions.

The way we deal with that is we get that locus of care -- which is really the hub of the health care system. It's the intersection between the community, outpatient care, and inpatient care linked into all three of those worlds, not, "Hi, I'm here, but you can't get to my medical record because it's locked up in the doctor's office," or "You can't access my inpatient record because I'm normally in another hospital but my ambulance was diverted here." If we can get the information connected and foster more team-based care, we really can make a difference. But as long as we see the ER as not really inpatient, not really outpatient, just the stupid place you go when you're not making a good decision, we shouldn't expect things to get better.

COMMISSIONER GABOW: I just want to make a comment about the data issue. I think that it's more complicated than may seem. I know Colorado developed a RHIO that was available, and we had electronic records for our whole integrated system. But what we saw was that data availability that is not pushed but is dependent on the doctor pulling is not used. And so I think that as we think about what data availability means, there has to be some way that the technology, as soon as you sign in, relevant, not the whole chart, gets pushed to you electronically, because then no one looks at it. And that's a very difficult problem. It's not as easy as having an electronic record or a RHIO. And I don't know if you have any thoughts about that, but that was certainly our experience.

DR. KELLERMANN: I think if we stay here long enough, we can solve the problems in the American health care system, but the reality is, as Denise said earlier, we have information systems that aren't usable. You can say we have a RHIO, but if it takes me 18 clicks of a mouse and five hours in class and a 25-year-old next to me is my scribe, I'm not going to do it. Instead of making information system

vendors design usable systems that are as easy to use as my iPhone, they want me to go to school for a month a year to learn how to use the damn EHR in the hospital.

So we've got to -- you know, the vendors can do a much better job. You're absolutely right, Patty. You know, we haven't realized the benefits of electronic health technology because we haven't engineered them the way we have consumer IT. If we make it like consumer IT, docs and nurses and dentists and everybody will fly and productivity will take off. Today we're forcing providers to adapt to the designers rather than the other way around.

DR. RAVEN: There is one, I think, sort of interesting example that Washington State has undertaken, and now they've penetrated I think into Oregon, and they're looking into California, and it's a company that I have no financial interest in -- but I happen to know the name because I find them really interesting -- called Collective Medical Tech, and they have developed this thing called the Emergency Department Information Exchange, and it's a relatively low cost way for any participating emergency department in a region to have information pushed to the providers in the emergency department, and also it can involve managed care organizations and primary care clinics as soon as the patient hits the emergency department. And as many departments participate and providers participate, that's how much information you'll get pushed to you as the treating provider at the time. And I think there's sort of an innovative, low-cost solution, and I think more and more people are developing programs like that.

COMMISSIONER CHECKETT: Just a quick question. Actually I was going to ask for your observations. You know, I'm amazed we've had this whole discussion, and we haven't talked about the use of the ED by people with behavioral health and mental disabilities and drug and alcohol abuse problems, which in Medicaid, you know, other than all the bad moms who aren't supposed to be there, this is the other

group for whom somehow there's like, you know, a moral failing. And I would just really be so curious to see if there's anything you would recommend to us in terms of like more literature or observations you have as practitioners about what works and what doesn't, because -- now, I would say my uninformed data is this is a big problem, but it may or may not be. And I would just really love to hear what you could say about that.

DR. RAVEN: It's a huge problem, and a lot of the reason is because there's not enough capacity to treat mental illness and substance use in the community. So, you know, every day patients come in, they might want a detox bed. They might want a long-term rehab bed. Maybe they need an inpatient admission to a psychiatric hospital, and if they have Medicaid coverage, it's highly likely that they're going to sit in the emergency department for three days. And that's for an inpatient psychiatric admission. If they need detox or rehab, they are going to be discharged to the street to go somewhere that can refer them when there is an open spot somewhere.

So there simply isn't treatment capacity in the community for this population, bottom line, and you may have different opinions or know more. This is from my perspective. But it's just not adequate.

DR. KELLERMANN: Typically hospitals will admit the paying patient, the elective admissions, get priority for beds. The last person to get into an inpatient bed is an ER patient. Medicare, Medicaid, doesn't matter. They're already in the building. They're captive. But the folks who nobody wants are the severely mentally ill, unless they've got really platinum coverage and can go to a boutique psychiatric facility.

I would only qualify, Maria, they don't sit in the ER for three days. They're either locked up in a room in seclusion or, God forbid, I hate to say it, they're restrained on a stretcher because they're suicidal and we're afraid they'll go out and kill themselves and we'll be liable. And it's barbaric in 2014 that people

have to literally be in a noisy emergency department hallway, profoundly depressed or suicidal, because no one will take them. But that's on any given night, the longest boarders in the hospital or in the country are psychiatric patients, and it's a national tragedy.

COMMISSIONER MARTÍNEZ ROGERS: I'm just going to make a short statement. I agree with you it's a major, major problem, and I think that as states closed their state hospitals or places where the chronic who become acute, in particular schizophrenics, paranoid schizophrenics, it's becoming a really big problem. And what has happened is that they're placed out in the community, and no one in the community knows how to take care of them, and there are no facilities for them to be taken care of, and private hospitals, for-profit hospitals, do not want them. And even those that have insurance can only stay for a very short period of time, and it is not enough to take care of the problem.

DR. RAVEN: And it's worth noting that a significant number of the very high utilizers have co-morbid behavioral health conditions, and so as utilization goes up, so do diagnoses related to substance use and mental illness.

CHAIR ROWLAND: And some would say that as we move forward through the Affordable Care Act where we're going to be enrolling more people prior to discharge from the prison system into Medicaid, some of the bump-up in what we might see in Medicaid utilization of EDs will probably come from that policy as well.

Well, we clearly have appreciated this frank and very informative discussion, and I think all of us are very anxious to continue to look at not only debunking some of the myths about ED use but about really how we can contribute to improving the way access to care is provided through the Medicaid and CHIP programs, and especially the role that emergency departments can play, and even improve their role rather

than reduce it. And, Art, we will remember that if we can avoid inpatient hospital admissions, that's actually the goal of primary care, and it ought to be the goal of ED care as well.

So thank you very much for joining us. We'll continue to work with you as best we can over the coming months to really develop our policies here.

DR. KELLERMANN: Thanks to the Commission for hosting us, and thank you for the good work you do.

CHAIR ROWLAND: Thank you.

We will now adjourn for lunch and return at 1 o'clock.

* [Whereupon, at 12:23 p.m., the meeting was recessed for lunch, to reconvene at 1:00 p.m., this same day.]

AFTERNOON SESSION [1:11 p.m.]

CHAIR ROWLAND: Okay, if we could please reconvene.

[Pause.]

CHAIR ROWLAND: We heard this morning a nice discussion from some of the Medicaid directors and from Alice Weiss about some of the simplification methods that have been put in place, and one of them is Express Lane Eligibility. So Moira is going to review for us the report that will be a Secretary's report that we will have to comment on in our time frame.

So, Moira, why don't you tell us kind of the status of the report and the content?

Session 5: Review of Secretary's Report on Express Lane Eligibility

* MS. FORBES: Sure. Thanks, Diane.

Yes, we'll discuss Express Lane Eligibility in this session. We first discussed this last May, and of course, Ruth Kennedy and Alice Weiss talked about it earlier this morning.

In December, ASPE released the final evaluation of the Express Lane Eligibility program. As we've said, one of MACPAC's responsibilities as outlined in the statute is to review reports submitted by the Secretary of HHS and submit comments to the Congress.

So what I'll do today is go over the key points of the final evaluation and raise some of the issues that could be included in a letter to the Congress. You may also identify other issues to raise in the comment letter.

The executive summary to the report was in your packets, and we can give you the link, if we didn't already, to the complete report, which is pretty lengthy and has a lot of detail.

I'll go quickly through the background since we've talked about ELE in the past and also this

morning, to leave a little more time for discussion.

So, just a quick recap, the Express Lane Eligibility option was one of several policy options and financial incentives included in the 2009 CHIP reauthorization to encourage states to increase the enrollment of children into Medicaid and CHIP. This option allows states to rely on the findings of other public agencies, including the National School Lunch Program, SNAP, TANF and WIC, to determine whether a child is eligible for Medicaid or CHIP.

ELE was originally set to sunset on September 30, 2013, which was the same end date as the CHIP reauthorization. The ACA extended CHIP through 2015, and H.R. 8, the fiscal cliff bill, extended Express Lane until September 30, 2014.

Thirteen states have approved state plan amendments to implement ELE and have taken advantage of flexibility in program design to implement different approaches, including the type of ELE process and the type of partner agency. So the next 2 slides summarize some of the choices that the 13 states made.

As you can see on this slide, states have made all kinds of choices in terms of the type of process to use, which program it applies to, and what partner agency and data they use. There is a lot more information on these in the evaluation report.

These are the remaining seven states.

I'd point you to the report for more explanation of this. This is just a quick summary.

The CHIP Reauthorization Act required the Secretary of Health and Human Services to conduct an evaluation of the impact of Express Lane on enrollment, administrative costs and the accuracy of eligibility determinations. The final evaluation was submitted to HHS in December 2013.

The evaluators looked at several different data sources as part of the evaluation. Again, the

complete evaluation report goes into this in length -- their methods and data sources -- but I'll mention a few here.

They used four years of Medicaid and CHIP enrollment data to assess changes in enrollment in states after ELE implementation.

They used a multivariate model to account for differences in policy, demographic and economic changes in those states.

They obtained individual-level claims and encounter data from four of the states to look at utilization.

And, to supplement the descriptive studies, the evaluators conducted site visits, interviews and surveys with states that had implemented ELE and with non-ELE states.

After controlling for economic and state policy changes, the formal impact analysis found significant evidence for the states in the study that ELE increased children's enrollment in Medicaid and CHIP by 6 percent on average.

The descriptive analyses and case studies found that in all states ELE contributed to enrolling or retaining children in Medicaid and CHIP although the magnitude varied a lot, depending on how the state had implemented ELE.

It also found that children who enrolled through ELE were no more likely to experience churn after disenrollment than were other children.

The biggest differences among states were the type of process used and the choice of partner agency.

So states can use ELE for automatic processing -- this is what Louisiana did -- where states use

eligibility findings from partner agencies, such as SNAP or TANF, to automatically enroll and renew children in Medicaid and CHIP without any additional action by the family.

Alternatively, states could use ELE information to simplify procedures for eligibility workers or to simplify the application process for families. Ruth mentioned this earlier today as the lead generation aspect of the ELE. All the ELE processes used by states helped to enroll or renew children in coverage, but the descriptive analysis found that the impacts on coverage and costs varied by state. States that used ELE for automatic processing enrolled the most individuals and had substantial administrative savings -- an average of a million dollars per year each year, recurring net gains, in the four states using automatic ELE processes compared to what those states would have spent to enroll and retain the same people, using traditional methods.

Non-automated ELE processes, including simplified procedures and simplified application processes, that rely on families to initiate or return an application, do have some impact. They can work. They require less up-front investment than the automated processes do. But the simplified processes were found to produce little to no administrative savings and had modest impacts on enrollment.

Given the size of renewal caseloads compared to new enrollment caseloads and the recurring nature of renewal, using ELE for renewals can generate administrative savings and keep kids covered, but ELE for renewal has not been as widely adopted as ELE for initial applications.

Analysis of utilization data in four states found that while children enrolled through ELE may have been passively enrolled most did access a variety of health care services through their coverage. So, while they hadn't come in necessarily to apply, once they had the coverage, they did use it.

ELE is one of many simplifications that states can adopt to try to expand coverage while simplifying

the enrollment and renewal process. The evaluation design called for a study of other simplifications besides ELE, and the team studied three other simplifications. They look at a state with presumptive eligibility, a phone renewal process, and an online enrollment and renewal system.

Like ELE, these approaches all increased the enrollment of children into Medicaid and CHIP by simplifying the process of applying for or renewing coverage. They also all produced administrative savings. So these comparisons suggest that ELE is not the only option states can use to simplify the eligibility process and achieve administrative savings.

ELE works. Other things work as well.

So that wraps up the summary of the evaluation report.

As the Commission considers the comments it would like to provide to the Congress on ELE, there are a few other issues to think about.

The first -- sorry.

CHAIR ROWLAND: So does the report recommend whether ELE be extended or not?

MS. FORBES: It points out the benefits of it, the consequences to the states that have implemented it if it is not extended and provides suggestions for if it is extended how it could be most useful -- like which aspects of the states that have done it show the most promise in furthering enrollment and retention.

CHAIR ROWLAND: But is this going to be the Secretary's report to the Congress, or will the Secretary then use this evaluation to put together an additional report that might have recommendations from the Department?

MS. FORBES: I don't know.

We talked to ASPE about this. They didn't say that there would be an additional report. They

described the report that we have reviewed as being the one that's --

CHAIR ROWLAND: To be transmitted to the Congress.

MS. FORBES: Yes, correct?

EXECUTIVE DIRECTOR SCHWARTZ: That's my understanding. We didn't hear anything from them to suggest, and they briefed us -- you know, they invited us to be briefed, including the contractor, Mathematica. So we had the impression that this is it.

CHAIR ROWLAND: So this is the secretarial report we'd be asked to comment on?

EXECUTIVE DIRECTOR SCHWARTZ: Yes, yes.

VICE CHAIR SUNDWALL: Moira, a quick question for before you move on.

Indulge me for a minute. You mention here other options. Could you explain to me what is in the ACA on presumptive eligibility, or what's new about that or different?

Is there something in the ACA that's new, or has that always been available under Medicaid?

MS. FORBES: The comparative programs that they looked at were not necessarily things that were in the ACA. They looked at simplifications that other states had chosen to implement using authority that either has been longstanding authority or was allowed through earlier bills such as the CHIP reauthorization in 2009.

They weren't necessarily looking for things that states had implemented because of the ACA.

VICE CHAIR SUNDWALL: Could you just explain presumptive eligibility to me? I mean, what criterion are used to make someone presumptively eligible?

MS. FORBES: The presumptive eligibility -- I don't want to misspeak.

Several states have implemented presumptive eligibility. In a lot of states -- I can't remember which.

I'm sorry.

VICE CHAIR SUNDWALL: I think it's primarily for pregnant women; is that right?

MS. FORBES: It's for pregnant women or for children.

CHAIR ROWLAND: It's allowing for eligibility determination to proceed, and then the documentation and the verification can follow.

VICE CHAIR SUNDWALL: Okay.

MS. FORBES: Generally, a full application has to be submitted within 60 days. A provider can move ahead with delivery of a service and get reimbursed for that service during the presumptive eligibility period, but permanent eligibility is not granted until a completed application is submitted and adjudicated.

VICE CHAIR SUNDWALL: When I was at the health department, we did a presumptive eligibility for someone needing a liver transplant. But for that procedure, they could die, and so we made that decision.

But I just wasn't sure the scope of services that you could do that for.

COMMISSIONER ROSENBAUM: It actually dates back the mid-80s and was introduced for pregnant women and then later, in CHIP, extended to children, but there's no -- now, of course, there's the hospital presumptive eligibility in the ACA.

But the notion of enabling somebody outside of the formal eligibility determination process to make even a short-term determination of eligibility is a relatively constrained aspect of the program.

MS. FORBES: Yeah. Presumptive eligibility for children was extended to states as an option in the 1997 Balanced Budget Act, so that many states have taken up that and implemented that over the years.

VICE CHAIR SUNDWALL: Thank you.

MS. FORBES: Sorry. So, back to the other things that were not addressed in the evaluation report.

The law that authorized Express Lane -- and we talked about this some this morning. It specifically addressed concern that this process either could introduce enrollment errors or at least that the effect on enrollment errors is unknown.

So CHIPRA required states to implement systems to track ELE cases separately so that error rates could be measured. States were supposed to conduct a full eligibility review of a sample of ELE decisions each year to determine whether they were accurate and take actions to reduce the error rate if it were over 3 percent.

The evaluation report was supposed to include information on the percentage of children erroneously enrolled in Medicaid and CHIP based on Express Lane agency findings, but CMS has not issued guidance to the states on how to do the sampling or review or calculate error rates. So we don't have any information to share at this time, including when CMS might issue guidance or when error rate information might be available.

Another issue is ongoing relevance of ELE given the extensive changes to eligibility processes as a result of the ACA. ELE procedures -- they were not specifically asked to discuss that in the evaluation report. So there's a little bit of information on that, but it wasn't a focus of the evaluation.

ELE procedures, particularly those that involve data-sharing with other agencies and reliance on trusted information, are similar to many of the new procedures states are implementing to comply with the ACA. Some states may not have implemented ELE because they didn't have the systems in place to share data with other agencies.

Now that states have made a lot of investments and upgrades to their eligibility systems to comply

with the ACA, they may be in a better position to adopt additional simplifications such as ELE. On the flipside, they may find that the additional benefits to be gained through ELE are sort of marginal now that they've done all of these other upgrades.

Another thing to keep in mind is that while the ACA creates a shared data services hub and requires states to use third-party data when available, states cannot accept eligibility findings from other agencies. If a SNAP program has verified a family's income and determined it to be below the federal poverty level, the Medicaid agency can accept the verified income data from the other program through the hub, but it still has to evaluate that information. Only Express Lane authority allows states to rely on the eligibility findings of other programs as opposed to just taking the eligibility data.

Apart from -- as was mentioned today, there are the temporary targeted enrollment strategies that states can implement to help with initial rollout of the ACA, and one of those strategies to facilitate the enrollment of low-income adults into Medicaid is the option to enroll people into Medicaid based on SNAP eligibility. So, while there is no statutory authority to do that outside of ELE and no statutory authority for adults, there's a temporary strategy that states can use through the end of 2015, and 6 states have taken that up.

And, as I think we heard today, some states -- including, I think, West Virginia – have seen a lot of enrollment resulting from that.

Another issue I sort of just alluded to and an issue that's been raised in the context of an ELE extension is its applicability to adults. Currently, ELE authority only applies to children. States can get permission from CMS to use ELE for adults through an 1115 waiver, and 2 of the 13 states that have implemented ELE have used waivers to extend ELE permissions to adults.

So, as the Commission reviews this report and thinks about what comments it might like to submit to the Congress, three potential issues include whether to extend or make permanent the ELE option in statute, whether to expand the scope of ELE policies to include adults and how to measure the accuracy of ELE decisions.

So I'll walk through each of these in a little more detail, and then we can go back and discuss.

So, again, under current law, the ELE eligibility option is allowed until September 30, 2014.

The evaluation of Express Lane showed that ELE saves time, reduces costs and contributes to positive enrollment gains. The evaluation did not provide any information on whether ELE processes result in more or less accurate eligibility determinations.

Thirteen states have approved state plan amendments to implement ELE and will have to change their processes beginning October 1 if ELE is not extended or some other provision made.

Ruth mentioned that they've reduced their staff by 200. I think Louisiana is particularly concerned about the impact if this sunsets on October 1.

If ELE is extended past September 30th, Congress may also consider whether it should be expanded to include adults. When ELE was first authorized in 2009, most outreach enrollment efforts were focused on children. However, the ACA expanded eligibility to a large number of adults who may quality for ELE partner programs such as SNAP and TANF.

So the administrative savings associated with the ELE option could increase if family-level applications or renewals could be processed as a unit. Otherwise, a state might have to process -- you know, could process a child through ELE but would still have to do the normal application or renewal processes for adults.

ELE could be a more attractive policy option for states if it could be implemented for adults as well as children, particularly in states that have opted to expand Medicaid to low-income adults. States that did not expand to cover adults might see little impact from extending ELE to include adults, and states may have implemented other policies that they would prefer to ELE, of course.

