



PUBLIC MEETING

Hall of States  
National Guard Association of the U.S.  
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Washington, D.C. 20001

Thursday, February 26, 2015  
10:12 a.m.

COMMISSIONERS PRESENT:

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P R O C E E D I N G S

[10:12 a.m.]

1  
2  
3 CHAIR ROWLAND: Good morning, and welcome to this  
4 meeting, the Medicaid and CHIP Payment and Access  
5 Commission, and we're going to continue our work today at  
6 looking at the issues surrounding the Children's Health  
7 Insurance Program, both its immediate extension and the  
8 options that are being pursued by the Congress to look  
9 forward to the next few months of taking some potential  
10 action on at least continuing CHIP during a transition  
11 period and then, after this discussion, turn to looking at  
12 some of the longer term issues.

13 But we're going to start with Ben and Chris to  
14 discuss short term, CHIP in the short term.

**### Session 1: EXTENDING CHIP: SHORT-TERM ISSUES**

15 \* MR. PETERSON: Thank you, Diane.

16 Last June, the Commission recommended that  
17 Congress extend CHIP funding by two years. We noted that  
18 if CHIP ends, as under current law, many children would  
19 become uninsured, and the cost of receiving care even for  
20 those obtaining other coverage would often be prohibitively  
21 high compared to CHIP.  
22

1           As you know, our March report this year will  
2 provide even more evidence of these and other effects. The  
3 Commission has made clear that it is urgent to extend CHIP  
4 as soon as possible.

5           Now it appears Congress is getting ready to  
6 extend CHIP. The day before yesterday, the Republican  
7 Chairmen of CHIP's committees of jurisdiction in both the  
8 House and the Senate published a discussion draft of  
9 legislation for extending CHIP, and Democrats in the House  
10 and Senate have separately introduced legislation.

11           Commissioners, you have in your materials some  
12 information on these. If you want, there is an opportunity  
13 now for the Commission to share its views with Congress on  
14 some of these specific issues.

15           So before the process gets too far along, we  
16 wanted to remind you of some of the relevant work the  
17 Commission has previously discussed in case you want to  
18 reemphasize some of those ideas. In addition, you may want  
19 to express your support for other changes to offer to  
20 Congress while an extension of CHIP is considered.

21           But first, I will provide you with a brief update  
22 of projections of when states will run out of their federal

1 CHIP funds if Congress does not act, based on the latest  
2 available information, and then I will turn it over to Ben  
3 who will walk you through issues you may want to raise as  
4 part of an extension of CHIP. Then as Diane mentioned, in  
5 the next session, we'll take the longer view to address  
6 affordability and adequacy of children's coverage.

7           So to reiterate, under current law, there are no  
8 new CHIP allotments after FY 2015. So CHIP funds will run  
9 out in FY 2016, which begins October 1st of this year.  
10 Remember that existing CHIP allotments are available for  
11 two years. So that means once FY 2016 arrives, states will  
12 have their unspent FY 2015 allotments that remain.

13           At the same time, when October 1st rolls around,  
14 the CHIP matching rate will increase by 23 percentage  
15 points, so that will increase the rate at which states use  
16 those remaining allotments. And then there will be some  
17 redistribution money that is available and will provide  
18 some limited relief.

19           So this is a chart we have shown before, but this  
20 reflects the latest numbers, and I will just start with the  
21 middle set there with FY 2015, which is a typical year.  
22 The kind of beige column shows the allotment, which was

1 just announced a couple weeks ago, I believe, and states  
2 were notified as to what the allotment amounts were. So  
3 they total \$11.3 billion, but then states also had unspent  
4 balances that they were rolling forward of \$5.9 billion,  
5 and that's against projected federal CHIP spending of \$10.5  
6 billion. So you see there's plenty of money in the system  
7 to cover states' expenditures.

8           As we go to 2016, you will note there is no beige  
9 column because there is no 2016 allotment under current  
10 law, but states are rolling forward \$6.3 billion in unspent  
11 money.

12           At the same time, spending goes up a lot, and  
13 that's primarily because of that 23-percentage-point  
14 increase, so that's where you see the gap between the  
15 funding and the spending.