A third issue is the review of error rates among ELE cases. As I said before, states are supposed to sample and review a number of ELE cases, but CMS has not issued guidance on how to do this.

A robust, separate sample of ELE cases would provide detailed information to inform corrective actions. Alternatively, ELE cases could be included in the universe of eligibility decisions reviewed in PERM. CMS could develop separate review guidance to be followed if ELE cases were sampled as part of PERM.

A combined sample would reduce costs and burden for the states, but it's a random sample. They would probably only pull very few ELE cases. So it's unlikely that we would learn anything about ELE in particular. They would sort of be lost, but they would be included in the review.

And then Ruth Kennedy mentioned a couple other things this morning that we hadn't included here.

One was if ELE is extended whether it should be limited to the full automatic processing. That's where the most gains in both enrollment and administrative savings were seen.

The lead generation -- the evaluation found that states that use it for that didn't see a lot of benefit. They didn't see any harm from it, but they didn't see a lot of benefit.

And so she had mentioned that as well as options for encouraging states to take up the ELE option if it is renewed. So those are some other things on the table.

Would you like me to scroll back a couple slides? I'm not sure how you want to --

COMMISSIONER GABOW: On your slide that says, Evaluation suggests ELE saves time and reduces costs, I think it has to be clear that you mean administrative costs because actually, by having an effect on enrollment, obviously, it increases total cost. So I think we just need to be -- when we're talking about costs, we need to be pretty clear about what costs we're speaking of.

MS. FORBES: Yes.

CHAIR ROWLAND: And also, about whether we're talking about initial enrollment or the renewal process, which was clearly the point of much of what Ruth talked about today.

Burt.

COMMISSIONER EDELSTEIN: Moira, you mentioned that there was, I believe, an aggregate 6 percent bump-up in initial enrollment. Was there quite a range across the states, or does that 6 percent hide better performance from worst performance?

MS. FORBES: Some of the states that used ELE for lead -- like some states had used tax information to identify very low-income families and sent them a thing saying, send this back, and literally, it was like dozens of people responded. I think in Louisiana and South Carolina it's tens of thousands.

So the 6 percent was on average, and yes, there was an enormous amount of variation among the 13 states.

CHAIR ROWLAND: If we are to respond to this report and it is a Secretary report to the Congress, the evaluation findings, they say, suggest four ELE best practices to maximize coverage -- to adopt automatic ELE processes, to use ELE for renewal, to choose Express Lane partners with centralized linkable data and to consider ELE processes that remove administrative barriers for families.

So wouldn't those be the kinds of recommendations that we would consider commenting on directly as part of the process?

MS. FORBES: You could.

I mean, those all sort of -- the question of whether or not it should be extended, I think, is the first question. If it's not extended, there's no -- they don't apply.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: I --

CHAIR ROWLAND: Well, it should be extended if we think it's a valuable method.

COMMISSIONER RILEY: Well, I think that's -- I don't think we know that.

You know, this morning's discussion was exciting, but it seems to me even if it's only an average of 6 percent bump it's not such a big bump.

And my biggest concern is we don't know the validity of the eligibility determinations. And, until we know more about the error rates and what the CMS might do about that, it seems to me we are not in a position to make a recommendation that it continues.

And even the discussion about administrative costs -- Louisiana is an unusual state in that its workforce is not unionized. In another state, it's not that easy to just eliminate staff as a way to create administrative savings. So they bumped other positions.

I just don't think -- without that better information about where the administrative savings really are and, most importantly, where the error rates and how effective this thing is, I don't feel comfortable saying one way or the other.

CHAIR ROWLAND: Okay, Andy and then Sara.

COMMISSIONER COHEN: I feel like it's a tough time to be considering this question, but I understand that that -- you know, we don't have an option there, both because there's a report in front of us and because the statutory authorization has a fixed timeline.

But it seems to me the world underneath this ELE option is changing dramatically, and there's a lot we don't know.

I would certainly not -- I come to a different conclusion than Trish. I think at the -- I mean the idea of telling a bunch of states that have gone to great efforts to implement something, to cut it off because we don't know enough -- I'm less inclined to do that.

You know, I'm inclined to say, without enough knowledge but with an awful lot of investment, we should invest in the knowledge before we sort of say the option is no longer available.

But I also think it kind of has to be evaluated at another time, you know, in the context of this new MAGI world, where systems have completely changed and the rules have completely changed for major chunks of the population.

And the data are going to be -- because the systems are different, the data are going to be very different.

So it just seems to me a very tough time to make a long-term decision but an appropriate time to say, why should we change the baseline in the absence of information instead of maybe pushing the deadline down the road and seeing what we can learn in the near future?

CHAIR ROWLAND: But the option is now available for children but not for adults except with a waiver.

COMMISSIONER COHEN: Right. And I guess at this point I'm just sort of addressing the

question of, should we recommend a continuation for children?

I'm not -- right.

CHAIR ROWLAND: But, on a temporary basis, adults are --

COMMISSIONER COHEN: Right.

CHAIR ROWLAND: They're using it as an adult option under the ACA. So it's actually being used.

Sara, you were the next, and Judy.

COMMISSIONER ROSENBAUM: Yeah, I think maybe it's a good idea on this one to sort of go back to basics.

So all the streamlining that's been happening under the ACA is happening in the context of essentially how the Medicaid program functions and how the Medicaid program interacts with the marketplace, with the exchange. And that's its own set of issues.

This is designed, as I understand it -- and I think it's the most important point Moira pulled out of the study.

This is designed to make it possible for other pathways into enrollment outside of the ones that are the principle pathways, meaning either the marketplace or Medicaid.

And so I think there's this sort of threshold question of, do we think it's a good idea to have other avenues into enrollment besides enrollment avenues now, which are the marketplace and Medicaid programs, or was Express Lane Eligibility fine when we were sort of thinking about Medicaid and CHIP, or whatever, in isolation?

And there are probably pretty powerful arguments to be made on both sides because of all of the

other information now that is part of the process of using these streamlined enrollment procedures.

But I would say that I think Andy and I are in the same place, which is that's a brand new question to answer.

And so what you want to do -- and I think we're going to find ourselves repeating the same mantra when we get to our CHIP deliberations, that there are new questions to be answered.

And so, for us, the issue is, do we recommend that you allow a piece of flexibility to continue while we try and get on top of this new answer?

And I certainly say at this point, given the uncertainty of so much stuff changing at the same time, that we really don't want to take a tool off the table until we're satisfied that we really don't need it anymore because it's so easy to get into insurance now, that you don't need to worry about whether to align it in with your taxes or WIC or whatever.

VICE CHAIR SUNDWALL: [off microphone.]

You're right. Well, yeah, I'm not sure that you'd really have a whole lot of takers to start something new anyway now.

I'm not sure I'm opposed to the notion of a state wanting to use the tool for the first time. I'm skeptical that we'd have a lot of newbies.

CHAIR ROWLAND: David has a comment, and then Judy.

VICE CHAIR SUNDWALL: Let me just give a little context to -- all of our things have to be thought of with some politics.

We're in our annual 45-day legislative session in Utah. We're one of those states sitting on our hands, whether to expand or not.

It is high drama. It is just amazing to have the Governor pitted now against the Speaker of the House, who apparently is going to run against him, and she's holding her ground -- no federal money, nothing; we're not going anywhere. And he's now put out an olive leaf and says we are going to some expansion.

But anyway, in that, the discussion is just really something to behold -- to hear the conservatives talk about how opposed they are to Medicaid expansion and adding people to the rolls.

So I'm in favor of anything that's simplifying or if it's going to streamlined, if it's going to be easier, more efficient. That sounds like good conservative policy.

However, the expansion -- you know, rapid promotion. That's something that we have to understand in the context of those states that are not in favor and how this might be perceived from the Medicaid Commission.

CHAIR ROWLAND: But this also is an option. It's not a requirement, so that it would be up to the state whether to use it or not.

VICE CHAIR SUNDWALL: Good point.

CHAIR ROWLAND: Judy, you've been patient.

COMMISSIONER MOORE: Nothing terribly new other than the fact that I think we are in a position -- I mean a time of transition. And, in a time of transition, you should maintain what's already happening and allow people to continue and to maybe add more states if they're interested, or if they're not.

I mean, it is -- I think it's best to maintain flexibility, but I think that we should -- if we go in the direction of suggesting continuation of this for another year or two years or three years, or whatever we might think is appropriate, we need to bang on CMS a little bit to look at the program integrity issues and to

get their guidance out so that states can, in fact, do what I think Ruth was saying they would like to -- is to know more about the impact of this on their program.

So I don't know how that goes in terms of coupling that, but I certainly would be in favor of continuing this beyond September of this year but also encouraging the guidance and the materials that CMS seems to be a little delinquent on.

CHAIR ROWLAND: Okay, Patty.

COMMISSIONER GABOW: Yeah, I would agree that we should allow the option to be extended and to be extended for adults as well in that they're using it temporarily, but clearly, guidance is needed.

But I think it fits. I would even go beyond that, but I'm willing to stop at that.

But, in an era when data are so robust and exchanging information -- I mean, we're not back where if you wanted information from SNAP or WIC you had to put it on a piece of paper and put it in the mail.

I mean, we're in an era now where electronic information is readily available. Every other industry uses it. Why do we want to handcuff our government insurance programs in a way that we wouldn't handcuff any other industry?

Why don't we want to simplify it for our people who need this, whose lives are complicated?

You know, if there's an argument with the integrity of the data, well, then it's from the agencies that it's coming from, and they need to look at SNAP and WIC and the income tax, or whatever else they're using.

But I would be very much against asking states that are experimenting to go back to a less automated, less simple approach at this point in time.

CHAIR ROWLAND: Well, I think the report itself reads as fairly positive about -- the conclusions

are that this is a good tool to have out there and may have some other places to be tested. I thought it actually reviewed the data verification in Oklahoma and other places and could start at doing that.

So I think we're being asked to really comment on whether this should be a tool in the tool box or not, not whether it should be mandated to all states, and so I assume that would be how we would want to handle our comments to Congress on it.

Other discussion?

Trish.

COMMISSIONER RILEY: I, obviously, agree it does simplify, but I really think we have to speak to all the oversight that goes on. It's not just CMS and the program integrity. It's GAO. It's OIG.

I just want a clear federal statement about working with states to make sure they don't get out there with this simplified system and then find themselves dinged from one source or another.

So there's got to be a more strategic approach to this.

And then also, Ruth made an interesting point about the administrative burden of changing systems to be able to do this efficiently and talked about the need for enhanced match, and that might be something we want to park in our discussion about administrative challenges to states.

CHAIR ROWLAND: Okay. Other comments?

[Pause.]

CHAIR ROWLAND: Okay. Thank you, Moira.

[Pause.]

CHAIR ROWLAND: Now we are going to turn to the future of CHIP and federally subsidized children's coverage, and we have a panel that I know is well coordinated, and I'm going to ask Chris to start

it off.

Session 6: The Future of CHIP

* MR. PETERSON: All right. Thank you, Diane.

In this session we are looking at the issues around the future of CHIP and federally subsidized coverage for children, building on several meetings and, of course, your recommendations and the chapter on CHIP in our upcoming March report.

In our September meeting and in our November meeting, we explored both short-term and long-term issues surrounding CHIP and the future of children's coverage. Then in our December meeting, we focused exclusively on the short-term issues as you approved two CHIP-related recommendations included in our upcoming March report. In January we began to shift to the longer-term issues with the panel on benefits for children and separate CHIP coverage. And now in this session we turn our attention toward the June report and the longer-term future of CHIP and children's coverage. We look forward to your thoughts on where you are interested in potential recommendations considering that states will begin exhausting their federal CHIP funding late next year and are soon beginning their budget cycles for that state fiscal year, while at the same time we have new coverage through exchanges and other major changes ongoing that are affecting the coverage landscape.

So the presentations that we'll be going through here today, as you see there, are going to touch on all of these various topics, and we will be summarizing the key points of the papers that you received in your materials.

We've talked a lot previously about the basics of CHIP eligibility and its interaction with exchange coverage, and you addressed this in the March report that's coming out with your recommendation to

eliminate CHIP waiting periods because of churning that could occur between exchange coverage and CHIP. But that exchange coverage alters the context for considering CHIP's future, the yellow you see here. Previously, if children did not have CHIP -- that is to say, before the ACA and the availability of exchange coverage -- if the blue went away here in the case of West Virginia, many of these children would not have access to any coverage. However, at the CHIP income range, subsidized exchange coverage is now available.

While this kind of figure might suggest that in the absence of CHIP all children will be eligible for Medicaid or subsidized exchange coverage, this is not the case. So we want to walk you through children's eligibility in a post-CHIP landscape.

So here's what to keep in mind, first of all, as you look at coverage in a post-CHIP landscape, the first question has to do with the program type that the state is using for their CHIP program. Recall that the ACA's maintenance of effort for children applies through fiscal year 2019, and so that affects Medicaid expansion CHIP programs differently than separate CHIP programs. For Medicaid expansion CHIP programs, that MOE still applies because those children are really enrolled in Medicaid. They're just funded by CHIP. So the maintenance of effort still applies. Those kids continue to be covered by Medicaid, albeit at the regular lower Medicaid matching rate relative to CHIP.

On the other hand, separate CHIP programs' only requirement is to transition enrollees who were eligible for the separate CHIP program to exchange plans that are certified by the HHS Secretary as at least comparable to CHIP in terms of benefits and cost sharing. And then Lindsay's presentation here in a minute will suggest that it's not possible for even subsidized exchange coverage plans to be comparable in terms of cost sharing.

So it raises a question that if certified exchange plans are not available, what is the future of coverage for these children? And if certified exchange plans are available, maybe notwithstanding these differences in cost sharing, what will happen? But not only that, not all of these separate CHIP kids will be eligible for that exchange coverage.

So let's talk about where states -- where children are now. Twenty-nine percent of CHIP-funded children are in Medicaid expansion CHIP, so likely these children would remain in Medicaid if CHIP funding runs out. In addition is the unborn children population. This is a population that we talked about in our June report last year and in other contexts when we've described the basics of the CHIP program, but just to remind you that under CHIP, children can include those -- the period between conception and birth, and so states have this option to cover unborn children, and many of these are to mothers who are not citizens or here legally residing. And so what this means is that in the absence of CHIP, these children currently do not have another coverage opportunity. They are not dependents for tax purposes for exchange coverage, and they are not eligible under Medicaid under current law.

But the bulk of CHIP enrollees are in separate CHIP programs who may or may not be eligible for exchange subsidies. Why wouldn't they be eligible for exchange subsidies? They would not be eligible if their parents are offered employer-sponsored coverage, and particularly the first bullet talks about parents who are currently enrolled in employer-sponsored coverage where the children are in CHIP. That's one group. And then you also have parents who are offered but not enrolled in their employer-sponsored coverage where the children are in CHIP.

A note here is kind of small that very few would be eligible for exchange subsidies because the employer coverage is not affordable. We've talked about this in prior sessions with respect to the family

glitch that currently employer-sponsored coverage is considered affordable if the self-only contribution to coverage requires more than 9.5 percent of a person's income. But my point also would be that even if you fixed this family glitch, if you will, and made it apply to family coverage, there are still families who would say we cannot afford, we're not going to enroll in that or the exchange plans. This becomes relevant as we look at this slide here.

So if we looking --

COMMISSIONER ROSENBAUM: That's because of a basic affordability issue.

MR. PETERSON: Correct.

COMMISSIONER ROSENBAUM: Not the glitch issue, but just the basic affordability of marketplace coverage?

MR. PETERSON: Yes.

COMMISSIONER ROSENBAUM: Okay.

MR. PETERSON: So what this slide shows, we obtained some projections from the Agency for Healthcare Research and Quality, estimates, looking at children currently eligible for separate CHIP coverage and what would happen if CHIP funding ended, where would these children end up. As you see in the blue, less than half would be eligible for subsidized exchange coverage. These are in families where no one is offered employer-sponsored coverage.

We are assuming that all employer-sponsored coverage is offered to dependents, which on the latest data we have available actually applies to 98 percent of individuals. Ninety-eight percent of individuals who are eligible for their employer-sponsored coverage have access to family coverage, notwithstanding its additional cost. And, in addition, as we've shown previously, the family glitch, that affordability test would

not make subsidized exchange coverage available to very many people.

So given that, the red wedge shows that 36 percent of separate CHIP kids would be ineligible for exchange subsidies. Not only are their parents eligible for employer-sponsored coverage, they're enrolled in it.

CHAIR ROWLAND: Chris, can I ask you, what's the n on that? What's the number of children that these percentages are applied to?

MR. PETERSON: I don't know that off the top of my head. I can follow up with you, but they pulled five or six years of data to bring up the n and used --

CHAIR ROWLAND: You don't -- I mean --

EXECUTIVE DIRECTOR SCHWARTZ: The number of kids covered under separate CHIP. Just the total number of kids currently enrolled in separate CHIP.

MR. PETERSON: Oh, gotcha. About 5 million.

CHAIR ROWLAND: Two-thirds of the total.

MR. PETERSON: Yeah, 5.7, 5.8. And then the final part of the pie there is that 21 percent are ineligible for exchange subsidies. Their parent is -- they have a parent who is offered but not enrolled in that employer-sponsored coverage. So this raises key policy questions with respect to eligibility. When we see these gaps in the post-CHIP structure for children's coverage, does this tell you that CHIP merits extending? Or does it tell you the post-CHIP structure should be altered? Or both? That is to say, if you think that CHIP merits extending, then do you also want to have a glide path for a post-CHIP world? And if CHIP ends, for example, should children losing CHIP eligibility be eligible for subsidized exchange coverage regardless of the availability of employer-sponsored coverage? Should there be a new Medicaid

eligibility group for unborn children? So those are just a couple questions. Then I'll move on to Ben, and once we have gone through the presentations, we can stop for your discussion.

COMMISSIONER ROSENBAUM: Can I just ask one more [off microphone] back to the --

EXECUTIVE DIRECTOR SCHWARTZ: Sara, can you use your mic?

COMMISSIONER ROSENBAUM: Oh, sorry. Back to actually Slide 5, the group of, as they are called, unborn CHIP children, now these children obviously are also pregnant women, right? So I am assuming that while the children as a legal matter are ineligible for exchange coverage because exchanges don't recognize unborn children, the exchange would recognize, depending on income and other factors, the mother.

MR. PETERSON: Except that a large majority of unborn children have a mother who is not documented.

COMMISSIONER ROSENBAUM: That's what I'm saying. So assuming that the mother --

MR. PETERSON: They would not be eligible --

COMMISSIONER ROSENBAUM: So there is some --

MR. PETERSON: -- for subsidized exchange coverage.

COMMISSIONER ROSENBAUM: There is some group of mothers of unborn children who don't translate cleanly into exchange coverage, and that's really what this -- the small pie slice is just the subset of all unborn CHIP children whose mothers don't translate into eligible women?

MR. PETERSON: Right. So we should not say that all of them would be eligible.

COMMISSIONER ROSENBAUM: Some of them. We don't know the exact number.

MR. PETERSON: Correct.

COMMISSIONER ROSENBAUM: Okay. All right. Thanks.

* MR. FINDER: Thank you, Chris.

For this segment we'll be discussing benefits packages in separate CHIP programs and qualified health plans, and this is an important topic because of the requirement that QHPs are certified by the Secretary as comparable to CHIP in terms of benefits and cost sharing should CHIP funding be exhausted.

So I'll start by briefly describing how states design benefit packages in separate CHIP programs and the state's role in QHP benefit design. Then we'll review some recent research on the key differences in benefits across separate CHIP programs and QHPs. And, finally, I'll discuss some of the key policy questions that these differences raise.

So I'm going to start by glossing over CHIP benefit design just really briefly. You'll recall that we covered this at last month's meeting, and there's a lot more depth in the paper as well.

So recall that states have two options. They can operate a Medicaid expansion CHIP program, in which children are generally eligible for all of the services that are covered by the Medicaid program, including EPSDT. For states who choose to operate a separate CHIP program, they have three options for benefit design: benchmark coverage, in which they're benchmarking their coverage to a commercial plan that's already existent; benchmark equivalent; or Secretary approved. And you'll recall that at the January meeting, Joe Touschner from Georgetown presented some preliminary research that showed that over half of the separate CHIP programs are Secretary-approved coverage.

So turning now to qualified health plans, you'll recall the QHPs are required to cover at least the ten essential health benefits, and those are listed here on the slide for you. Federal regulations defer to states to define the essential health benefits necessary for QHP certification. These regulations require that states

define these benefits by selecting a benchmark plan. If states choose a benchmark plan that doesn't include one of the ten essential health benefits, a state can supplement by using the same benefit category from another benchmark.

But there are special rules in place for habilitative and pediatric services, and we're going to stay on these services for just a minute because, as we'll see in a minute, it turns out that they're kind of important. So habilitative services refer to the services that help a person learn new skills and functioning for daily living. The usual example is speech therapy for children who aren't talking but are at an age when they're expected to. These services aren't typically offered in employer-sponsored insurance, although they are sometimes covered under rehabilitative services.

So if a benchmark plan does not include habilitative benefits, the regulations provide states with four options: the state can define the benefits themselves; a plan can offer habilitative benefits at parity with rehabilitative benefits; the state can defer to the issuer or the insurer to define habilitative benefits; or a plan could provide additional rehabilitative benefits at the same value, the same actuarial values that habilitative benefits would have had.

For pediatric services, a state can supplement with a vision or dental plan available to federal employees or the benefits that are available in the separate CHIP program. You'll recall that at the January meeting the GAO presented research that shows that most states have chosen the plan available to federal employees for dental and vision benefits.

So because exchanges and QHPs are so new, there's very little research at this point on the differences across plans. One of the first studies to weigh in on the differences was the GAO study and which they presented to the Commission at the January meeting. For this study, the GAO compared

separate CHIP programs and the EHB definitions, essential health benefits definitions, in five states. Firstly, they found that most benefit categories were covered in both programs. Secondly -- and I alluded to this earlier -- where they did find differences were with the habilitative benefits and pediatric hearing services. They found that for habilitative benefits and pediatric services, coverage was really inconsistent across separate CHIP programs and exchange benchmarks. And, finally, they also found that separate CHIP programs generally include fewer benefit limits relative to exchange plans. And one small caveat to this is that the GAO was comparing separate CHIP programs to the essential health benefit definitions in each state. Exchange plans have to provide at least the essential health benefits, but can provide additional services, so actual coverage may vary.

So these differences raise some key questions, the first question being: Should benefits be similar across separate CHIP programs and QHPs? Or, more broadly, what should coverage for children look like or what should benefits packages for children look like? What benefits should be in and what benefits should be out?

Secondly, in light of the requirement that the Secretary certify QHPs as comparable to CHIP, if the differences between CHIP and QHP benefits are considered significant, is this reason to mean CHIP either in the short term or long term? Or, alternatively, should policymakers consider alternatives such as a requirement that child-only plans cover an enhanced pediatric benefit or amend the law to allow Medicaid to supplement subsidized exchange coverage?

And now I'll turn it over to Lindsay to discuss affordability.

* MS. HEBERT: Thanks, Ben.

So as you heard both Chris and Ben say, the Secretary of HHS may need to decide whether or not

subsidized exchange coverage is comparable to CHIP in terms of benefits and cost sharing, and so now we'll review some analyses we've done regarding affordability, specifically looking at whether or not the cost sharing is comparable.

In assessing the future of the program, the affordability of CHIP for enrollees relative to other forms of coverage is a key consideration.

One of the measures used in determining the affordability of a health plan is to look at the plan's actuarial value. Actuarial values measure the percentage of covered benefits that are paid for by an insurance plan for a standard population of beneficiaries. A higher AV means that the required cost sharing is lower. But bear in mind that two plans may have the same actuarial value and actually have different cost sharing.

Rather than looking at all of the plans' cost-sharing amounts across every service, actuarial values provide a useful summary measure to make comparisons.

The Center for Consumer Information and Insurance Oversight has released an actuarial value calculator that states and insurers have been using in developing exchange plans, and together with the cost-sharing information provided in GAO's recent report, which Ben has mentioned and was presented at our January meeting, we used this calculator to estimate the actuarial values of five states' separate CHIP plans.

So in Table 1, we show the actuarial values of these five separate CHIP plans. As you can see, they are all between 97 and 100 percent with the exception of the highest-income group in Utah's separate CHIP plan, which has an actuarial value of 90 percent.

Table 2 shows the prescribed actuarial values of exchange plans for individuals qualifying for cost-sharing reductions as outlined in the ACA. These would apply to individuals with incomes below 250

percent of the federal poverty level.

As you can see, in comparing the actuarial values in these two tables, subsidized exchange plans do not appear comparable to separate CHIP plans in terms of cost sharing. Even in the case of Utah, which is the outlier here, in the highest-income eligibility group, the 90 percent actuarial value is still higher than the exchange plan's required 87 percent actuarial value.

Moving now to CHIP premiums, we know that in 2012, 44 percent of children in CHIP programs faced premiums in 33 states, including some in Medicaid expansion states. While not all states charge CHIP premiums, among the states that do charge premiums, they all require beneficiaries at 200 percent of the federal poverty level and above to pay premiums. And some states require enrollees below that threshold to pay premiums as well.

We know that the amount of premiums increases with family income, and as we have talked about before, in state charging CHIP premiums, the stacking of both CHIP and exchange premiums could be substantial for families.

So some key policy questions to consider when thinking about the affordability of coverage for individuals who may be affected by this might be: If the Secretary finds that exchange plans are not comparable to CHIP plans because of higher cost sharing, what are the coverage options for kids formerly eligible for separate CHIP? And just to go back to what Chris has said, remember, two-thirds of CHIP kids are in separate CHIP plans.

And, alternatively, if the Secretary defines comparability loosely so that children may enroll in subsidized exchange coverage, how would children's access to care be affected by the increased cost sharing?

So now I will turn it over to Veronica to discuss network adequacy.

* MS. DAHER: Thank you. Okay. So another aspect to consider in the future of CHIP is its network adequacy compared with other programs, the key question being: Absent CHIP, are network adequacy requirements, which are one measure of access, sufficient or comparable in exchange plans? In this segment I'll discuss CHIP network adequacy as compared to QHPs and Medicaid.

There's a widely stated assumption that CHIP networks are better than Medicaid or QHP networks either because CHIP is built on private plan networks or because CHIP pays providers more. Despite the prevalence of this assumption, we've actually found limited information to support it.

The formal requirements for Medicaid, CHIP, and QHP network adequacy provide some of the clearest systematic information available. We also looked at access to care for Medicaid and CHIP enrollees as expressed by reported personal experiences because this can be one measure of an adequate network.

We found that Medicaid, CHIP, and QHP network adequacy provisions are similar. You'll find detailed comparisons in your background paper, and I'll go on to discuss the highlights in this presentation.

So first we looked at Medicaid managed care network, adequacy rules. Sixty-two percent of non-disabled children are enrolled in comprehensive risk-based managed care plans. Federal Medicaid managed care rules apply to these plans, as well as to Medicaid expansion CHIP. So Medicaid managed care plans must have a network of providers sufficient in number, mix, and geographic distribution to meet the needs of their anticipated enrollment, and they must cover services provided at federally qualified health centers and rural health clinics.

In addition, children covered by Medicaid are entitled to EPSDT, which means that these children have the right to any medically necessary care they require regardless of the network, but they still may face

barriers in accessing that care.

In many states, they have gone beyond the federal Medicaid managed care participation requirements. For example, most states have developed more detailed requirements for the types and numbers of providers that must be included in managed care networks.

Looking at federal CHIP network adequacy requirements, I focused on managed care because the majority of those enrolled in separate CHIP are in managed care organizations. Network adequacy requirements that apply to Medicaid MCOs also apply to CHIP MCOs.

CHIP MCOs must make covered services available within a reasonable time frame to ensure continuity of care. They must have adequate capacity to serve enrollees' primary care and specialty care needs. They must be able to serve the number of enrollees that they expect to have. And they must provide an appropriate range of services, including preventive and primary care. In addition, CHIP MCOs must assure access to out-of-network providers when the network is not adequate for the enrollee's medical condition.

States take various approaches to ensure that their CHIP plans comply with these network adequacy requirements, including making 24-hour coverage available, setting a maximum time and distance that a beneficiary must travel to reach an in-network provider, and setting maximum wait times for appointment scheduling.

So comparing Medicaid to CHIP, the same federal network adequacy requirements apply, and children in both Medicaid and CHIP have a right to access out-of-network services when it's medically necessary, Medicaid enrollees through EPSDT and CHIP enrollees through requirements in CHIP regulation.

In addition, children in both CHIP and Medicaid report that they are generally able to access the care they need in a timely manner, which could indicate that networks are sufficient to provide that care. And you'll find more details in your background paper.

Taking a look at QHP network adequacy requirements, QHP provider networks must be sufficient to permit access to care without unreasonable delay and must also include sufficient essential community providers. ECPs are providers who serve low-income, medically underserved individuals. Oversight of network adequacy and ECP inclusion depends on the exchange type, and federal standards will be adjusted again for 2015.

In 2014, to monitor inclusion of ECPs and federally facilitated exchanges, HHS will verify that the issuer contracts with at least 20 percent of ECPs in its service area and at least one ECP of each available type, which is FQHC, Ryan White provider, family planning provider, Indian provider, and hospitals in each county, and offers a contract to all available Indian providers. And they have the option to contract with a smaller percentage if they can provide a satisfactory justification.

In states running a state-based exchange, they can issue their own regulations that comply with federal network adequacy requirements, and you'll find examples of that in your paper.

So comparing QHPs to CHIP network adequacy requirements, unlike CHIP, QHP network adequacy provisions don't specifically require access to out-of-network care if the network is not sufficient for the enrollee's medical condition. In contrast with QHPs, CHIP programs are not required to contract with ECPs, although many of the programs do.

So there remains this powerful perception that CHIP networks are better than those in Medicaid or QHPs, but we haven't found enough evidence either way.

QHP network access is largely untested at this time, and regulations appear to provide similar protections to enrollees in CHIP, Medicaid, and QHPs. A fuller picture of QHP network adequacy for children will emerge in the coming months as enrollees begin to access care, and complaint tracking and network adequacy reports from consumer advocates may be the first signals of any access issues.

While some reports suggest that narrower networks are a trend in both employer-sponsored coverage and QHPs, it will be important to monitor the effects of such networks on children's access to necessary care.

MS. DAHER: So, I'll turn it back over to Chris now for CHIP Federal financing.

MR. PETERSON: So, now to the money.

[Laughter.]

* MR. PETERSON: States, as you know, just to recap some of the basics, states receive annual Federal CHIP allotments and the Federal matching rate on CHIP is enhanced relative to Medicaid. If states exhaust their Federal CHIP funds, there are actually other funds, other CHIP funds, available -- contingency funds, for example. But, it is theoretically possible for a state to exhaust all of its CHIP funding, although this has not happened since CHIP was reauthorized in the 2009 bill.

If these funds are not adequate, so that the funds that are currently in CHIP are not adequate to a state and they experience a shortfall of Federal CHIP funds, those states that have Medicaid expansion programs can fall back to Medicaid coverage.

So, the final CHIP allotment under current law will be provided October 1, 2014. That will be the fiscal year 2015 allotment. And the ACA increases CHIP's matching rate by 23 percentage points for fiscal year 2016 through 2019.

So, one of the points to keep in mind is that CHIP's authorization does not expire at the end of fiscal year 2015. States will have leftover 2015 allotments and they will be able to use that during fiscal year 2016. But, they will run out of that during the year, at various points during the year, depending on how much they are going to spend and how much leftover money they have going into 2016. Those CHIP contingency funds are not authorized for 2016, so that will not be available as a fallback, and the ACA's 23-point increase in the matching rate will cause states to run out of that CHIP money -- use it more quickly.

CHAIR ROWLAND: What was the rationale, if one was ever given, for the 23-point increase?

COMMISSIONER ROSENBAUM: [Off microphone.] Because of the differential.

EXECUTIVE DIRECTOR SCHWARTZ: That's the 64-million-dollar question.

COMMISSIONER ROSENBAUM: The differential between the -- and for separate CHIP programs, I think, the differential between what an enhanced Medicaid rate would look like and what CHIP would look like. In other words, CHIP was way lower than the enhanced Medicaid. So, it was a boost to keep the program so that people wouldn't pull out of it in 2014 because the contributions were too low.

CHAIR ROWLAND: But the money didn't change, so it means they spend the money more rapidly.

COMMISSIONER ROSENBAUM: [Off microphone.] Same money --

COMMISSIONER COHEN: I just have a question, not a big-picture comment, on the money. What does the CBO baseline assume about CHIP spending? In other words, if Congress were to say tomorrow, CHIP is continued until 2019, would that -- what would -- would there be a cost? Would there be a -- at existing matching rates, you know, if that was the new statute, what would CBO say about that, do we know?

MR. PETERSON: I'm only going to answer this because you asked.

[Laughter.]

MR. PETERSON: You asked.

COMMISSIONER COHEN: Thank you.

MR. PETERSON: So, the way that CBO does things, typically, for a program like CHIP, is because it meets a certain threshold in terms of its size, that when it ends, CBO assumes for its budget purposes that it continues at the last appropriated level. That is --

COMMISSIONER COHEN: Forever.

MR. PETERSON: Forever. Except that when in CHIPRA they came up with what we call the magic language, so that even though the last appropriated year is something like $17 billion, there's language to make the CBO baseline go down to three, so they didn't have to pay for that additional -- those out years. Because CHIPRA only extended funding for five years, CBO's window is ten years; they didn't want to have to pay for ten years.

So, it will be an issue for the next Congress to deal with, on the one hand. On the other hand, what has changed that will be less of a coster [sic] is that many of the children who go off of CHIP if CHIP ends would go to subsidized exchange coverage, which is federally subsidized.

COMMISSIONER COHEN: Right.

MR. PETERSON: So, in that sense, because an extension of CHIP would be taking kids from federally subsidized coverage to federally subsidized coverage, it may not cost as much. So, there's a couple opposite things going on here. You also have the 23-point FMAP increase, so that's going to --

COMMISSIONER COHEN: Right. Like, will CBO consider that, or no?

MR. PETERSON: What's that?

COMMISSIONER COHEN: Does CBO assume that's happening?

MR. PETERSON: Yes. That's current law. I mean, that's written into the statute.

COMMISSIONER COHEN: But past the allotment.

MR. PETERSON: Right. So, CBO assumes that after 2016, there will continue to be allotments of $3 billion a year --

COMMISSIONER COHEN: Three billion --

MR. PETERSON: -- just because that's the language.

COMMISSIONER COHEN: Right. Okay. Okay. Thank you. Thank you. I understand, I think, as much as I need to.

MR. PETERSON: Again, just because --

[Off microphone comments.]

MR. PETERSON: Okay. You know, a future Congress wouldn't necessarily have to do that.

CHAIR ROWLAND: [Off microphone.] Back to the presentation.

MR. PETERSON: Back to the presentation.

So, again, the point I want to make here, we've tried to draw this dichotomy of what happens in Medicaid expansion states versus separate CHIP states, but in terms of Federal funding, what it means is if you're a Medicaid expansion state, you are still liable for these children and for the increased state share under Medicaid if the CHIP money ends, versus states with separate CHIP programs. They are freed of any responsibility once the CHIP funding ends, although they could elect to expand Medicaid.

So, this raises key policy questions. If CHIP is extended, for how long? Should the 23-point

increase remain in effect through the duration of the maintenance of effort, which is how it is currently structured? Should that maintenance of effort actually continue, or should states be able to reduce their CHIP eligibility levels? And you could even imagine that there are kind of interactions where one could, say, do something with the maintenance of effort versus the 23-point bump to encourage certain things.

If CHIP is not extended, or if you want to put a glide path in place for a post-CHIP world, even if you decide to recommend extending CHIP, there are some other questions to answer. Should funding for exchange coverage be increased to promote comparable benefits and cost sharing for all formerly CHIP-eligible children? So, to Lindsay's point, the actuarial values are not the same. Should they be so if CHIP ends? And then, should states with Medicaid expansion CHIP programs be required to continue to enroll these children in Medicaid at the Medicaid matching rate, and what are some options around that?

So, those are the issues that we've teed up for you in the papers, that we've highlighted here around these issue areas, and I hope that was helpful.

COMMISSIONER ROSENBAUM: Umm -- yes.

[Laughter.]

COMMISSIONER ROSENBAUM: Well, this is -- first of all, it was a fantastic presentation. I mean, you really did a wonderful job taking us through the issues.

So, I'm willing to start with my take-aways from all of this, and I think maybe it would be good for us to get some take-aways up on the table before we ponder the ultimate. So, the take-aways I have -- the principal take-away is that the exchange system is doing yeoman's work right now. You know, it is sort of this -- you can see this sort of mighty engine starting up, and as it runs, all of its strengths and limitations are going to show up.

Taken together, I would say that one decided limitation that's showing up is how it's dealing with pediatrics, and I would -- and on behalf of Burt, I also throw the dental piece on the table, which we didn't even get to. It's got some real shortcomings in terms of eligibility, the points you've made very well. And even if the exchange system were fixed, even if we fixed some of it, you make the point, and I think it's really important, that there are still children who wouldn't be able to get help.

It's got some real limitations on benefits. Here, from my perspective, one of the great disappointments, I think, has been the Secretary's failure to use the authority granted to her in pediatric coverage -- under the pediatric coverage provisions to articulate a strong pediatric coverage standard, both in terms of benefit classes, which she could have done, details of benefits, prohibited exclusions, prohibited limitations, and actuarial value. She could have addressed both and she didn't.

And I think plans are totally understandably -- I can't say this for a fact, but I'm sure Donna and Richard may have more light to shed on this -- if I were a health plan struggling to allocate my cost sharing reduction assistance, I would really be trying to focus on adults with serious and chronic health conditions because they're higher users. They're costly. You want them in very regularly. And I think that we're going to see the cost sharing reduction assistance skewed toward adults and away from standard pediatrics, not to say that the copays will be horrendous, but they could be. With a $2,000 out of payment maximum, even for low-income families, you could end up with unaffordable pediatric care.

I think the network adequacy issue in CHIP has always been the canard, so I'm going to set that aside.

And so I would say that, from where I sit, exchanges are not yet ready to function as a -- from a strong pediatric policy point of view. I actually think that we erred -- collectively, not us, we didn't exist --

but somebody erred in allowing the CHIP debate to go first, because what happened was everybody said, oh, we did pediatric policy. We did CHIP. And so issues that really should have been hashed out seriously in the building of the exchanges, which might have helped us sort of in an upstream way or downstream way with things like the IRS regulation. All of that didn't happen because everybody said, well, there's CHIP.

And so now where we are is sort of this huge crossroads. I mean, it's this debate over this little program, but it's a much bigger issue, and the issue is, what do we want in the long run in pediatric financing policy? Is it a good idea to make a universal marketplace, meaning all ages, function more responsibly for children, or is it actually a good idea to have -- to keep a separate pediatric financing arrangement, maybe link the two in terms of risk pooling, but keep the financing arrangement separate, because every time children get thrown in with adults, at least in this kind of context, you worry that things will skew toward adults.