16           Which leads to this, that states are going to run  
17 out of CHIP funds, and they are going to run out of CHIP  
18 funds at various points during the year, depending on how  
19 much they project to spend and how much in unspent funds  
20 they are rolling into 2016. This is the first time that we  
21 have published state-specific numbers of when they will  
22 exhaust their funds, and this is based on the latest

1 information that we have on states' final FY14 spending,  
2 the new FY15 allotments, and projections that states  
3 provided of their own spending as of November.

4           They provide those projections quarterly, so they  
5 are in the middle of submitting a new set. So these  
6 numbers will change, but this gives you the latest that we  
7 have right now.

8           Just to reiterate that the effect of the  
9 exhaustion of CHIP funds varies by states' program designs,  
10 separate CHIP programs if the money runs out. They can  
11 shut down those programs. The maintenance of effort does  
12 not require them to continue their separate CHIP programs  
13 in the absence of federal money, but the Medicaid expansion  
14 CHIP programs, that coverage is really Medicaid coverage  
15 funded by CHIP, and so if the CHIP money runs out, states  
16 fall back to the Medicaid money, albeit at a lower federal  
17 matching rate, but those children's coverage continues.

18           This slide shows you -- again, this is one we  
19 have seen multiple times, but on the right-hand side are  
20 the states that have more than 90 percent of their CHIP  
21 spending through Medicaid expansions. So, again, those  
22 states won't see a large decrease in -- they won't see a

1 large increase in uninsurance if the CHIP money runs out,  
2 but they will have to pay more in terms of federal money to  
3 cover those children versus on the left-hand side where you  
4 see less Medicaid expansion CHIP coverage in those states  
5 and greater reliance on separate CHIP programs.

6 And so, with that, I'll turn it over to Ben.

7 CHAIR ROWLAND: Let me have a pause here for a  
8 minute. Does anyone have any questions on the material  
9 that Chris has just presented?

10 Patty.

11 COMMISSIONER GABOW: Could you just -- I think to  
12 make sure we all understand this completely, why do states  
13 run out at different periods of time, given the way CHIP  
14 is, CHIP funding goes to the states based on the program  
15 that existed in the previous year? I think just running  
16 through that might be useful.

17 MR. PETERSON: So what your point is, that if  
18 CHIP allotments are based on prior year spending, then  
19 there should be some kind of uniformity of when states  
20 would run out under current law, and that's true the  
21 allotments are targeted in that way. But one of the unique  
22 features of CHIP is that there is two years of availability

1 of these funds, and so the balances, essentially, that they  
2 are rolling forward from previous years kind of become  
3 legacy balances. And so that just affects how they spend  
4 the money in the future.

5 So states are going to begin 2016 with different  
6 leftover amounts, which is somewhat -- I want to say  
7 "atavistic," but that's not the right word -- but somehow a  
8 legacy from prior years.

9 COMMISSIONER RILEY: I think this is extremely  
10 useful information, as "CHIP" always provides.

11 The other piece of this, though -- the chart  
12 doesn't tell the whole story, as Sharon and her colleagues  
13 have reported to NASHP in the survey -- the actions that  
14 states have to take, to begin to notify people, to begin to  
15 change the budgets, states that are on a July 1 budget  
16 year, so this is a little bit misleading in terms of how  
17 much up-front time states need if this program is going to  
18 go away.

19 CHAIR ROWLAND: So, Sara, did you have a comment?

20 COMMISSIONER ROSENBAUM: Yes. Just to follow up  
21 on Trish's point, that suggests that, for example, if there  
22 were rolling short-term patches to the funding, that that

1 might in the end -- I mean, you can say, "Well, states are  
2 going to sort of expire over time, so we only have to fund  
3 and make decisions about CHIP a few months at a time." But  
4 what you're saying is that states need a very long lead  
5 time on the planning part, so you can't view it the way you  
6 might view, say, the SGR payment where you can keep it sort  
7 of a few months ahead of when it's supposed to fall back.

8 CHAIR ROWLAND: Sharon.

9 COMMISSIONER CARTE: I just wanted to reiterate,  
10 first of all, thanks, Chris, for going through this  
11 material again. I'm sure you could probably do it with  
12 your eyes closed now, but it is such a good summary of  
13 things that we have previously looked at for short-term  
14 points about the extension that I would hope that we could  
15 consider a letter to go to the committees.

16 CHAIR ROWLAND: What I was going to recommend is  
17 that this get out as a policy brief as quickly as possible,  
18 just so this information is available. I mean, obviously,  
19 anyone in the room today who picks up our slides will have  
20 the information, but let's put it out with some context.  
21 And if we go forward with a letter, this would clearly be  
22 then an attachment to the letter and something we consider.

1           But I am noting Sharon and Chuck both want to get  
2 in here.

3           COMMISSIONER CARTE: The other part of my point  
4 is to reiterate or reemphasize what Trish and others were  
5 making, that states have very unique conditions.

6           I believe I have pointed out before, like in my  
7 own state, that we have a provision in our state code that  
8 authorizes our separate CHIP program, and it does state  
9 that if there is an insufficiency of federal funds, the  
10 program is terminated. So I feel like, as a director with  
11 a board, that I am faced with making a decision very soon,  
12 so I hope that we would make a clear statement about the  
13 urgency for making a CHIP extension decision in the  
14 Congress. It is not like shutting out the lights to close  
15 down a program.

16           CHAIR ROWLAND: Well, I certainly think, given  
17 the timing of the congressional consideration, that in  
18 addition to the material that would be in our March report  
19 that we will clearly want to reiterate to the Congress that  
20 what we are discussing here today, rather than wait for the  
21 publication of a future report, be included in a letter to  
22 Congress, and these are good points to include in that

1 letter.

2 Chuck.

3 COMMISSIONER MILLIGAN: Along those lines -- and,  
4 Chris, it's a great presentation -- I think that it's a  
5 little overstated, though, for the Medicaid expansion  
6 states to say that because of the MOE, there is really no  
7 effect on coverage. I think for a state that has a  
8 Medicaid expansion version, if CHIP isn't extended, the  
9 change in match rates will have budget consequences that  
10 could cause the state to change, provide reimbursement  
11 rates or other features, or some of the other features of  
12 authorization ground rules and utilization management  
13 inside of the Medicaid coverage for children that would  
14 have effects on coverage.

15 So I just think we need to be careful in how we  
16 nuance the description of the effect on Medicaid expansion  
17 states.

18 CHAIR ROWLAND: Great point. Well taken.

19 Marsha.

20 VICE CHAIR GOLD: Yes. Just apropos that point -  
21 - and I think this is correct -- I mean, a good example is  
22 California that had a separate CHIP program and moved it

1 over, I think, to become a Medicaid-expansion program, and  
2 yet we know they have had all those budget consequences for  
3 all those years. And if then the match rate changes, that  
4 might be a good example to think about, making some of that  
5 real. They were doing that to help integrate coverage for  
6 children, I think, so there would be fewer barriers, and so  
7 you can create some really counterintuitive things.

8 CHAIR ROWLAND: Okay. Well, to move on to Ben.

9 MR. FINDER: Thank you.

10 As Chris mentioned earlier, the Chairman and  
11 Ranking Members of CHIP's committees of jurisdiction in  
12 both the House and Senate have publicly called for an  
13 extension of CHIP, although the timing remains unclear. As  
14 Congress considers an extension, it is possible that  
15 changes to the way the program currently operates will also  
16 be considered, and today, we have highlighted some issues  
17 that the Commission may want to weigh in on during  
18 conversations about an extension of CHIP.

19 The first set of issues that we have highlighted  
20 focus on recommendations that the Commission has previously  
21 made. The Commission has previously recommended that  
22 Congress provide states with a statutory option to

1 implement 12-month continuous eligibility in separate CHIP.  
2 Continuous eligibility is a strategy to address churn and  
3 allow states to enroll children for 12 months, regardless  
4 of changes in family income or composition that may occur.

5 CMS permits states to use the strategy under  
6 regulatory authority currently, and the Commission  
7 recommended creating statutory authority for this policy.  
8 The recommendation also emphasized the importance of  
9 eligibility determinations and meaningful verification of  
10 applicants' self-reported income.

11 The Commission has also recommended eliminating  
12 CHIP waiting periods. Waiting periods are a strategy to  
13 prevent crowd-out of employer-sponsored insurance, and 18  
14 states have CHIP waiting periods in 2015.

15 In its rationale, the Commission noted that it is  
16 unclear whether they have been effective at deterring  
17 crowd-out and that many of the affected children will churn  
18 back and forth between exchange coverage and CHIP or remain  
19 uninsured during the waiting period.