I don't think we know the answer to that. We don't know the answer to that, and I -- I mean, I've always sort of been very suspicious of separate pediatric programs. But, because we don't know the answer to it and because the exchanges are so raw at this point, and because the early evidence, as you guys suggest, is pretty weak for pediatrics, you know, particularly the actuarial value stuff, that and the -- because on the benefit classes, actually, the exchange categories, the essential health benefit categories are better.

But I would say what we really need to think about is a multi-year extension, a chance to let the exchanges mature and then a much more in-depth deliberation with more evidence on the table about whether there are real merits to keeping a separate pediatric financing arrangement in the marketplace with its own actuarial value and coverage rules, but linking the risk pool somehow, or whether we can then, you

know, once it matures, move pediatric policy into the group. So, that's where I am.

CHAIR ROWLAND: Judy.

COMMISSIONER MOORE: I want to agree with Sara and say it in a little bit different way, and that is first to say -- to repeat what she said, which was a great presentation, wonderfully structured, to help us walk through a very difficult subject.

Fifteen-plus years ago, I think we made a commitment to children's health care coverage and access, and I am worried that if we don't look at this in a transitional way, we could end up undoing a lot of the very excellent work that's been done in the states and the Federal Government by a lot of groups in reaching out and getting many, many, many children covered under CHIP. And I think now is a time of transition to a whole new world in health care coverage and access, and I don't think that we should be pushing things that we don't really understand very much about while the world is settling out around how plans and benefit design and exchanges and Federal versus state versus heaven only knows what else.

So, I would be very much in favor in the early years of ACA of maintaining a CHIP program with some thought towards how -- and some discussion towards how long that's appropriate and what the questions are to ask about where you're going in five to ten years with pediatric coverage, as Sara has said.

COMMISSIONER SMITH: I'm going to just point something out with a very big "but" on the end, because I don't want you to take this that I'm advocating for it. For a lot of the habilitative services for children, they can receive them in school, public school, and I can only speak to South Carolina, but starting at age three. I don't find them adequate for most of what they need. The requirements to qualify are very strict compared to in another medical setting and they don't -- they only provide what is needed for an educational purpose, so it doesn't encompass the child's entire life, you know. It's only for what they need

to be able to manage in school, to maintain in school. But, if I don't throw that out there, then somebody else will somewhere, so it is something for us to address, I think, is that there are habilitative services available.

I know that in South Carolina, you can sign something that says that they can charge Medicaid if your child has Medicaid. You don't have to if your child is receiving other services outside -- if they're receiving speech therapy or PT outside of school, as well, then they don't charge Medicaid, but it's just a thought, is that there are some things available elsewhere.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: I would agree with Sara and Judy's approach but put some more -- you know, the fact that only 44 percent of these kids will be able to go into the exchange, and the issue of the actuarial values and the cost sharing, begs a bigger question that's sort of the elephant in the room about how affordable are the subsidies in the -- so, it seems to me we almost have a control group to look at as we think about how these exchange plans roll out. We know that the exchange plans can have child-only plans, and maybe there's a way to design them to look like CHIP. But it strikes me that if we make this recommendation for an extensive -- it ought to be more explicit about what's the glide path that we'd be looking for. How will the Congress make the decision? You know, you can kick the can for three or five years, but at the end of that point, what are the criteria that they will use to make the decision?

It strikes me that it's a great opportunity to sort of look at some of these issues about affordability, about whether the child-only plan could be changed, the benefit structures, the dental. And it seems to me it's a great opportunity, but only if the recommendation is pretty clear about it's not just extension, it's extension with a glide path and a planning process.

CHAIR ROWLAND: I guess one question is whether there's a private option in the exchange for CHIP, which --

COMMISSIONER RILEY: Right. Well --

CHAIR ROWLAND: -- which is something we should put on --

COMMISSIONER RILEY: Yes. And in some ways, it almost models some of the private option plans, because the way CHIP operates with its cost sharing and with the -- there's a lot of learning here.

[Off microphone discussion.]

COMMISSIONER RILEY: Yes. Yes. But they ought to charge someone to look.

COMMISSIONER GABOW: I actually have two questions. I don't even know where to begin with an answer, but it sounds like in the discussion that we've had so far the assumption is that CHIP, if it went away, would somehow move to the subsidized premium in the exchange. I wonder why it can't move to Medicaid, since there are already CHIP plans within Medicaid. Are we assuming it has to directionally go into the exchange?

And then my second question is, how does a child-only plan in the exchange differ from CHIP? I mean, we now created a child-only plan in a different bin, and what would be the benefit of that? So, I'm confused about both those issues. But, otherwise, I agree that now's not the time to -- we don't know enough to pull the rug out from the existing --

CHAIR ROWLAND: And I think some of the background that might be helpful, too, is when we look at the possibility of going into the subsidized exchange, where are those kids? How many of them are they? Because we know that the income eligibility levels for CHIP do vary widely across the country and there may be different strategies for those who are closer income-wise to the Medicaid population than we

have for those who are more toward the subsidized end.

MR. PETERSON: And to your point, Patty, so, on Slide 5, that was the set-up of what is really the default in terms of what would happen if CHIP goes away, and that is the 29 percent of enrollees who are in Medicaid expansion programs, they would remain in Medicaid.

To your point, though, yes, while that bigger wedge, states would be released of any responsibility if the CHIP funding goes away, it is certainly true that those states could say, you know what? We want to expand Medicaid in the absence of this CHIP program. The challenge there, of course, is budgetary, because instead of getting, on average, a 70 percent matching rate, they would be getting a 57 percent matching rate. So, it would be, one, less matching, and two, potentially greater benefits and actuarial values and less flexibility to do cost sharing, which they might be able to get around with waivers, but those are some of the considerations.

COMMISSIONER GABOW: But assuming that if they were going to go into subsidized premiums, there would have to be greater subsidy in order to make it work. So, whether you up the subsidy for them in Medicaid or you up the subsidy for them in the subsidized premium, you're still moving money to cover them, it would seem like. And so that's why I'm not sure why we chose one direction over Medicaid.

MR. PETERSON: And it's also, remember, the state side of it. So, the state has no skin in the game, if you will, on the exchange side. So, they may be, from a purely budgetary standpoint, put them in exchange coverage and bump up those actuarial values rather than put them in Medicaid.

COMMISSIONER COHEN: Thanks so much. I'll just echo what a great and clear presentation you gave.

I will tell you that the lawyer in me was sort of craving a fifth person at the table to talk about one other topic that I think is important but is maybe a little bit fuzzy, and it's one where it really may turn out the differences aren't that significant. I think they'd be much more significant in a comparison of Medicaid to QHPs or CHIP.

But, the issue of oversight, enforcement, contract administration, and sort of enforceability of, you know, rights and things in a practical way under the various programs. So, CHIP is, in many states, much more like a private option, in some states, Department of Insurance overseen more or entirely rather than Department of Health, and that may be similar to what a lot of QHP oversight looks like. But, there is variation in the states.

And just sort of like the specificity of state regulation, again, the enforceability of different provisions, like, it's one thing to say that there are network adequacy standards where the words look similar, but what that really means in terms of what happens when a kid can't get a doctor's appointment. Is there someone to call, does the state have a responsibility? Does it exercise a responsibility to intervene? I think those are really important questions that get to what is truly the experience on the ground of being a member of something in a CHIP market versus a QHP market.

And I realize, like, there are some overlapping and maybe sort of multiple issues there, but I do still feel like that is a piece of the analysis that I would love to understand a little better, or at least to have some sort of comment around when we do make a sort of larger statement on this point.

I feel like the conclusion that Sara started with is, at least to me, somewhat inescapable, like the thing -- but I might articulate it a little bit backwards from the way it's been articulated. If you sort of do the analysis of what would happen if CHIP ended as the statute provides it to end, we would have some drastic

holes and changes for the children who are currently on CHIP, and so significant that I think people -- I think the Commission would agree, kind of contrary to decades of public policy prioritizing child health coverage and, you know, and untenable.

So, the question really sort of is -- to me -- if you assume that, you can't just let CHIP end and have no other policy. The choice is either extend -- is either to extend CHIP or to develop some other policy that will fill in those holes. And then the question sort of becomes, for how long, you know, how long will that take? Is it realistic? I mean, we are in a political environment and we really do have to think about that. And what exactly those changes would be to sort of move the policy forward.

But I kind of start with this. The question is, if we sort of did nothing and just let CHIP end, what would happen? What would happen from your presentation is a pretty dramatic drop-off in coverage and benefits and affordability for children, really contrary to, I would say, a national policy that's been exhibited over a couple of decades to prioritize children's coverage.

And then the next question is, well, then what? Maybe we're not ready yet to answer all the policy questions that would have to be answered, and so there's a period of sort of transition and extension for CHIP.

CHAIR ROWLAND: For the children that were moved from separate CHIP programs into Medicaid, they moved with the CHIP matching rate, is that right?

MR. PETERSON: Yes.

CHAIR ROWLAND: So, is it another policy issue, if you're extending it, what the matching rate ought to be on those children? I mean, or should they be treated the same as the -- you could conceivably go forward with a CHIP policy that treats the Medicaid expansion one way because it's permanent and the

separate programs another way as part of the phase-out, because, obviously, these transitional issues don't occur when they're already in the Medicaid program.

Sara. I'm sorry.

COMMISSIONER ROSENBAUM: I do want to reiterate that while I think sort of the -- from the presentation, the conclusion is relatively inescapable, whether you frame it the way Andy did or you flip it around and frame it the way I started off. Either way you come at it, you have this sort of inescapable conclusion. But I do think we need to think seriously about the circumstances that should attach to another three years of funding or four years of funding or whatever it's going to be, because, I mean, there are some very significant issues.

I absolutely appreciate, Robin, the point you made about habilitative services in schools. If I showed you the unending line of insurance denial cases about habilitative -- I mean, in a standard policy, it's just not a covered benefit. And there is no protection on benefit design. There's less protection on benefit design in CHIP than there actually is in a qualified health plan. There's much better actuarial value protection, but I think a lot of that is also not just because of the lower threshold, but because all the reduction is being distributed only to children as opposed to across the family.

There is the issue that Andy raised, which is, you know, that CHIP is aggregated financing. It's not an individual entitlement, which means you can have wait lists, which means we should be recommending something, such as the premium subsidy, as a back-up according to CHIP rules in the event that you hit the limits on the CHIP aggregate financing.

So, we've got a lot of work to do --

CHAIR ROWLAND: Yes.

COMMISSIONER ROSENBAUM: -- because I think CHIP, as it stands now, has really serious deficiencies that have shown up because it's being juxtaposed against other changes that have happened, like premium assistance, like the essential health benefit package.

So, I just didn't want to leave unaddressed this issue of what does the extension look like? Should there be an extension is a question, and then another question is what does the extension look like.

COMMISSIONER CHECKETT: Well, I think it's not only a great presentation, but an extremely interesting discussion, and I think as terrific as CHIP has been and was a huge step forward, it's just very important for us to recognize that, you know, I think when you line things up at this point, it doesn't have the breadth or protections that we see people getting if they're on either Medicaid or they're in a qualified health plan. And I think it makes sense when you look at where it was in the history of the program, but we need to look at where we are now.

It really concerns me, and, you know, so many nuances, but just when somebody said, wow, we could wind up having kids on a waiting list because they're in a state that has a CHIP program, that's not acceptable. I mean, there just -- to me, that's just not acceptable. You know, it's just craziness.

And so I really appreciate the complexity of it and I also feel, you know, working at this point in time in a company that's in the throes of experiencing the ACA across, literally, much of the company, there's just so much chaos that I think we also need to move with caution and not destroy anything, but also not just let something go on in perpetuity whose time may have come and gone. So, my thoughts.

CHAIR ROWLAND: As I just said to Anne, we also need to think about, going forward, the children that are in the Medicaid part of CHIP and have been put into Medicaid are in a very different situation than the separate CHIP and it may require looking analytically at those as different groups and

what the choices are.

Any other comments? Sharon, I'm sorry.

COMMISSIONER CARTE: That's okay.

CHAIR ROWLAND: I thought you had nothing to say about CHIP.

COMMISSIONER CARTE: I really -- I don't. I'd just like to say, thank you, thank you, thank you, and thank you, as others have said, for the thoroughness and the completeness of this. I think it really has helped many of the Commissioners maybe look at CHIP with new eyes. I think those of you who have heard me talk about it before know that I've felt strongly that we do need a multi-year transitional approach due to the scope and the complexity of these issues.

CHAIR ROWLAND: Any other comments?

[No response.]

CHAIR ROWLAND: Well, I think that you have done a remarkable job, both coordinating all of your remarks and laying out such great presentation. Obviously, we have a lot of additional issues that we will continue to face, but I think it's a great -- we've got a great CHIP team there, so thank you very much.

And now we'll take a brief break, and we're ahead of schedule, so we'll convene at three. We're what? We're ahead of schedule.

[Recess.]

CHAIR ROWLAND: If we could reconvene, good luck on that. We're now going to look at the assessment of need for long-term services and supports, an area which we have begun to really try and dig deeper into how to proceed on really looking at a better way to provide these services both to the disability community that is dependent on Medicaid as well as, obviously, for the issues it raises for the dual-eligible

population. So, Angela, why don't you kick us off?

Session 7: Assessment of Need for MEDICAID Long-Term Services and Supports

* MS. LELLO: Yes, good afternoon, and today we'll be hearing from a panel of experts on Medicaid long-term services and supports, and as Diane mentioned, this is a continuation of the work you've begun on long-term services and supports.

As you recall, enrollees who use LTSS are a small portion of the total number of enrollees, but they use a significant amount of -- account for a significant amount of Medicaid expenditures, about half. And since September, you've heard from the Chair and Vice Chair of the Commission on Long-Term Care who discussed their recommendations around uniform assessments in LTSS, and your discussion in December also focused on the needs of enrollees who use long-term services and supports. So today's presentations will highlight the role functional assessments play in service planning and eligibility determination and how assessments are used to identify those LTSS needs.

Our panelists -- Lisa Alecxih from The Lewin Group, Chas Moseley from the National Association of State Directors of Developmental Disabilities Services, and Jennifer Mathis from the Bazelon Center for Mental Health Law -- will discuss how assessments vary across states, populations, and service delivery systems. And you will hear about the methods states use to identify the unique needs of enrollees with diverse conditions. So hopefully information from the session should feed into the foundational chapter on Medicaid's role in providing LTSS, which should be included in the June report.

So with that, I'll let Lisa start us off.

* MS. ALECXIH: Good afternoon. Thank you for having me. Can you hear me okay? Okay. All right. Let me see if I can get all the technology working.

So as Angela mentioned, LTSS assessments are used for a variety of things. It can be screening, level-of-care determination for waivers and other Medicaid authority eligibilities, support plan development, sometimes resource and budget allocation, and then quality and outcomes is a newer area that they've been focused on.

Kind of the domains that generally get covered are on that left-hand side, and then the Balancing Incentive Program domains, which had some core elements that those states need to include to receive their enhanced federal match, kind of parallel those pretty well.

I wanted to put this a little bit in context in terms of your role with Medicaid, but also that piece which is dual. So if you look at the universe of Medicare and Medicaid enrollees and you try to look at long-term services and supports users within that, you know, there are only about 5 percent of the combined Medicare and Medicaid enrollees, but they account for about a third of the spending when you look at both Medicare and Medicaid. And most of the time we're looking at just the Medicaid or just the Medicare. But if you kind of look at it as a whole, they're a small group that has very high spending. And they're also, as you all know, a very significant proportion of the ones who are enrolled in both, Medicare and Medicaid enrollees. But the other piece of it that -- so this includes those who are using Medicaid home and community-based services or in a nursing facility or an ICF/MR, and it includes Medicare beneficiaries in a nursing facility, even if they aren't on Medicaid.

So there's another chunk of people, about 15 percent of Medicare beneficiaries, that have a functional impairment but aren't receiving any type of Medicaid home and community-based services. They may be receiving assistance from family and friends. They may be getting Older Americans Act services. And then there's an unknown number of Medicaid beneficiaries who aren't qualifying for home and

community-based services who probably also do have functional impairments, but we don't have good estimates for that.

And the reason this is important is because identifying functional status is something that might be useful beyond long-term services and supports, because we only identify people who have a functional status need if they present to the system and they get assessed and we qualify them for eligibility. There are lots and lots of people out there who don't actually present to the system who have a functional need, and as this graph demonstrates, their spending and their likelihood of being really high spenders is much greater than people with multiple chronic conditions and no functional impairment. So it's a very important marker for service intensity and use, and it just is ignored by the medical system. There's no place to check this person has, you know, issues with mobility or functional impairment or anything like that.

And, you know, when you think in terms of dual eligibles, Medicare and Medicaid enrollees, people who aren't on Medicare and Medicaid have just as high spending as the people who are on Medicare and Medicaid if they have functional limitations. So if you segment by institutional or some community -- or community with some functional impairment, the spending levels for those populations are very similar. They're different sources of spending, different sources of payer, but they're just as service intense.

So that brings me to four recommendations related to assessments. One is in agreement with the Long-Term Care Commission and not necessarily in agreement with Chas, which he will do next, but that's charting a path to a nationwide uniform electronic long-term services and supports assessment, and, you know, in deference to where Chas will go, you know, maybe that means there needs to be modules for different populations and additional detail if you trigger in a certain way. But the fact that we have, you know, not quite 50 but, you know, there's probably only a half a dozen states that are using the same

assessment tool and not for all the same populations for long-term services and supports has just hindered us in our ability to understand what's going on in the system and really doesn't allow us to move forward because we lack data a lot.

I also think that there should be at least some minimal functional status information as part of medical claims somewhere. It could allow a proactive approach if -- you know, if a physician or a nurse practitioner, someone who is providing services to an individual notes that and that, you know, if we get far enough along in electronic health records, somebody could be notified of that, there could be some proactive interventions that could prevent further deterioration that we don't have the ability to do right now because, again, it's a system where you have to present to the system.

The third recommendation revolves around developing an evidence base for linking the resources for long-term services and supports, both the types of services and the amount, to desire outcomes. Basically that's really difficult with existing data because you've got these historical allocations. You know, they get X number of hours a week if they meet X criteria, and it's not really need driven; it's, you know, precedence or historical practice driven. And it may actually require a demonstration in order to actually figure out, okay, what is the right service mix and intensity in order to get the best outcomes?

And then the final recommendation is to continue this momentum toward a person-centered interdisciplinary team approach to how we're dealing with long-term services and supports, behavioral health, and the acute-care system.

Thank you.

CHAIR ROWLAND: Thank you.

* DR. MOSELEY: Thank you very much. It's a pleasure to be here.

I just want to start from the very beginning, that I don't -- it's not that I'm against functional assessments by any means. I think that everything has its place, and there are some areas where functional assessments can be extremely helpful and others where they're probably not.

I am with the National Association of State Directors of Developmental Disabilities Services. Our members are the 51 state agencies, 50 plus the District of Columbia, across the country, and we work very closely with them, providing a wide range of supports, technical assistance, around Medicaid, around systems change, around assessment development, and other types of activities.

All states use assessment processes to determine the need for long-term supports and the character of the supports that are furnished to the people who receive them. There's a couple of different types -- functional assessments that we're talking about that tend to identify specific physical, intellectual, or cognitive differences or limitations; and support related, those identifying the supports that are needed as a result of the disability. The Support Intensity Scale that was developed by the American Association on Intellectual and Developmental Disabilities is probably the one that states are leaning towards most at this point. The ICAP is a functional assessment tool that many states have used, and there are several others, the InterRAI and others that states are looking at.