20 The Commission recommended that the Congress  
21 provide the children with family incomes below 150 percent  
22 of the federal poverty level not be subject to CHIP

1 premiums. This would align CHIP policies with premium  
2 policies in Medicaid, and the Commission noted that  
3 eliminating premiums would remove a barrier for families to  
4 take up coverage, and that this recommendation would remove  
5 states' burdens of collecting and administering relatively  
6 small premiums.

7           The Commission also noted that the combination or  
8 stacking of both CHIP and exchange premiums could result in  
9 financial hardships for some families.

10           In a letter to the Secretary and Congress  
11 reviewing evaluations and other reports, the Commission  
12 supported certain CHIP policies. For example, the  
13 Commission supported a permanent extension of the Express  
14 Lane Eligibility policy option in a letter to the Secretary  
15 on an evaluation of the ELE policy. Express Lane  
16 Eligibility allows states to rely on the eligibility  
17 information from other public agencies to determine whether  
18 a child is eligible for Medicaid or CHIP.

19           Fourteen states and one territory use Express  
20 Lane Eligibility for their Medicaid and CHIP programs, but  
21 the provision permitting it will expire on September 30th,  
22 2015.

1           In November of last year, the Commission reviewed  
2 two HHS reports to the Congress on quality. We supported  
3 continued funding of state and CMS quality measurement  
4 efforts, although we did not specify funding level. These  
5 quality measurement efforts were funded in the CHIP  
6 Reauthorization Act of 2009 for the Secretary of the U.S.  
7 Department of Health and Human Services to identify,  
8 publish, and periodically update a core set of child health  
9 quality measures for states' voluntary use in Medicaid and  
10 CHIP. The funds are also used to encourage states to  
11 engage in pediatric quality measurement.

12           In reviewing the mandated evaluation of CHIP, the  
13 Commission expressed its support for improving data  
14 collection and monitoring of individuals moving between  
15 Medicaid, CHIP, and exchange coverage. These data would  
16 allow policymakers and researchers to better understand  
17 lapses in coverage and to evaluate those in the coverage  
18 gaps.

19           The Commission has also discussed additional  
20 legislative issues for CHIP, and the first is the  
21 contingency fund, which was designed to coverage a portion  
22 of qualifying states' shortfalls of federal CHIP funds.

1           One issue is that, as it currently operates, the  
2 fund can provide states with more money than the shortfall  
3 they face, although this has only happened once. The  
4 contingency fund is authorized for the end of FY15, after  
5 which no payments can be made, regardless of the fund  
6 balance. To address this issue, the CHIP statute could be  
7 amended, so that no state receives contingency funds in  
8 excess of their shortfall.

9           The second issue is that the CHIPRA bonus  
10 payments or performance incentive payments, which we  
11 discussed at a meeting last April, CHIPRA created a way to  
12 pay out annual performance bonuses to states that both  
13 experienced substantial increases in child Medicaid  
14 enrollment and implemented at least five of eight specified  
15 outreach and retention efforts in their Medicaid and CHIP  
16 programs.

17           In April, we noted that states are now required  
18 to implement four of the eight outreach and retention  
19 efforts, and that the authorization for the bonus fund has  
20 expired. At that meeting, the Commission noted that it was  
21 unclear to what extent the bonus payments were effective at  
22 incentivizing states to implement enrollment strategies and

1 reduce uninsurance among children who were eligible and not  
2 enrolled.

3           The Commission considered some scenarios for the  
4 future of these payments but did not draw conclusions about  
5 whether the program warranted extension.

6           Another issue to consider is whether to change  
7 the baseline year for measuring enrollment growth in those  
8 bonus performance incentive payments.

9           Finally, there are more substantial changes under  
10 discussion as Congress discusses an extension of CHIP. One  
11 of these changes would be to eliminate the 23-percentage-  
12 point increase in the federal CHIP matching rate. The ACA  
13 applied this change to the CHIP matching rate for FY 2016  
14 through FY 2019. This would increase federal CHIP  
15 spending, and states will spend their CHIP allotments more  
16 quickly.