Increasingly states are turning to standardized measures to make sure that people are receiving the same quality of assessment, no matter where they are in a particular state, what region they're in a particular state, and also so that a state knows that a particular tool that it's using was used successfully in other states.

As Lisa mentioned, assessments are used for a variety of different purposes: eligibility, identifying support needs, identifying the presence of physical or mental conditions, intellectual functioning or adaptive functioning, identifying the level of risk for hospitalization, out-of-home placement, threat of harm to self

or others. And, increasingly, state DD agencies are using assessments for prioritization for urgency of need. As most of you know, the waiting lists in DD services are extremely high. I think the Kaiser Foundation numbers are around 244,000 people. Data gathered by the University of Minnesota is about half of that. But several large states don't report their numbers, so it's pretty hard to tell. So many states find them themselves in the position of really needing to prioritize whose needs are the greatest today at this point in time.

Service utilization, individual funding allocations, system and outcome performance, the national core indicators is now being used by 40 states across the country to identify the performance of the service delivery system and a whole series of personal and systems outcomes. And, of course, the assessments are used to inform the person-centered planning process.

I think it is important to note that people become eligible for benefits based on the presence of a particular disability or condition, but they request services based on the lack of supports in their lives. Assessments cannot adequately control access. People typically entered the system -- and the DD system I'm speaking of -- during periods of crisis when their current support systems are no longer able to meet their needs. Assessments that focus only on functional deficits may miss the fact that services that people generally need are frequently social in nature. They're not medical and they're not therapeutic, but they're really other types of supports. And many times the immediate needs that people have may be able to be addressed not necessarily by the delivery of a service but, rather, by the delivery of an item such as a clothes washer.

People who need long-term supports basically need sort of four categories of service. One is direct support to enable them to access, participate in work, family life, community activities, through personal

assistance that compensates or works around their functional limitations, somebody to roll your wheelchair into the grocery store, for example. Training and education to strengthen an individual's functional abilities to enable them to perform activities or tasks, to get employment, hopefully with less external support. Treatment, folks do have co-occurring conditions at are very high rate. People with intellectual disabilities, in fact, about one-third, 33 percent, have mental illness and significant numbers of other disabilities. And ancillary services, such as transportation, adaptive equipment, environmental modifications. If you talk to people with disabilities directly about what they want and need, almost invariably they will say transportation is one of their key areas.

Functional assessments are deficit based and focus on the problems or physical conditions, and service needs are extrapolated from those. Assessment of service needs, by contrast, directly looks at the challenges that people experience in their lives, and the assistance that they need to participate in society, to go to work, to carry out their activities of daily living. And people with the same functional deficits may have drastically different service needs. You can imagine a person with significant disabilities living in the home of a family that is an extended family, with aunts and uncles and everybody else around who can participate and help the person with supports. You might have the same person -- we call them "developmental twins" -- who have the same needs but lives in the home of a single mom who works eight hours a day and has two other kids, and the support needs for that individual may be significantly greater.

Functional assessment assumptions are based on the idea that people needing long-term care share certain characteristics, and standardizing the design of the assessment and services will standardize the outcome. But in reality, the needs for support and treatment and training differ for each individual, and they change over time in response to personal and environmental factors. The emphasis on achieving

uniformity of care can actively inhibit the ability of the system to meet each person's unique life situation. Standardizing the approach can make it virtually impossible to take advantage of opportunities for natural support that are in the community that might enable a person to make it on their own with fewer publicly financed supports.

Person-centered planning assumptions, the person receiving support is thought to be in the best position to determine the nature of the supports that they need and to define the role that the service provider will play in their lives. Support must be balanced to enable a person to get a life, addressing things that are important to the person and things that are important for the person to make it on their own.

Planning involves a focused discussion of the supports that a person needs to participate at work or in the community or in the family.

Functional assessments typically identify the specific disabilities or functional limitations, as we discussed, frequently administered by neutral parties who are considered to be conflict free -- ideally anyway -- without competing interests or responsibilities. They're performed by someone who's generally unknown to the person, introduced for the purpose of providing the assessment, such as an evaluator or case manager, and provide data that can assist in the planning process, and some of that data can be very important. They may provide also information for use in developing funding.

Person-centered approaches, by contrast, the planning process is led by the person receiving supports or by the person who's chosen by the individual. The planning team has a continuing relationship with the individual over time. The team works with the person to identify support strategies to enable him or her to have a satisfying and productive life. Service needs and support needs are identified through a structured process that uses a series of person-centered planning tools, and this slide has a quick shot of

several of those that really help to structure the conversation around what is important to the person, what kinds of things will help you in life in terms of people and relationships, things to do and places to go, and what's important for the person. And this really focuses on issues regarding health, prevention of illness, issues of safety, and what others see as being really necessary for the person to become a valued contributor to society.

Appropriately designed, computerized, universal assessments can effectively gather information on eligibility and in some cases can identify service needs, but they should not take the place of assessments for specific treatments or for person-centered -- or take the place of person-centered service planning. The functional assessment should inform but never supplant the person-centered planning process.

How do we know that people are getting what they need over time and they continue to get their need? CMS requires states to monitor services delivered to make sure they address a series of waiver program assurances, and there are certainly other programs through which states fund service to individuals. I highlighted the waiver because that's where the majority of folks are receiving their funding.

They ensure that -- states must ensure that people get what they need consistent with the person-centered plan. Each state has a quality management system that focuses on discovery, remediation, and improvement with their provider entities. And functional assessments typically aren't used to assess service utilization in this way. Reviews generally focus on the person-centered plan and the related documentation to determine the extent to which goals are achieved in discussion with the individual.

Each person-centered planning meeting evaluates services and supports. The plan itself is used as the basis for reviewing services as well as the quality of services that the person receives. And, again, focusing back on what is important to the individual so that they can get a life and feel good in society, and

what is important for them in terms of meeting the functional deficits that they have.

The second question there -- and I've mentioned it several times now -- is: Do the services really enable the person to become a contributing member of society, as in the Olmstead integration mandate, in the most integrated setting suitable for their needs?

Thank you.

* MS. MATHIS: Hi, I am Jennifer Mathis, Bazelon Center for Mental Health Law. We are national nonprofit here in D.C., and we do a lot of policy work as well as litigation around primarily community integration issues, Medicaid, and the Americans With Disabilities Act. So I am going to give you sort of a broad frame, really talking about assessments of need and assessments of choice, since I think both of those are things that we are routinely assessing in the processes that we have.

I would say I think it's fair that, you know, typically assessments don't reflect accurately people's needs and choices as they exist in a lot of places. They will often reflect, I think, you know, that people have a certain set of limitations and that they, because of those limitations, will live in a place where we typically put people with those limitations. And, you know, sort of a very different thing than some of the stuff Chas is talking about with, you know, sort of doing a process where it's driven by what somebody wants and giving somebody the opportunity to have a normal life, you know, as we often talk about sort of living -- people with disabilities living like people without disabilities.

And I am also focusing, to some extent, on assessments of settings, what setting people should live in, in part because, you know, those assessments I think are largely driving what package of services people will get, and the kinds of services that you get will look dramatically different based on the kind of setting that you live in.

So I thought it was useful to start with just a slide about sort of what's the purpose of the assessments, what are the goals, where are we trying to get to with this. Chas mentioned Olmstead and the integration mandate. That is very much, I think -- you know, what should be the goal of the assessments is getting people to live in the most integrated setting and to have the same opportunities as everybody else. These principles that I put up actually came from a document called "Key Principles of Community Integration," and it's in the materials, and it's just a nice one-page document laying out some of the principles that people should live in their -- or should have the opportunity, if they want, to live in their own home and to have control over who they live with, how they live, what they do during the day; people should have the opportunity to work, et cetera. And these are all principles that are agreed upon, embraced by 28 national disability organizations, including Chas' organization, the developmental disabilities directors, as well as the state mental health directors, and some of the, you know, big, major disability groups. I think they're pretty much all on these key principles. There's widespread consensus that, you know, this is where we want to go with our service systems, and this is what our assessments should be trying to get us to.

You know, the other piece is choice. We talk about needs and choice. How is choice supposed to be determined? You know, in the key principles we said people with disabilities should have full and accurate information about the options, including not just the services but what does the financial support look like. If you're going to live in something like, say, supported housing, people ought to have the opportunity to visit settings, like integrated settings, supported housing settings, talk to people, to peers, people with disabilities who live in those types of settings now. If people have concerns, they ought to be able to get the concerns explored and addressed. Too often I think it is sort of a one-off: Do you want to live in this type of place? No. And, you know, people have many reasons, legitimate reasons why they

might say no when maybe if they had more information they would say yes, including, you know, that people sometimes just don't know really what you're talking about when you say "supported housing" or to have a mobile crisis team or an ACT team and, you know, need some information about what that means, what it looks like. People have sometimes lived in similar settings before and failed, and they didn't have adequate supports. And so now what you're talking about is something a little different, but they don't know what it means and what it looks like. People have been told in many cases, you know, you can't do that, you're not going to make it on your own, you failed before, you know, you need to live in a kind of setting with, you know, structure and supervision and that's kind of where you belong. And so for all of these reasons, I think people really need to have good information and the ability to see and talk to people, talk to people who live in these places. Sometimes they have virtual tours so that people can at least look on the computer and understand what it is that you're talking about.

I often divide things into old think and new think or old thinking and new thinking. That's how we think about it at the Bazelon Center when we've worked with states kind of transforming their systems, and it's kind of -- I think there are some key principles that really reflect how things were done versus how things are starting to change and be done now, with old thinking -- and this still happens in, you know, a lot of assessments around the country. There's very much a focus on deficits, and you understand what people's limitations are. You don't get a whole lot beyond that often. You get, you know, you need help with this or that, you need help with your activities of daily living, you need help with your instrumental activities of daily living. Often it reflects, you know, the limitations that we have actually imposed on people. If we have people in institutional settings for a long time, you know, they're not doing their own shopping and laundry and cooking. It doesn't mean that they can't. Maybe they need help. The longer

they've been there, the more help they probably need to gain back skills that they've lost. But, you know, we do assessments, and they reflect that people don't have these skills. And so we say, oh, they don't have these skills and so, you know, they're not capable of living in a more integrated setting. And so that's sort of old think.

There's a big focus on levels of care and scoring, at least in the mental health world. We have a tool called the LOCUS, the Level of Care Utilization System, which is, you know, used in different ways, but it used to be used and still is in many cases used to say basically, well, if you have a score between this range and that range based on all these questions we ask you, this is the kind of setting you belong in, you belong in a structured residential setting. If you have a score between this range and this range, then you can live in your own apartment. And it's really very different from, I think, where we want to get to, sort of current thinking, which is really, you know, starting with the presumption that people can live in their own homes with appropriate services, and figuring out what would it take. And, you know, maybe some people can't, but you work backward from there, if you start with the presumption that you're talking about having somebody live in their own home, that's what they want, you know, what specific services would they need, not just what problems do they have, not just do they need supervision, 24-hour supervision, supervision for what, what kind of tasks are you talking about, you know, could it be done in their own home? If not, why not?

And actually defining the circumstances in which the presumption that people can live in their own homes can be overcome, if you have that current thinking.

Also, includes determinations that a person can't live in his own home should be supported by specific information about what services are needed that couldn't be provided in that setting. And that is

often because maybe they're not in the state Medicaid plan. Maybe they are, and they should be provided, but they're not available. Maybe it's something the state wants to do.

Without that kind of information -- and it is typically not reflected in these types of assessments. Typically, the assessment comes out looking like this person has bipolar disorder; therefore, this person needs prompts and needs significant help and needs supervision and, therefore, belongs in this kind of setting and these kinds of services.

You never get to, actually: What would it take to support this person in her own home? What kind of supports would she need? What does she need help with? What does she want? And how can we do that? And, if it can't be done, sort of what is it that she needs that couldn't be provided in her own home?

That will help with actually planning service system better, figuring out what the gaps are, identifying the gaps in the service system, rather than just, as I call it, blaming the person and saying the problem is this is a person with a lot of limitations as opposed to the reason we can't serve her is because we don't have these things in our service system.

But, when you start doing that on a regular basis with you assessments, you will have a better idea of what it is, what are the themes, what is missing, time after time in your service system that doesn't enable people to live in their own homes or with the supports that they need.

And this is a little small. I apologize for that. I just took a set of assessment provisions from one of the Olmstead settlements.

I think my main point was that there are a lot of these Olmstead settlements now. A lot of them are on the Justice Department's web site, and some of them have actually some nice specific kinds of models of what I'm talking about, where you start with a presumption that everybody can live in their own home and

then you might have some narrow circumstances that you have to define of when that presumption might be overcome.

So these are, I think, the standard things that tend to come up and sort of the reasons why you might overcome that presumption -- somebody who has significant dementia, somebody who would be a danger to self or others in their own home even if they're receiving services, somebody who needs skilled nursing care that can't be provided outside of a nursing home or a hospital, or somebody who needs a kind of service that just isn't available from any funding source. And with that, again, you want to know sort of what that service is.

And then, finally, just going back to choice, I wanted to highlight some key principles about choice that are actually consistent with what I talked about at the beginning -- you know, our vision about how choice should work.

This is from Senator Harkin's HELP Committee report from a few months ago on Olmstead, and in that report they actually highlight a bunch of things that they think are key elements that will ensure that people have meaningful choice when they are assessed.

And that includes, again, sort of educating people sort of on an ongoing basis, not being a one-off but actually going -- and this is certainly in the context at least of people in institutions already, who might come out, but kind of the need to have an ongoing process where you are not just asking somebody one time but building trust and building a relationship so that maybe today they might say, I want to stay here and get what I'm getting, and then six months from now they might tell you what they really want, actually, or might have enough courage to feel like they can do something else.

Providing opportunities, again, for people to visit and talk to folks who live in those settings and

actually developing sufficient capacity so that when people are making the choice, that the housing exists and services exist.

I think that what often happens -- and there are some studies about this, that assessments tend to reflect what's available. And so the more that you can actually do assessments in the context of actually available housing and services, the more that those assessments will sort of more accurately reflect what people would choose.

And then, finally -- I can't read that.

Yeah, in fact, I just dealt with the last bullet. So that's it, and I am probably just a little over my time.

CHAIR ROWLAND: Oh, thank you very much.

Clearly, looking at how to match individuals with both the eligibility for programs that they need but then with the services they need within the program remains a huge challenge. We've always been talking about what triggers eligibility for the Medicaid benefit and, then beyond that, for the services.

I'm going to open it up to some questions now.

Trish.

COMMISSIONER RILEY: Where to begin? It seems to me we've been talking about assessment and what's the appropriate assessment for at least 40 years, at least as long as my career. So it would be nice to get some closure.

I'm trying to get my head around all of this, and I've been studying IDD a lot lately and trying to learn more about that.

I'm not sure, I guess, that I see a differentiation. I see the value of assessments, and I loved Lisa's presentation because I think we've got to begin to think about integrating medical.

It's not an assessment -- we're sort of user-based. We look at use as opposed to need or strengths.

And what we really need to do is restructure this to think from a baseline, what are the both health and support needs that people have, and integrate health and support. And I'd like to do that across populations, recognizing that there are differences.

So, inarticulately, as I am, I don't necessarily see the difference between the sort of functional assessment and person-centered assessment because I think you've got -- in many ways, the person-centered focus and assist doesn't include the physical health, from what I understand.

To me, there's almost a differentiation between the assessment and the care planning process. And the assessment is some way to be fair and equitable about what kinds of levels of services or expenses or costs we can afford, at what different population. Then the care planning, it seems to me, has to be far more person-centered within some kind of umbrella.

So I don't see the two as necessarily separate, and I'd be intrigued to know more about the balancing incentives single assessment.

I'd also like to know more about -- it seems to me it's not only important to have some kind of standardization about assessment given that we live in a world of limited resources. And, how do we equitably care for people who needs supports and services?

But I'd sort of be interested in knowing something -- and I forgot where I was going. Sorry.

Oh, to think more globally about the total expenditures for these populations, not just long-term services and supports, not just waivers, but think about the total expenditure.

And we may need a different set of services. It may be almost a managed care kind of approach because it seems to me if you were going to do one single thing in serving this populations it would be to

recognize housing is health and to begin to invest more in housing and different kinds of activities.

So, inarticulately, let me sort of just summarize. I'd like to know more about the single assessment and then who does -- in your worlds, who would do the assessment and who would do the care planning.

MS. ALECXIH: Okay. I wanted to respond to one thing you said in terms of just a little bit of a caution around getting the medical involved. I do think it's important, but we don't want the medical to take over, and there's --

COMMISSIONER RILEY: [off microphone.] I guess I meant incorporate.

MS. ALECXIH: Yeah. So on the BIP core assessment, there are certain questions that CMS is requiring the BIP states to include in assessments across populations, and that's as far as they went.

They did not say they were going to require the same assessment across populations. I think that might have been where they started, but they backed off because of state concerns.

So states are taking different approaches. Some of them are uniformly kind of going through all the different assessments they do across all the populations, mapping them to each other and trying to figure out, okay, do we go with a whole new way of doing it, or do we just stick in a few questions in each of them and do it that way?

So there are different approaches states are taking to that.

And there's another aspect of the question that --

COMMISSIONER RILEY: [off microphone.] Who does it?

MS. ALECXIH: Who does it?

COMMISSIONER RILEY: [off microphone.]

MS. ALECXIH: State-specific, you know. In aging and physical disabilities, there are some states

who require a physician certification, and there are some states that have social workers go out and do the in-person assessments, and some states have combined those two. In Washington State, their assessment is two and a half to three hours long because they're doing both the determination of whether they're eligible and the care planning process or supports planning process. It varies.

COMMISSIONER RILEY: [off microphone.] providers versus independent assessment in care planning.

MS. ALECXIH: What tends to happen when the providers are doing it, if it's a physician, it's more like a check-off; or, it's like five or six questions, and it's more of that approach. There are not that many states that are still doing that.

And CMS has been very clear about the need for an independent assessment, and so there's much less of like the providers who would actually be providing the services actually doing the assessments for eligibility.

UNIDENTIFIED SPEAKER: For all populations.

MS. ALECXIH: Yeah, yeah.

DR. MOSELEY: Although it's not --

MS. ALECXIH: It's not 100 percent.

DR. MOSELEY: It's not 100 percent. As you know, you've been to one state, you've been to one state.

It seems to me that it's important to go back to the purpose. What do you want to gather information for?

Do you want it for demographical purposes, eligibility purposes? That's sort of one constellation of

questions.

Do you want it to set rates? That's a different purpose for an assessment.

If you want to set allocations for individuals coming in, regarding how much money they're going to be allowed to receive services, or do you want to determine the nature of the services and supports a person will receive?

Each one of those is different, and the use of a particular assessment that's good for gathering data for statistical and demographical purposes may not add value to the process of determining how much you're going to spend for that person or what their life is going to be.

So, when we talk universal assessments, I have had several conversations with people about this, and sometimes they're structured really as multiples of assessments that have the same face plate, but under the hood they're actually quite different. And you have a different one for DDs, a different one for aging, and each one digs into the specific nature and needs of the folks receiving services.

And the idea is to do it in a way that is affirming to the individual.

In our system at least, we have talked -- and I'm talking not one system but 51 -- that families frequently feel abused at the end of an assessment process. They feel like they've just been run over by a truck.

The first question that's asked of the person is, do you need help going to the toilet? And this is an adult who may be working or they may have a life, and that's not what's important to them.

What's important to them is, can I see my girlfriend? Can I go to work? That type of thing.

So I think as we think about assessments we have to really think about the impact of whatever is done on the person who is the recipient of those assessments, obviously.

I have had some conversations with some folks who are really working hard to do sort of a universal assessment, but it sounds like as they're kind of going through the process they're creating a lot of sort of back doors.

So, if a family member, for example, is coming to a state DD system and really only wants respite, they can get respite and be on their way. But, if in fact they have a whole lot of other needs, the process itself will allow them to move into a person-centered planning process.

In that way, the structure of the assessment appears -- and I don't know. I haven't been through it in detail yet, but it appears to really support a person to have more options in their life to where they can really get involved in care.

And one of the things I've heard mentioned around person-centered planning is, okay, you talk to somebody about what you want and what you need, and they tell you they want an SUV and they want to have a boat and they want, you know, blah, blah, blah. How do we keep this in control?

And state DD agencies, by and large, have separate systems to identify the cost of services. And those are either based on historical costs, which I think are notoriously inaccurate, or they can be based on a funding model that looks at how much providers are paying for particular staff to provide a particular service and then project a cost from that. Other states have come up with rate-setting systems.

But the two kind of lay next to each other. So the planning process is done within a subscribed -- prescribed amount of funding so it doesn't run off the other side.

MS. MATHIS: The one or two things I would add -- just, I think in the mental health world, certainly, service planning is done by providers with assessments. Really, it's all over the map because it depends not only state by state but where the person is, where you're coming from and where you're going.

It might be a community service board or a base service unit or whatever it's called in different states. It might be an institutional doc or something who's doing it.

But, ultimately, the providers often are involved really in a practical sense. Somebody else may be doing the assessment, but then there's a negotiation process with the provider, where it really comes down to kind of can you serve this person or a negotiation of do you need extra stuff and what is it that this person would need -- which is, I think, separate from service planning.

I'm thinking really sort of a separate process being done once somebody is in a place and sort of having a much more detailed conversation about what the service needs and desires are for service planning than for the assessment process.

But I feel like the providers are certainly involved in both in mental health.

And, yes, there is conflict-free assessment now so that it's not the same providers necessarily who will serve the person. But it seems like in most of the systems that I've seen there is still significant provider involvement in both of those processes.

And, as far as the universality of assessments, I think to me certainly it's less of a concern about sort of what the specific questions look like because they would look different for different populations. They're going to have to look different in a lot of ways and in different situations.

But, really, sort of what the frame is -- and that's why I tried to focus on sort of where you're trying to get to because that really is kind of what tends to be missing in a lot of the assessments.

I mean, we could come up with a universal form. And one of the fears that I have is sort of as we move in that direction is that some of the good work that people have done to actually get to assessments that really are framed in the right way goes away when we have some universal form that looks the same

everywhere, but it's not necessarily good.

COMMISSIONER HOYT: I'll try to more articulate than Debbie. I mean Trish.

[Laughter.]

COMMISSIONER HOYT: So where I get confused is I feel like the way the question is being posed is sort of like I'm being asked to choose between having a person-centered approach versus moving towards a uniform assessment type tool, whereas, in my mind, it seems like instead of either-or it should be both-and.

COMMISSIONER RILEY: That's what I was trying to say.

[Laughter.]

COMMISSIONER HOYT: So my thinking was I can't see a reason why this wouldn't work or you wouldn't do a functional assessment per se.

I think we get hung up on the word, needs. So what does this person need functionally in the behavioral health sense of acute care because of their disabilities?

That would be the starting point so you'd have all the different needs that they have.

Then the next question is, what do you need the Medicaid program to do for you?

So, depending on where you sit in a family structure, or it might vary geographically or urban versus rural. I don't know.

Then those needs would be considerably different, and that might even drive eligibility or certainly what the person is going to cost, but I don't see why we'd be thwarted in a goal to have a uniform kind of assessment across the states.

DR. MOSELEY: And when you say uniform assessment, what exactly do you mean?

COMMISSIONER HOYT: I mean this might be Pollyannaish but move towards a single assessment tool that would, if possible, always be administered by the same type of agency or group of people, but a single -- you know, the way the recommendation is written, an electronic assessment tool about what their needs are.

And then like, what do they need the Medicaid program to do for them?

But there are different categories of people, where the needs are all the same, but personally -- and that would be the personal planning -- not everybody needs the same level of assistance from the Medicaid program.

DR. MOSELEY: When I think of a functional assessment, I think of those tools that identify particular conditions or disabilities a person has, whether it's an intellectual disability or a head injury or specific impairments.

And, typically, when people do those -- the ICAP is a good example -- there is then an assumption made from that that if you have quadriplegia you're going to require these types of services.

And so what some people did when they developed this support intensity scale was to acknowledge that the functional disabilities, or the organic impairments, may or may not have a direct impact on a particular service need. So what they wanted to do in their tool is to ask a whole series of questions about what are your needs for support.

And so several states have seen that as a way to get a better handle on how they should be designing their services.

I think, from there, then you kind of take the next step around the person-centered planning, to say, okay, you've got these needs; how do we address those needs in the context of both your life and the service

delivery system itself? And, kind of work from there.

I'm not sure if you're saying I've conceptualized those as a single -- as part of -- as multi-stages of a single assessment or if you look at them as three different assessments.

I think they can be constructed in such a way that you have a basic core set of data elements that are gathered, whether it's one assessment or four assessments. If they're all gathering the same data elements, you'll be able to summarize those across and do the demographical analysis that you may want to do.

I don't know if I'm responding to your question or if I'm just --

COMMISSIONER HOYT: Partially. I might not be asking the question as well as it could be asked.

I think just given the nature of how much money is spent per person it's inevitable that people are going to drive towards a better understanding of the age-old question of: Well, this is what I spend. What do I get? How does this compare to other states?

And it's just extremely frustrating to the federal government or the state treasurer or the Medicaid director or whoever, that a lot of times you get into these discussion and it's like: You know what? I have no idea at all how this compares to anybody or even these quadriplegics, what we spend, because people want to know, how can we spend our money more efficiently and deliver medically necessary care?

DR. MOSELEY: I completely agree with you.

COMMISSIONER GABOW: I think I'm following on you in some way, but I think in the more easy-to-do part of health care, we've really been struggling with defining value, you know, and saying, well, how do we integrate cost, quality and outcome?

I think there's even more of a struggle in this terrain, but it has to happen, I think, because of the

cost and because we don't know the quality and the outcome very well.

And it appears that if you're going to start to try to define value in those three dimensions, that there has to be some standardization. I don't know how you determine value without some hard data in each of these categories.

So while it's tempting to let everything be individualized and sort of a craft, an art form, I don't think that's going to work over the long haul.

So I think something -- and maybe you're going to have to help us as a group to think what that is. But without some construct --

DR. MOSELEY: I think you're raising a really good point. About in the mid-1990s, our association, in collaboration with the Human Services Research Institute, basically at the push of our directors -- and I was a state DD director at the time -- developed the National Core Indicators, and the reason they were developed was because state agencies -- state agency directors, DD agency directors, were saying at that point -- a lot of you will remember it was our first national flirtation with managed care, and directors were coming to meetings and saying, you know, "My governor and legislator are not asking me how many people I'm serving. They're asking me what difference it makes, and I don't have any data for it."

And so the purpose was to come up with a series of outcome indicators that looked both at systems issues and at things such as personal choice. Are you working? How much are you making? What do you do during the day? Do you like your staff? Are people responsible? A whole series of -- there's over a hundred indicators that were developed at that time, and they are adjusted so that you can do state-to-state comparison data. And it is systems outcomes. Although they're based on individual outcomes, they're systems outcomes.

But a whole lot of work was done with the DD agencies at that time to come up with a mutually agreed upon set of core background questions that look at co-occurring conditions, types, and frequency, look at age, sex, all of the demographical variables, as well as a whole series of other indicators.

We're expanding that. There's 40 states doing it now. We've got some funding from ACL to expand that to all states. We're talking to the people in the aging community about doing a similar tool that has the same basic demographical questions for both populations, but we'll have more specific questions that are relevant to outcomes of people who are aging in the aging and disability network.

And so the idea was to kind of expand out in terms of outcome indicators on just what you're saying, the common set of questions -- not common for all, but at least the key piece will be. And I think going into it, you're saying that as far as an assessment tool, it would be really nice to know kind of what states are looking at, and I think as a researcher, that will provide a lot of really good data to allow you to compare, because you can't -- it's really almost impossible to compare one state to another. And when we look at the core indicators outcome data, one of the strongest variables that causes -- that you can -- predictor variables, for example, is the nature of the state itself. So states have different variables based on their service delivery systems -- excuse me, different outcomes based on their service delivery system.

COMMISSIONER SMITH: The topic of disabilities in general is just so broad, there's so many variations, and it's just a very complicated subject, so I don't envy anybody trying to come up with a single assessment tool. But one of the things I am -- when I'm looking at this and it's person centered, what do you do when -- or what are your thoughts when there's someone with a severe cognitive disability? Dementia also falls into that. I dealt with that with my dad. But that's sort of not what I'm talking about. Someone with a cognitive disability who is very child-like doesn't have the ability to process or even learn

much past perhaps toddler, or less. Where does the family come in in this process, especially at the end of the assessment, making decisions and things like that? Because I'm seeing person centered, but when you have a person who really is not capable of making decisions, then what?

MS. MATHIS: Yeah, and I think obviously to some extent this is kind of a state-by-state issue in terms of what state guardianship laws or other laws that legal representatives say in terms of the roles that those folks play should play in this process. And I think it's probably more an issue that the DDA folks have explored. I mean, it is an issue for mental health as well, although I think it's less of an issue, but certainly in your world I think there is sort of a set of kind of ideas about, you know, how to best make something person centered when you do have maybe a guardian or a parent.

DR. MOSELEY: That is our world. People have intellectual disabilities, and while having an intellectual disability doesn't mean that you're unable to determine the events of your life by any means, it does mean that many people either have guardians or they need others to help them in the decision-making process.

The person-centered approach is really based on the idea that, to the fullest extent possible, the person should be able to decide who's going to be in their lives, as I mentioned, and what the role of the service provider is going to be in their life.

The team concept really rests on the assumption that you're going to bring in your family members and others. If you don't have families, providers and state agencies have been, working with the advocacy agencies in states across the country, have been good at identifying guardians ad litem and other people who can come to the person-centered planning process and try to figure out what the person wants and needs.

I've been in the business for over 40 years, and I've never met someone who -- people always know

more than you think they do, and people are always able to contribute more than you think, even when you think you know them. And so I think a lot of time is spent on figuring out how best to relate to the person and to communicate with him and to find out everything that you can about them so that when you plan a life for them, it will be done in the most integrated setting.

The DD system has a very strong philosophy and values base that kind of goes back 30 or 40 years and talks a lot about community participation and valued social roles and that type of thing, and those help people who maybe are not family members in the decision-making process to figure out kind of what's right and what works for this person.

MS. MATHIS: And there is certainly, I think, a greater interest now in things like supported decision making and kind of moving away from having a guardianship model, to the extent possible, to having that be the last resort, and really doing much more of a model where you have somebody working with a person who may need help in decision making rather than just making those decisions for them.

COMMISSIONER SMITH: And why wouldn't the family that raised the person not be the people to make those decisions? I'm coming from family-centered care, you know, health model. I have adopted a child who is significantly cognitively disabled, and the idea that somebody else is going to -- it just makes my head spin. I'm sorry. I was not prepared --

DR. MOSELEY: It's always --

COMMISSIONER SMITH: I wasn't prepared for this, I guess.

DR. MOSELEY: No, I mean, the family's always the first.

MS. MATHIS: Exactly.

DR. MOSELEY: The only time --

MS. MATHIS: I think it's sort of a "with" versus "for" issue --

DR. MOSELEY: Yeah. I mean, you wouldn't bring in other people unless the family wasn't available, there was no family. It always defaults to the family first.

COMMISSIONER SMITH: Then I'm misunderstanding, because I'm making -- I feel like you're saying that my child would know more and be able to make his own decisions and be able to say, "I don't want to live with them," when he raised him and he -- I mean, would you let a toddler say that? I just -- I'm not understanding.

DR. MOSELEY: Yeah --

COMMISSIONER SMITH: I'm talking about cognitive disability, severe.

DR. MOSELEY: It's not in place of the person, and in the DD services, there has been a lot of discussion focused on the individual. But that doesn't mean that you ignore everyone else.

COMMISSIONER SMITH: So, where is that in here, though? I'm not seeing family included in -- we sort of -- I heard a little bit here and there come up, if they have a family, but I'm not seeing a focus. I mean, to me, it seems like that would be the first thing we'd be seeing in here, and -- and I'm not seeing it. So, it concerns me that it --

DR. MOSELEY: Well, please don't take the slides from a ten-minute presentation and expand too far beyond those. The family is a very key part of the person-centered team and the person-centered planning process. We're right now working with five states -- six states -- to expand the ability of state agencies to support people with disabilities and the families that they live with. Person-centered planning is a key part of it, but it is done within the context of the family and with the full support of family members.

People with IDD -- more people are served -- more people with IDD, 58 percent who receive

public financing, are living in the home of a family member, and we all need to recognize the incredibly important role that families play, and there's no intent in the person-centered planning process to ignore that --

COMMISSIONER SMITH: I'm just not seeing it reflected in the language --

DR. MOSELEY: Understood, yeah.

COMMISSIONER SMITH: -- and that concerns me, and I'd like to see it -- family -- reflected in the language.

DR. MOSELEY: Mm-hmm.

COMMISSIONER SMITH: I think it's important.

DR. MOSELEY: Mm-hmm.

COMMISSIONER SMITH: I think most people with cognitive disabilities, unless they're in a very dysfunctional family, would want to be with their family.

DR. MOSELEY: Oh, I agree with you. Yes. Totally.

CHAIR ROWLAND: David.

VICE CHAIR SUNDWALL: Okay. Well, thank you. This is another example. Every time we get into a topic, we find out how complicated it is. It's not simple, and it's not -- obviously, this population is challenging.

My question is this. We heard, as you know, from representatives from the White House Commission on Aging, or what did they call it, Long-Term Care, and it was interesting, but the main message I took away was this vigorous plea for the Commission to help them get this simplification and uniformity and assessment. And what I've heard today is not supportive of that. Am I wrong? Maybe I'm

misunderstanding your message, but I hear that it is so important that the individual be the center of how they're assessed that you really can't have uniformity in assessments of their capacity or of their needs. Maybe I am just misunderstanding. Do you support their recommendation?

DR. MOSELEY: I haven't read the recommendation, to tell you the truth, and maybe I'm not articulating clearly or I'm not saying what I'm hoping I'm saying. I think there are different assessments for different reasons, and if you're going to look at the various characteristics that states might use to determine eligibility and look at the functional need, I think probably a universal assessment could be very helpful in that.

I had an extended conversation -- I mentioned it earlier -- with the folks in Minnesota last week who are developing and had spent a lot of time on a universal assessment that is composed of several other types of assessments, and what they were putting together made a lot of sense to me. Where I begin to feel nervous is when the assessment of the physical conditions a person has then jumps right into person-centered planning. And what I was really intrigued by, what the person was describing the Minnesota model to me, what I was intrigued by was the fact that they basically said there was kind of an open door, and if the family really wanted to go to a person-centered planning process through this other assessment, they could do that. So, they could kind of move from one right into the other, which sounds like a pretty good deal to me. I haven't -- I don't know enough about it yet. This was just on a call last week.

So, I think assessments for determining eligibility, doing demographical [sic] background of people make a lot of sense. Looking at the service needs, I think there frequently needs to be more discussion. When I've talked to people who are using the support intensity scale, which is all about identifying service needs, many of them feel that the constellations of needs that come out of that process really don't -- and

this is family members -- really don't approximate what they want services to be when they sit down and design the services. So, I think those tools can inform the person-centered planning process. I just don't think they should supplant it.

CHAIR ROWLAND: Go ahead.

COMMISSIONER COHEN: Can I just -- what I'm struggling with a little bit is the concern that the services available do not match the needs and desires of the person and their families, when that's appropriate, and it's really about a match between the available services and the desired services, because I am still struggling, and I think many of us around the table are, with this question of why the, again, the assessment, and maybe historically, assessments have been completely focused only on the available services, have been designed and driven to drive you to ceratin kinds of narrow services, which are not the services that are needed necessarily, and that is the concern about having such assessments. But, to me, it strikes me that the issue that you're describing is really the issue about the available services and not about the assessment.

MS. ALECXIH: No. I think the distinction is, there's assessment for eligibility, and that, I think we are in agreement, could be standard. It could be universal. It may have to differ --

COMMISSIONER COHEN: Eligibility for what?

MS. ALECXIH: For services.

COMMISSIONER COHEN: For a given program.

MS. ALECXIH: For a given program. So, to receive home and community-based services or even nursing facility services, or ICF/MR, you have to have a certain level of need --

COMMISSIONER COHEN: All right --

MS. ALECXIH: -- you have to need some function --

COMMISSIONER COHEN: So, not a tailored thing, like are you eligible for X service or Y service --

MS. ALECXIH: No, no, no --

COMMISSIONER COHEN: -- but are you eligible for the program.

MS. ALECXIH: It's for the program, in general.

COMMISSIONER COHEN: The program. Right.

MS. ALECXIH: Okay. So, that, I think, that could probably be standardized nationwide and we'd be in a much better place than we are today. It may need to vary a little bit by population, you know, like there's probably 20, 30, maybe 40 percent that could be the same across all populations and it needs to branch a little bit because there are different needs among different populations, depending upon --

DR. MOSELEY: And different eligibility requirements.

MS. ALECXIH: Right, and different eligibility requirements. So, I think that's one aspect. But then when you get to the point where you're going to work with a person as to what they need -- what supports they need, that's where you really do, ideally -- and actually, CMS is supporting this -- is you want to flip to sort of a strength-based approach, a person-centered approach. What does this person need to have a life, as Chas said. You know, it's not -- and that can vary -- that varies dramatically from person to person, independent -- probably not independent. You know, it's still dependent upon what the functional eligibility types of needs are. But the other types of things in their life and what's important to them will drive what service needs.

If I don't need to go -- you know, if I don't want to go to school and I don't have to go to school

legally anymore, then that would not be something that you would try to support within the context of getting them transportation to get to school and that kind of thing. I don't know if that helps.

DR. MOSELEY: And I think --

COMMISSIONER COHEN: And you're worried that -- do you mind if I just play this out for a second? Am I stepping on someone's toes? Are there others in line?

CHAIR ROWLAND: [Off microphone.] There are others in line, but --

COMMISSIONER COHEN: Are you sure? You're concerned that if there's some standardized assessment and the standardized assessment says, you are eligible for a constellation of services which might include supports going to school, and this person says, umm, that's actually not for me. I'm not required to do it. I don't want to do it. But some day, that program is going to be judged on how many people who were eligible for school support services actually got them, and some concern that there will be, like, a quality ding because that person didn't receive them. Am I playing that concern out correctly?

DR. MOSELEY: No, I don't think so. I think with the concept of person-centered planning, it's some basic questions -- what do you want? What do you need? What's important to you and for you? So, one person says, I want a job, and so when you assess the extent to which those services did what they were supposed to do, you look at the person-centered plan and it said, this provider is going to enable me to get a job. Some person-centered plans are very specific. They'll put 90 days in there. A job needs to be found within 90 days.

And then -- and some states will treat it pretty much as a contract between the person and the provider. Did you offer these services? Did you enable the person to get a job? Did you provide case management? Was there therapeutic services delivered four times a day -- a week, like they're supposed to?

Did you receive transportation to go into the community on the weekends, as you're supposed to? A whole series of different goals and very clear objectives that are identified in the plan.