17           Competing perspectives on the percentage point  
18 increase will emerge. On the one hand, CHIP directors in  
19 18 states indicated that their governor's proposed budget  
20 assumes the 23-percentage point bump, and 17 states were  
21 unsure. Ten states did not assume. That's from the NASHP  
22 report recently on states' budget efforts or budget

1 decisions as CHIP goes forward. On the other hand, some  
2 believe that the bump is not an effective strategy to cover  
3 more children.

4 Another change would be to lower the CHIP income  
5 eligibility cap. States have the flexibility to set their  
6 own eligibility levels, and CHIPRA changed the federal  
7 matching rate for children with incomes greater than 300  
8 percent of the federal poverty level from the enhanced CHIP  
9 matching rate to the regular Medicaid match rate. Since  
10 this provision applies to states expanding after the  
11 enactment of CHIPRA In 2009, no state has yet been subject  
12 to the lower matching rate.

13 EXECUTIVE DIRECTOR SCHWARTZ: Ben, I just want to  
14 point out that it is a percentage point increase in the  
15 CHIP matching rate, not a percent increase.

16 \* MR. FINDER: Thank you.

17 We look forward to hearing your thoughts on these  
18 issues, and we are ready for feedback. Thank you.

19 CHAIR ROWLAND: And I would note that the  
20 material that you have predates the discussion draft that  
21 was released on the 24th of February by Senator Hatch and  
22 Representative Upton, so that there are some other issues

1 that have been raised in that draft that were not included  
2 necessarily in the materials here.

3 But I'll open the floor for discussion of where  
4 we go next.

5 [Pause.]

6 CHAIR ROWLAND: Okay. Well, there's a number of  
7 provisions here that we have not yet commented on. I think  
8 Ben did a nice job of reviewing our recommendations to  
9 date, but now it is a time to say if we are supporting,  
10 which we are urgently, that the CHIP program be extended,  
11 so that children's coverage can be maintained at least  
12 during a transition period. What are some of the key  
13 provisions that ought to be included in that extension?

14 Sheldon.

15 COMMISSIONER RETCHIN: Can I just ask on this,  
16 the distribution of the states, that either assumed or have  
17 not assumed the 23 percent increase in -- percentage  
18 increase?

19 CHAIR ROWLAND: Point.

20 COMMISSIONER RETCHIN: Percentage point increase.

21 Was there any pattern there? Is it just the  
22 states' budgets are a different time? Why would 10 states

1 not assume and then others assume?

2 MR. FINDER: I'm not sure. In the report, it  
3 just lists the numbers of states. It doesn't go into  
4 specific detail about which states go which way or the  
5 other. I'm not sure how states are thinking about this  
6 budget, aside from how the decisions they make.

7 CHAIR ROWLAND: Patty.

8 COMMISSIONER GABOW: Well, I think that we had  
9 put a fair amount of thought into the previous  
10 recommendations, and I think we should reiterate them in a  
11 letter to Congress saying that this is what we think. And  
12 I think we should be clear that we thought the extension  
13 was necessary to create a more robust and adequate program  
14 for children within the other options, not that we were  
15 supporting CHIP be extended forever, but rather the other  
16 options which now exist have to be not a step back from  
17 what we've done to coverage children, and I think  
18 reemphasizing that we don't want to step backwards from  
19 where we have been, which has been an important change for  
20 America's children. And we want to continue that because  
21 they're our future.

22 So I think reiterating our recommendations are

1 good, and I would go beyond reiterating our recommendations  
2 to the things that we supported in letters in addition to  
3 what we had as a formal recommendation because it shows our  
4 intent.

5           The one thing that is listed here that we didn't  
6 really either say -- I don't think we said in a letter or  
7 recommended -- was contingency fund not be -- states not  
8 get more than covers their contingency is, it seems to me,  
9 like an obvious thing to do. Why would you want to do more  
10 than that? So supporting that seems reasonable as well.

11           CHAIR ROWLAND: We have previously been on record  
12 in supporting that in discussion.

13           Sara.

14           COMMISSIONER ROSENBAUM: Among the issues that  
15 I've certainly focused on myself are the ones that, of  
16 course, as we just noted were proposed, but they were  
17 proposed after the slides were prepared, so the proposal to  
18 lower the upper limit on allowable income levels in CHIP.  
19 It seems to me that that proposal actually has an effect  
20 that's sort of the opposite of our previous recommendations  
21 in that it creates more of a divergence between CHIP and  
22 our other principal subsidy system now, and the irony is

1 that until we address the family glitch problem, which, of  
2 course, is a longstanding recommendation, by lowering the  
3 cap, you have the potential to push more children into the  
4 tax subsidy system where we run into a family glitch.