And if when the state goes in to do their quality assessment they find out that, in fact, that didn't take place, then they go back to the provider and say, we've identified X-number of people -- typically, there's a statistical sample that's drawn of a provider agency and they will look at the findings in terms of strengths and weaknesses and deficits that a provider has, all going back to the person-centered plan plus other state requirements around health and safety and that type of thing.

I think the danger is, and what people are really worried about, because we've had this in the past, was you'll do an assessment and as a result of the assessment, you'll say, well, you need four hours of day habilitation every day. You need two hours of case management a week. And the people will be locked in.

COMMISSIONER COHEN: And then the provider will be judged on that rather than on whether the person's goals were addressed.

DR. MOSELEY: Yes.

COMMISSIONER COHEN: Got it. Thank you.

DR. MOSELEY: Yes. Yes.

COMMISSIONER COHEN: Got it.

CHAIR ROWLAND: Norma.

COMMISSIONER MARTÍNEZ ROGERS: Okay. I'm going to go along a little bit with what Robin was saying. I hear you talk -- you mentioned that you had worked with Minnesota. The people of Minnesota wanted to do an assessment tool. And this process, you're all talking about assessments. What I have not heard from any of you all, or maybe I missed it, is that where was a consumer or a family member

of the consumer, were they ever asked about the assessment? What is it that would be best for them in an assessment? How could their needs best be met? Were there ever done any focus groups with them? I mean, not every consumer has an intellectual disability. So, I'm just -- and a lot of consumers have family support, live with their families. So, I'm wondering, has that been, because I have not heard that mentioned at all.

MS. MATHIS: Yeah. Well, I think that's, I mean, a big part of, certainly, the choice piece and how you build in choice. That's about asking the person. That's about making sure that the person has the tools that they need to actually make a decision, that somebody's not just coming and saying, you know, you could have this or you could have that, but, you know, actually having the person go visit places, having the person talk to other folks, having the person understand.

COMMISSIONER MARTÍNEZ ROGERS: I guess I'm talking about, since if you want to standardize, standardizing this assessment, which is what I heard that you -- or make it universal, which is what Minnesota was trying to do.

MS. ALECXIH: Yeah. And the Minnesota process did involve the participants of the programs in a very extensive way, and a lot of the states that are doing the balancing incentive program look at, you know, they've got the agency-level folks and they've got the local-level folks, but they also have people who are getting services from the programs.

DR. MOSELEY: Yeah. And this is just -- this is really hard stuff. I mean, Minnesota has been working on it for eight years, and they're -- and they're still working on it.

MS. ALECXIH: [Off microphone.] And that didn't have to do with just developing --

DR. MOSELEY: No, you're right. There is more.

MS. ALECXIH: -- had a lot more to do with IT than it did --

DR. MOSELEY: That's right.

VICE CHAIR SUNDWALL: Diane has empowered me to take over, so I have now Trish and then Sara.

[Laughter.]

COMMISSIONER RILEY: [Off microphone.] I'm going to try this in English this time.

VICE CHAIR SUNDWALL: [Off microphone.]

COMMISSIONER RILEY: It strikes me that, you know, what's the problem we're trying to solve here, and the uniform assessment has value and the ability to do comparatives state-by-state to be equitable about resource allocations. So, to me, it seems terribly important.

But, I hear and agree that it seems the problem isn't the assessment, but, again, the care plan and the process to do that, because it seems to me that what we want to avoid is the cookie cutter, everybody gets these kind of services. We want to avoid what it sounds like the system may be, which is service-driven rather than person-driven. So, to that degree, I could almost envision a uniform assessment, some kind of care planning activity where the care manager or the care planner with the individual has some flexible dollars as opposed to dollars that are allocated to specific kinds of services, or only that.

So, I was intrigued by your, Chas, allusion that -- and it would be outcome-driven. So, you do an assessment. You determine some kind of level of -- maybe an aggregate level for a group of people, of costs. And then you determine a set of outcomes for each individual and have some flexible money to be able to fill gaps in what may not be available in the service system today.

So, I was intrigued by -- you made some allusion to state-by-state, you see different outcomes based

on the kind of state. Can you tell us more about that? Where are the better outcomes? From what kinds of states? What do they look like?

DR. MOSELEY: Yes. The National Core Indicators is a system that has been going for 15 years now, and by the way, if any of you are interested in looking at state data for your state or any state, the website is www.nationalcoreindicators.org, and you can pull down the reports. Everything is on there. In fact, you can make your own report. If you want to see how many people with intellectual disability -- what percentage of people with intellectual disability in Maine have employment written into their support plan, it's in there.

So, that kind of information -- I've just forgotten your question.

COMMISSIONER RILEY: [Off microphone.] -- the state-by-state differences --

DR. MOSELEY: Oh, the state-by-state difference. Yes. Yes. States have different --

COMMISSIONER RILEY: [Off microphone.]

DR. MOSELEY: Right. Yeah. Hey, I'm with you.

[Laughter.]

DR. MOSELEY: States have different eligibility requirements. Looking at intellectual disabilities, for example, in the past, eligibility required a diagnosis of mental retardation, now intellectual disabilities, period. After the DD Act was passed in, what was it, 1974, it created a new definition of developmental disabilities, and over the years since then, more and more states have expanded their eligibility from intellectual disabilities only to include developmental disabilities. Some states have gone full DD, and so they're serving approximately three percent of the population as opposed to -- or that's our catchment group -- one-and-a-half percent of the population.

Still other states will have eligibility that is intellectual disability and autism, or people with intellectual disabilities and Prader-Willi syndrome, or people with intellectual disabilities and autism as long as they have an IQ of 70 or below. So, there's a big difference in eligibility requirements in states.

So, who comes through the door differs. There's about -- most states, the criteria is an IQ of 70 or below. There are two, I believe, who have more restrictive eligibility. You have to be 55 IQ or below to get public services.

So, this is a long way of saying that states are quite a bit different. States have the waiver program, but each waiver program is constructed differently. So, in some areas, you can get supports to families. In others, it's much more focused on specific kinds of programs and services. Some states will have capped waiver programs which will have a dollar value, say, $20,000, and they're completely designed to serve people in their own homes. There's no residential services. Others will be --

So, anyway, you have these big differences in states and the result is that you have states will spend different amounts on a per capita basis for every person with disabilities, and they'll have different service configurations. The average number of people per place right now, people with disability per residential setting, is about 2.4, and that ranges from 1.1 up to about 12, I think, in one state. So, those have cost implications, as well.

COMMISSIONER RILEY: I guess that was my question. Is there any way to look -- make apples-to-apples comparisons, so I can look at a state that has a definition of eligibility like mine and see what their service program is like --

DR. MOSELEY: Yes.

COMMISSIONER RILEY: -- because that doesn't -- I'm trying -- you mentioned outcomes. I

mean, who has the better --

DR. MOSELEY: Right.

COMMISSIONER RILEY: If I look at a similar person in state A and state B, can you tell me that one state does better on outcomes?

DR. MOSELEY: The only tool that does that is the Core Indicators, and basically, when you look at the, say, choice of residential setting, it will list all of the states who gathered data on that during a year. It'll show you the mean percentage of people who had choice versus no choice. It'll identify the states above the mean and below the mean and provide that data. State agencies have found that really helpful because they look at where they're below the mean and then identify that to improve in the future.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: So, I want to go back, actually, to Robin's question, because I think she touches on something that's really complicated, and the question is what should we, as MACPAC, do with that complexity.

So, of course, throughout the document, when each of you talks about persons and individuals, I assume, and your answers have suggested, that it is essentially implicit that where individuals are -- and I'm using the word legally, obviously -- where they're competent to express their own needs and desires, they do. Where they are not legally competent to express their needs and desires, they -- you use an alternative process that has someone who is empowered to represent them stepping in and playing that role.

Where, you know, where it's parents and minor children, that's one set of complexities, because while children are legally minors, obviously, their needs and desires are very important. Where it's parents with adult children with disabilities, it's another complex set of considerations. I'm sure you all, you know,

are completely aware of the sensational case we had in Virginia where there really was a complete break between what the grown-up daughter wanted for herself and what her parents wanted for her in terms of her living arrangements.

And I guess the question is, that complexity of how one resolves personhood questions in assessment situations, I'm just wondering whether as the Commission -- as we start down this assessment pathway, whether we've got to think about that a little bit and bring in, you know, and get another layer of analysis about what the approaches are, what the models are for how states deal with personhood questions, because so many of the individuals we are talking about have very complex -- there are going to be very complex personhood questions, and I don't know whether there are models for dealing with that and we've just sort of glossed over it here because we're assuming that issue in our use of persons.

I mean, for example, Bazelon, I assume, you have a lot of thought about what is a model way of coming at the complexities of people who are unable for age, for disability, for other reasons, to speak for themselves --

MS. MATHIS: Yes.

COMMISSIONER ROSENBAUM: -- but whose needs and interests have to be taken into account.

MS. MATHIS: Yes. Exactly. It's sort of a whole -- it's almost like another report, is what I'm thinking. It's just --

CHAIR ROWLAND: It's another panel.

[Off microphone discussion.]

COMMISSIONER ROSENBAUM: [Off microphone.] And that's what I'm asking --

CHAIR ROWLAND: Judy.

COMMISSIONER ROSENBAUM: [Off microphone.] --

well, I can't -- we haven't dealt with it and I think it's -- we have not dealt with it here, and I just want to be sure, since this is an on-the-record hearing, that we are clear that we have not dealt with this question here. And so as we work on this problem, we have to deal with the issue that Robin raised at some level.

MS. MATHIS: Yeah, and it may be that, you know, what makes sense for you in this context in this report is to kind of reference the issue, say something about it, it is an issue, and it's just, you know, it's so complicated that you wouldn't -- I mean, getting into it, I think, in any detail in this kind of report, it's, like, it's going to take over this report, so --

COMMISSIONER ROSENBAUM: Right.

MS. ALECXIH: But the other thing to potentially consider that we did not talk about is assessment as it relates to the role of the family caregiver and whether the caregiver should be involved, not even not only just as part of the assessment, but assessing their needs and what supports they might need in order to best support the --

COMMISSIONER ROSENBAUM: [Off microphone.]

MS. ALECXIH: Right. And they should be.

COMMISSIONER ROSENBAUM: [Off microphone.]

MS. ALECXIH: Yeah, and they should be.

COMMISSIONER MOORE: Okay. Thank you all very, very much. I think we need to have you back another time, and we certainly all need to think very carefully about this, and I want to bring up one -- another issue that occurred to me a little while ago, and it may be an impolitic question, but I seem to recall

that provider communities are very important within the context of these services and assessments. And I know that states are getting away from providers of a service doing assessments, and that's -- I think that's the way it should be.

But there are so many different kinds of providers. There are states that are providers that have small and large institutional settings or other kinds of gate-keeping services that are more or less intensive. And as you move towards person-centered approaches, I suspect that the status quo and what has been and what providers and state agency folks have come to expect is discombobulating, to say the least, and I wonder if you can just comment on the extent to which person-centered approaches are a tough road because of that or how you -- how we, maybe, should consider that as we go about looking at these more standardized approaches that I think we come to looking at equity concerns across states as much as anything else.

DR. MOSELEY: Person-centered planning has been going on in states since the 1980s, in state DD systems. The concept was pulled into the 1915(c) waiver regulations and applications and is really designed around the idea that you have a person-centered plan.

Providers, by and large -- well, what I can say is I haven't heard any real discussion of difficulty getting providers to do person-centered planning unless it is around the funding of it, because you do need to have somebody who knows what they're doing to run the person-centered planning process.

There was, in the developmental disabilities world in the late 1990s, the Robert Wood Johnson Foundation funded a series of self-determination pilot projects in states. I was a director of the program -- co-director of the program, and we worked with several states to help them develop person-centered planning systems that were led by the individual with the idea that the person would control the dollars that

were allocated on his or her behalf. And in some cases, that totally involved the family. In fact, in most cases, when dollars were involved and the person was actually the supervisor of the staff, the person with disabilities, families were directly involved for the intellectual disability group. So, I think it's something that the DD systems generally know pretty well.

There's been kind of two approaches. Some states have said, we're going to put regulations requiring person-centered planning, and other states have said, we're not going to do that because we don't want to endorse a particular model. We want it to be changeable over time and continue to improve, which is sort of the philosophy of what you do.

The process itself has been -- there are several consultants out there. Michael Smull is known really well for what he's done in this area, John O'Brien, Beth Mount. There are several people who have written extensively about the person-centered planning process. So, it's pretty well understood by both states who use that as really the core of their quality management program.

CHAIR ROWLAND: Okay. Well, I want to thank the panel very much. You've obviously given us a great deal to think about, to discuss, and to further prove that nothing in the Medicaid program or in long-term services and supports is without complication and without diversity, and we will appreciate being able to reflect upon your comments today and obviously have you also follow up with us in the future. So, thank you very much.

And now we will move to look at issues of Medicaid and public health, and Amy Bernstein will join us to talk to us about the work in progress on a chapter on Medicaid's role in public health.

Session 8: MEDICAID and Population Health: Policy Issues

* MS. BERNSTEIN: Thank you, Diane. So you've heard a lot of complicated issues today, and this

last one I think was particularly complicated, and now we'll move on to something easy and really simple to understand.

CHAIR ROWLAND: At 4:30.

MS. BERNSTEIN: At 4:30, so please bear with me.

CHAIR ROWLAND: You certainly set yourself up for a big test, Amy.

[Laughter.]

MS. BERNSTEIN: Okay.

CHAIR ROWLAND: We've been waiting all day for this presentation.

MS. BERNSTEIN: The best is last. That's what we say.

[Inaudible comment.]

MS. BERNSTEIN: Well, it is, it is. And so briefly for this presentation, let me remind you that in December you did ask us to investigate this issue, and we were given the charge of investigating the relationship between Medicaid and population health, and you saw a panel in January that had three experts that talked about various things: screening, CMS initiatives, and sort of how the Medicaid program can deliver non-medical services.

Briefly today I'm just going to define population health quickly, talk about what Medicaid now is doing to promote the health of the Medicaid population, describe some of the new ACA provisions that relate to population health, and then present two areas for discussion where there actually are some policy levers that you might want to consider.

Let me remind you that the paper that is in your materials is not the chapter. It is not a draft chapter. It's an issue paper that is designed only to sort of stimulate your discussion, and if you decide to

have a chapter, it will be, you know, based on what you tell us and what you want to include.

So just for the record, to set this into the transcript, population health can be defined as "the health of a population as measured by health status indicators and as influenced by social, economic, and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services," and probably some other things as well.

Studies have shown or at least estimated that less than half of health, however measured in the study, is actually due to the provision of medical care. So -- sorry?

VICE CHAIR SUNDWALL: Ten percent [off microphone].

MS. BERNSTEIN: Well, the estimates range from 10 to, you know, 35 or 40, depending on how you define health, which is not a standard definition, and what else you include. But basically not all of health is determined by medical care, and population health is more of a philosophy, really, than a thing. Basically, when you're looking at the cost-quality-outcome paradigm, it starts with the outcome, that the goal is to have a healthy population, and you want to do things that make the population healthy. And one of those things is medical care, but there are other things you can do. And you've heard about many of them today, and you've heard about them in the context of the Medicaid program in general. The Medicaid program provides many services that are not curative or treatment of medical conditions, and the goal of that is to promote health.

So when we're talking about Medicaid and its relationship to population health, I sort of had to narrow the scope a little because, you know, we can't do everything and Medicaid can't do everything. And when you're talking about the social determinants of health, which are implied by that definition, you know, when you're talking about environment and education and early childhood development, you know, the

Medicaid program can't provide all things to all people.

So one of the things that it would be helpful if you would think about in this discussion is sort of how broad you want this definition of population health to be. Are you concerned with the health of the Medicaid population? Are you concerned with the health of people who might qualify for Medicaid? Are you concerned with the health of everyone and what Medicaid might do for the United States population? And those are, you know, as broad or as narrow as you would like to make it.

But what I did for this presentation in terms of discussing the possible policy levers was to define it as the sort of non-treatment-oriented services that Medicaid can provide that promote, improve, and maintain the overall health of its enrollees while improving the health of the population overall. So these are things that the Medicaid program could do.

Now, if you want it to be broader than that, then certainly please let us know.

So just very briefly -- and this is all in the paper that's in your book -- there are many things that the Medicaid program is doing now to promote health that are not the treatment of medical conditions. As you heard from Sara Wilensky last month, they provide preventive benefits, and we'll talk about that a little bit more later. They do counseling. They educate people about healthy lifestyles. Tobacco cessation, you know, counseling is a mandatory -- for pregnant women is a mandatory benefit. They provide incentives for providers to encourage healthy behaviors and practices through ACOs and CCOs. You know, in some long-term services and supports, they can help improve the built environment. They do address some social determinants of health through various ways, and these are not always provided by medical practitioners.

And there are several vehicles through which the Medicaid program currently provides these services. There are mandatory and optional state plan benefits. Medical care including some preventive

screening and other practices are provided as mandatory benefits, although it does vary by -- well, they're not always consistently defined. I won't say they vary by state. They are mandatory. There are optional state benefits as well that have preventive services, counseling, other things. The EPSDT program is probably the most comprehensive program, and the EPSDT, as you know, was initiated because it was noted that people entering the army had conditions that could have been treated or prevented that, you know, was interfering with our military force. But it is designed to prevent future problems that children might have, and it is supposed to provide all necessary services, not just medical treatment services.

As you know, waivers and demonstration programs provide many long-term services and supports, but also many other programs that you heard about last month that CMS is providing in other presentations. The use of administrative funds was mentioned by Dr. Cha when he gave his speed talk last month on using the smoke quit lines -- it's very fast, so I'll tell you -- but, yes, the Medicaid program, there was a ruling from CMS that they actually could use administrative funds to fund smoking quit lines when people called in. Enhanced pregnancy benefits, which can be anything from coupons to counseling to nutritional services, can be provided to pregnant women. Managed care contracts can provide non-medical services that promote health as part of their contracts with the state, and the July rule that was also mentioned last month allows physicians to refer to non-traditional providers of services for non-medical services that may promote health, doulas being an example.

The ACA in its initiation also included a lot of emphasis on population health, and there are many provisions in it that promote population health over and above providing actual medical services through exchange coverage and increased coverage in general and Medicaid expansions.

I'm just going to go through these really quickly. There are mandated benefits both for

immunizations for children and for women that have been proved to be effective, and these have to be provided with no cost sharing. Other preventive benefits include a lot of outreach campaigns, wellness programs, demonstrations to states and grants to states, and a 1 percent increased match for states that provide all of these mandated services. So there is a movement to do more of this type of thing.

So that said, two issues that sort of emerged both from the discussion at the last meeting from the panel discussion and from the ACA initiatives, and from other things that kept sort of occurring to me were areas where Medicaid actually could -- not necessarily change, but things you could think about that could be possibly improved to increase the provision of these services. And the first has to do with Medicaid preventive benefits.

So as you heard from Sara Wilensky last month, the ACA does have these mandated benefits that I just ran through very quickly, but this does not apply to the existing Medicaid programs. So as Sara described to you, there are many provisions -- it is possible for states to provide preventive benefits, but a lot of the language is not clear. So it could say something in the state plan amendment like, "Provide all necessary services," and it's not clear which services they would be.

An example that's coming up with the essential health benefits has to do with screening for colonoscopy, and colonoscopies are quite expensive. But the question is whether you can have screening colonoscopies or whether you can only have diagnostic colonoscopies, and if it's not written specifically into the state plan, it's not clear which one of those you can get, so -- because, you know, it's basically a required service for a certain population. So, you know, it's like what is the age limit? You know, do states only have to provide fecal occult tests and then if that's positive then they have to do a colonoscopy? So it's ambiguous what they have to cover, which may have to be covered in the new adult group and in exchange

plans.

Again, another example that Dr. Wilensky told you about last month was whether a service is age appropriate. Well, you know, for some services age appropriate is defined differently. There's different screening recommendations, and the question is which recommendation they take. So if a Medicaid plan says we provide an age-appropriate immunization, you know, the question is, well, what does that mean?

And then there's just confusion about whether preventive services are medically necessary, and sort of by definition, if it's preventive, then you don't have a treatment yet. So there is confusion about that, which Dr. Wilensky described to you last month.

So things that could happen to sort of alleviate this confusion are listed on this slide, which are you could -- or CMS could say or some one could say cover all Medicaid enrollees for the same things that everyone else is covered for. Well, again, I don't know quite what the mechanism would be, but it would be possible -- and that was something that she mentioned as well, would be to clarify exactly what was covered and how it should be covered.

Advocates. Someone could advocate for improving the education of beneficiaries about their rights, so there could be public education campaigns that help beneficiaries or enrollees know that, yes, I can get this service, and go tell their physician that they should provide it to them because that would be a good thing to do.

Promote methodologies to make it easier to claim the 1 percent FMAP increase. Right now states basically -- my understanding is that states basically sort of say that they do this and have to sort of provide claims data that says, okay, we've provided all of these necessary services, and then tell them the amount, and then they would get a 1 percent increase. But how they would actually provide this information is not

clear, and it's sometimes very complicated to actually go through all the claims data and figure out which are the preventive services and which aren't the preventive services and which are the ones that are mandated. So it would actually be a lot of work for states -- or for some states to do this, so there could be more guidance on that.

There could be more guidance on what is medically necessary in the relationship to preventive services. And there could be more required reporting of preventive services based on what is required, but also not what is required, so you would know sort of who is getting what.

The second issue that sort of leaped out was for population health initiatives, the first thing you need are data on the health of the population, which means, first of all, you need to define what the health of the population is with a consistent methodology; and, second of all, you need to collect the data and put it in a central place where people can analyze it. And the overall state of Medicaid data you have heard for the last three years now is not as good as some other data sources, especially at the sub-national level.

So, for example, there is a Dartmouth Atlas of health care, which can be considered a population health initiative. You look at small areas, and you look at health status measures and utilization in those areas. You can say some areas have worse health status indicators or higher utilization than other areas. CMS produces county-level indicators -- actually, health service area level indicators, which are sort of areas around hospitals that tend to use the same services within a geographic area. And they produce these annually for many clinical conditions and by race and ethnicity and by other data that they have for the Medicare program, but they do not provide a similar set of indicators for the Medicaid program, because it's hard. It's much easier to use Medicare data than it is to use Medicaid data.

And so if you really need data on the overall health status, specific components of health for the

different groups, the social determinants of health and the environmental determinants and health care utilization, you need that before you can actually assess the health of those populations. And right now the data for Medicaid, as I say, is not that great.

What we have are MAX and MSIS and soon to be T-MSIS where there will be more granular data. We have the EPSDT reporting data, but some studies have shown that, you know, there's a limited number of indicators, and that the data might not be consistently reported across states. So there's work to be done there.

There are many national health surveys, and you've seen a lot of data from the National Health Interview Survey and from other national surveys, but most of them cannot be used at the sub-national level, and they don't have detailed utilization data. So you sort of know that Medicaid populations have characteristics that are the same or different from other populations, but you don't have a lot of detail on what services they use or how it changes over time.

The Behavioral Risk Factor Surveillance System has been going on for several decades and is used at the -- you actually can get estimates at the county level. Yes, you can get estimates at the county level. It's mainly run for states, and it's basically what states use actually to look at the health of their populations. It's a CDC initiative. They have never until 2013 had a question about Medicaid on it. Some states have added a question on Medicaid. In 2013, there was actually money allocated specifically to look at the health of populations. For the expansion they added a question on Medicaid, but it's not clear if they're going to continue with that question after 2013. So for calendar year 2013, we will be able to look at the many socioeconomic and other surveillance system indicators from the BRFSS, but we have no trend data if you want to compare populations of Medicaid enrollees versus other people. And soon there will be the

Medicaid Consumer Assessment for Medicaid Health Plans, which has some -- it has a lot of satisfaction data. It has some health status data. It has some utilization data. But that also is not available yet.

So sort of anything that could be done to improve the state of data for Medicaid I think would really help, and some things that could be done would be to work on refining and improving the Medicaid administrative data, which we are doing here, but we're a small organization. We can only do so much.

We could support work on the creation of sub-national Medicaid indicators so we could compare the health of Medicaid populations to other populations. We could support efforts to improve the quality of CMS Form 416 measures and reporting, which would help at least assess the health of children and could be linked to enrollment or claims data.

There could be more Medicaid-specific questions added to existing national surveys, particularly those that can be analyzed at the sub-national level. There's a current Medicare beneficiary survey where they ask incredibly detailed questions on Medicare enrollees and can link it to administrative data. There's no Medicaid current beneficiary survey.

We could -- one could fund creation of better health status indicator development for Medicaid sub-populations. You just heard a lot about the need to assess different functional outcomes for people who receive LTSS, and, you know, figuring out what their needs are. There are many Medicaid sub-populations where there could be different measures of health that would be more or less useful. And we could work -- one could work with state Medicaid data programs to sort of promote the idea that collecting data was a good thing as opposed to violating privacy and all of the things that scare people about collecting data. But there have been efforts to, you know, try to convince people that collecting data for some purposes might not be a bad thing.

So as we think about this area, we really would welcome your ideas about where you would like to go, the parameters of this issue, which is huge, and sort of what your thoughts are on what the most useful way we could allocation our time to write this would be.

CHAIR ROWLAND: Okay. David?

VICE CHAIR SUNDWALL: Who's first? Sara.

CHAIR ROWLAND: Actually, I was going to say something.

VICE CHAIR SUNDWALL: Oh, good. I'm sorry. Madam Chairman, go ahead.

CHAIR ROWLAND: I was going to ask Amy if, as you look at these things, because of EPSDT and the role of Medicaid for children, do we not need to do some of this analytic work for children versus for adults? I mean, I am assuming that a lot of the preventive services that we want for children ought to be covered, and I was at a meeting the other day where there was a discussion about the tremendous challenge of childhood obesity, and that many of the children we know are on the Medicaid program and many more will probably be enrolling as we go on. But are there not ways that we can think of maybe one case study of how Medicaid could be working on a public health challenge and problem more aggressively?

MS. BERNSTEIN: I think there's a lot of different populations, sub-populations, and I guess one question back to you would be sort of which of them or all of them would you want to focus on. I mean, in the ACA they are requiring obesity interventions, and the Secretary has a mandated report every year on obesity reduction programs for children. There are just so many different ways you can cut this.

VICE CHAIR SUNDWALL: Let me just make --

CHAIR ROWLAND: To David and then Sara.

VICE CHAIR SUNDWALL: Then I'll just make a general comment. Thank you so much for

doing this. I really appreciate your work on this. As you know, it's near and dear to my heart and my values, and I do hope the Commission will support our highlighting this population health issue. I don't think it needs to be a comprehensive chapter. It doesn't need to have a series of recommendations. I think we can have some recommendations without them making mandates, you know, without them being too onerous. While I appreciate your focus on data, I also think we can highlight where there is already good data. I know that Utah has something called the IBIS, information-based indicator system, about 180 health indicators regionalized, and while they're not Medicaid specific, they're very useful. And I think 11 states have adopted something like that.

But, anyway, there is this movement that you called it that is very real and tangible, and I sense that it started with our IOM report on integrating public health and primary care. But I've never heard -- I've never seen HRSA and CDC collaborate like they are now. I've never seen CMS brought into it. Dr. Cha was excellent. Remember the presentation by Mary Selecky and the HCFA guy -- not HCFA. What do you call it?

CHAIR ROWLAND: Medicaid Director.

VICE CHAIR SUNDWALL: The Medicaid Director from Washington State was really, really good. I know Kathleen Nolan has a ton of good ideas because her mother was the state health officer. Anyway, the point is there's CMMI, there's the SIMs grants. And what does SIM stand for? State Innovation --

CHAIR ROWLAND: Innovation.

VICE CHAIR SUNDWALL: Models. And some of those are very Medicaid specific and they're payment reform. So I don't think -- I think it would be very useful for the Commission to kind of try and

capture this movement in population health and acknowledge that as a payer we are important lever to promote this. And you've got a good beginning here. I think it's really good work, so thank you.

COMMISSIONER ROSENBAUM: This was totally exhaustive -- exhausting, exhaustive.

[Laughter.]

COMMISSIONER ROSENBAUM: It was really great. When I think about these services or think about this issue, I sort of make mentally in my head three bins. The first bin is services that I could -- if I were a provider, I could generate a claim for under the state Medicaid plan as it exists. Okay? The second bin is services that I can't normally generate a claim for, but if the state instituted certain kinds of demonstration waivers, I could. So whether it's a special home and community-based services waiver, an 1115 waiver, like when Rhode Island many, many years ago got a waiver to allow for window abatement under its 1115 demo. So that's the second bin.

And the third bin is things that I'd like to do that are population based that in my wildest dreams and in CMS' wildest dreams are never going to be able to generate a claim for. I mean, SIM is just outside of what CMS would ever tolerate, like, for example, cleaning up a school playground. You know, at that point you're into what for the Internal Revenue Code is known as community building activities. They're wonderful to do. They improve health, according to the preventative services -- the National Prevention Plan, but they're just way beyond. And I think what we need to decide as a Commission is are we going to aim all the way up for things that have no existing basis in a claimable activity, and things that go beyond where even CMS has been willing to go up until now. That's number one.

Number two, I really liked your point about the mass confusion about the new preventive services regulation. I have gotten so many calls from so many Medicaid agencies and other people. What does this

mean? What does this mean? What it really means is it expands the scope of what you can generate a claim for, depending on the personnel. It's a personnel expansion more than an intervention expansion. And I think that what CMS has put out today is not clear enough, and I also think that where CMS has been remiss and we should be making recommendations is on the issue you raised of, you know, what do you need to do if you want the 1 percent? If you want the 1 percent, it's not -- it's the U.S. Preventive Services Task Force recommended screening guidelines. It is the ACIP recommended immunizations for adults. They're already covered for children, obviously, as are pediatric screening guidelines. The one that's really tricky is family planning, because, in fact, there are many states that do not cover all FDA-approved contraceptive methods, and so there are state Medicaid agencies whose family planning benefits are not up to the HRSA preventive benefits standard. But I think it's very mushy for states. I don't think they understand what gets them the 1 percent. It seems pretty self-evident to me. I mean, the law is clear that if you do the things that are an approved preventive benefit under 2713, you get the 1 percent. And so I don't know why there's the confusion, but I think we should be clear in our own writing about it.

COMMISSIONER HENNING: Okay. So I'm going to, big surprise, make a plug for pregnant women and having them have access to vaccines, because right now the way I'm reading it, the new adult group, a woman who is not pregnant, who is, say, 26, childless woman, I can get her a pertussis vaccine; however, my pregnant patient who is four to five times more likely to end up in the hospital if she gets pertussis does not get it. Not only --

COMMISSIONER ROSENBAUM: [off microphone].

COMMISSIONER HENNING: Exactly, but in the state of Florida, they do not pay for pertussis.

COMMISSIONER ROSENBAUM: [off microphone].

COMMISSIONER HENNING: Exactly. Exactly, right.

COMMISSIONER ROSENBAUM: Florida does not qualify for the 1 percent increment either because it is not covering immunizations according to the ACIP schedule. You have to do that to get the 1 percent.

COMMISSIONER HENNING: Right.

CHAIR ROWLAND: Denise wants them to have to do it regardless of the 1 percent.

COMMISSIONER HENNING: What I'm saying is if you're pregnant, you ought to get the vaccines that the ACIP says that you ought to get, period.

I also think that pregnant women need to have access to decent dental care. I think they need breast-feeding support. And this goes way beyond -- you know, in the hospital but also once they get home. They need doulas for labor. It will pay for an anesthesiologist and will pay for epidurals, which are very expensive ways to provide labor pain, but not doula labor support, which has been shown to be much cheaper and much better pain relief. And family planning, you know, just out of the box. So those are things that I think are population health related and things that could be done.

If we could -- yeah, there's research that backs up all of this stuff, and especially breast feeding. I think that, going back to population health, if we could increase our breast feeding rates and increase the length of time that women breast feed, their children would be so much healthier, and it has already been shown that, you know, they not only get less sick, but the childhood obesity rates are a lot lower among breast-fed children, asthma lower, SIDS deaths lower, childhood leukemia lower. I mean, I could go on and on, and I probably won't.

MS. BERNSTEIN: Can I just clarify, though? Most of those things are covered under the ACA in

the exchanges, and the --

COMMISSIONER ROSENBAUM: We are mixing up two issues.

MS. BERNSTEIN: Right, right. So --

COMMISSIONER ROSENBAUM: In a good way.

MS. BERNSTEIN: But your current Medicaid patients who aren't in the new adult group, right, they are not necessarily covered for those things.

COMMISSIONER ROSENBAUM: But they're also not the preventive -- I mean, that's where you see we've got to be so careful with our terminology. The preventive 1 percent bump is for very specific things. It's for what's called the 2713 preventive services package. Now, in Florida you have a separate, deeper, more awful problem, I would say, which is that putting aside the list of things --

COMMISSIONER HENNING: Our legislature.

COMMISSIONER ROSENBAUM: -- in 2713 that are determined to be clinical preventive, you know, Preventive Services Task Force, ACIP, you have a state that, going to our forthcoming report, has just completely poorly designed its maternity benefit. I mean, I don't care if you want to call it preventive or bleu cheese. It's a really poorly defined maternity benefit. And that issue, I think, is something that we might want to say that we, MACPAC, are going to in our recommendations beyond the 1 percent bump issue. We want to speak more broadly to preventive services on a scale that's much beyond 2713.

COMMISSIONER COHEN: Amy, great job with a broad amount of materials. I have a mish-mash of comments and suggestions that I will throw out, and I can't even swear they're all --

CHAIR ROWLAND: How many questions?

COMMISSIONER COHEN: No, they're not questions. They're comments, and they're short.

They're short.

So one is I think we need a better definition of our goal on population health, and I have shared David's enthusiasm for this topic from the very get-go, but I think we need to do a little bit -- we need to go a little deeper and be clear what sort of the goals are, because right -- it does feel a little bit like as we sort of tried to put a little meat on this, that it's like a recitation of everything that is not a completely traditional fee-for-service service, and to me that's not exactly what, you know, I sort of thought the sort of population health approach was. But I realize there are components that may -- you know, there are components that could be about like prevention claims, and I think as a Commission we have often said a lot of things, and we could support and do more research into, you know, a recommendation around leaving Medicaid, you know, sort of out or treated differently than sort of minimum benefit packages, you know, in every other government-funded program, et cetera, et cetera. I mean, I think that is like a body of work that we could do and I would support us doing, but to me that's sort of not the bulk of the population health. I think to me it sort of goes a little bit more to are there -- it goes to Sara's second and third buckets. And I guess I would say to Sara, in your third bucket of activities that really seem very far afield from what a claim could be, you know, we could do some more creative thinking around it may not be that a Medicaid program would pay -- write a check for cleaning up a playground, but are there flexibilities or ways for intermediaries to more be able to do that, like a health plan? You know, there's many, many restrictions on the kind of like environmental health things I think that you can do. It all has to come out of admin and, you know, there's a lot of things that you might find might have some sort of ROI, but for reasons -- and health benefits to a community that you serve, but for reasons that have to do with like, you know, particular regulations or payment policy, you can't do them and there's real impediments to them.

So one thing I think we could explore a longer-term big picture is whether there are some intermediaries like ACOs, health plans, other things that might be incentivized to do more stuff that's along the lines of what Sara's saying is not really claim, you know, typical.

VICE CHAIR SUNDWALL: Sort of like community health needs assessment --

COMMISSIONER COHEN: Things like that. For example, you know, encouraging them, requiring them, having conditions of participation. I don't know.

And then the last point that I wanted to make is that -- and I have come back to this a few times, too. You know, birth is a sweet spot for Medicaid. I mean, it is a place -- it is a place where Medicaid should be a leader and where prevention is like everything. I mean, you know, at birth almost everything you do for the health of a child is sort of prevention for later. So I do also think that that is an area where there's such a strong argument for Medicaid to sort of go a little bit beyond what the claim is for a claim. There's often such a strong argument for ROI, and I do think that is an area where, again, just because of the huge role that Medicaid plays, that we could look a little bit more ambitiously. And I am sort of less interested in, you know, to me talking about sort of care coordination as population health or something, it doesn't fit to me.

CHAIR ROWLAND: Okay. Now, I am faced with a dilemma, and I don't want it to seem like I'm aiming this at Andy. But Anne has just told me that they need to come into this room around 5:15, which is in several minutes, and start breaking down the room. So before they eject us, I think we can obviously continue this discussion with Amy, and we've started on a good path, and we're going to be able to pick it up and continue it. So you're not finished having to respond to us, but for today I think we need to quickly ask if there's anyone in the audience who would like to make a comment and then adjourn for the day so

that we don't get kicked out of the room. So thank you, Amy. We'll resume with you.

Public Comment

* MS. STERNTHAL: Hi. I'll be very quick because I'm the --

CHAIR ROWLAND: You don't want to get kicked out either, right?

MS. STERNTHAL: I'm Michelle Sternthal with the March of Dimes. I've commented here before. Two points briefly.

I'm really glad you brought up the issue of vaccinations in Section 2713. Another state besides Florida is Louisiana that for pregnant women who are on existing Medicaid, it does not cover pertussis or MMR vaccines, which in our mind is ridiculous. Yes. So I strongly -- and the March of Dimes feels strongly that making sure that -- extending the preventive services that are available to those in the expansion population to those in the existing Medicaid population makes perfect sense.

The second point I just want to make really quickly is we appreciate the work -- the conversations you had about CHIP earlier today, and the March of Dimes has a new fact sheet out that we did based on research commissioned to NASHP on pregnant women and their coverage in CHIP. So I'm not distributing it because I know that's not allowed, but if anyone is interested in taking a look at this two-pager, I have it here.

Thank you.

CHAIR ROWLAND: Thank you very much.

Yes?

MS. MARTIN: Hi. I'm Michelle Martin. I'm with the National Council on Medicaid Home Care, which is the Medicaid-only focus arm of the National Association for Home Care and Hospice. We are a

provider -- a trade association representing only Medicaid home care providers.

So first I want to say thank you for focusing on long-term services and supports. You have unearthed an incredibly important issue that is -- you know, it's getting -- the importance is getting bigger and bigger the more people we need to pay for. We all hear the figure of how much the baby boomers are going to age into the need for home care in the next decade, so this is a huge topic, and we are grateful for it.

The provider community is very focused on the work that MACPAC is doing, and so we offer ourselves as any amount of assistance that we can offer, and certainly appreciate the work that you're doing and hope that you will continue to look beyond the assessment issue into all of the other issues that plague LTSS, and we hope that we can help.

Thanks.

CHAIR ROWLAND: Well, we certainly intend to go beyond the assessment issue. As was clear today, there's a lot in the assessment issue, but the entire issue of long-term services and supports is a core part of Medicaid and a core part of how we deliver services to many of the vulnerable individuals. So thank you, and we'll continue with that in mind.

And with that, I will adjourn the meeting so that they can come and disassemble the room. Thank you.

* [Whereupon, at 5:13 p.m., the meeting was adjourned.]