5           Now, already, many, many states have income  
6 eligibility standards under CHIP that are much lower,  
7 significantly lower than the tax subsidy levels, so we have  
8 an unknown number of children caught already. If you  
9 combine both a narrowed amount of funding going forward  
10 with a downward pressure on the upper limit of the  
11 eligibility standard, my concern is that states reading the  
12 two together may be concerned about length of time, amount  
13 of money, whatever further comes down, and then we'll have  
14 more children in the family glitch. So that is the area  
15 that I think of all the things that Ben has laid out, the  
16 one that I am the most focused on.

17           COMMISSIONER RILEY: It seems to me, to Patty's  
18 point, that we ought to reiterate strongly where we've been  
19 on this one, that we view this as a transition point, and  
20 as such, there is an urgency to do it because the more  
21 there's uncertainty, the more confusion for the states and  
22 the more likely there will be impact on children and

1 families. And then make the case for consistency that this  
2 is a bridge, this is a transition period to resolve the  
3 issues like family glitch. So to change the program now  
4 would be to add a layer of complexity that's really  
5 confounding and unnecessary and costly.

6           So what we ought to do is reiterate that this is  
7 a glide path to buy time to make the fixes that need to be  
8 made, to think about a future in which children are better  
9 integrated into existing systems, but again to stress the  
10 urgency because the waiting game is just really very  
11 troublesome.

12           And to the point of the 23-percentage-point  
13 increase, to me it's fundamentally important to keep that  
14 commitment. It's part of the law. States planned on it.  
15 It was the deal, and as such, it needs to stay that way, or  
16 we, once again, invited the discussion about can you trust  
17 the federal government, and there are broader issues of  
18 concern to that.

19           Whether it was a good policy idea or not, it  
20 seems to me, go with consistency, make the changes over  
21 time.

22           CHAIR ROWLAND: Chris, it would be helpful, I

1 think, if you would re-read to us the exact language of our  
2 previous recommendation, so that we know what it is we're  
3 talking about reinforcing.

4 MR. PETERSON: My Acrobat had crashed, so give me  
5 a few minutes.

6 VICE CHAIR GOLD Do you want to borrow the piece  
7 of paper?

8 [Laughter.]

9 EXECUTIVE DIRECTOR SCHWARTZ: It was a chapter  
10 from the June report that I think for the purposes of  
11 briefing Hill staff last year, we pulled it out and bound  
12 it separately, and there were a number of copies left over  
13 that I shared with the new Commissioners.

14 MR. PETERSON: So are you referring to just the  
15 general recommendation which says the Congress should  
16 extend federal --

17 CHAIR ROWLAND: The one that you showed Anne  
18 earlier.

19 MR. PETERSON: "Congress should extend federal  
20 CHIP funding for a transition period of two additional  
21 years, during which time the key issues regarding the  
22 affordability and adequacy of children's coverage can be

1 addressed."

2           And then under the rationale, there was this  
3 sentence that's in the June report, "This recommendation  
4 assumes no changes in any other aspect of CHIP-funded  
5 coverage as it exists under current law, including the 23-  
6 percentage-point increase in the CHIP federal matching  
7 rates slated for FY 2016 through 2019 which states have  
8 built into their budget estimates."

9           CHAIR ROWLAND: And I would reiterate for the  
10 Commission members that we did discuss whether there should  
11 be other changes and opted for a simple straight extension  
12 as creating less administrative burden. No new regs would  
13 have to be written, and the program at the state level  
14 could continue without having to figure out how to  
15 contemplate other changes. So the straight extension was  
16 there to say there's lots of other fixes that we want to  
17 see made, but for simplicity purposes and for ease of  
18 administration and for continuity of coverage for kids, the  
19 best way to go forward may be a straight extension.

20           All we didn't do was say four years. We said two  
21 years instead of four, but we were doing a straight  
22 extension, because as you might recall at that time, there

1 was still some movement in the Congress to try and do a lot  
2 of other things to extend and fix CHIP for the short term,  
3 and we opted not to go that way.

4 But I now have -- I did you, Trish, right? So it  
5 is Marsha, then Chuck.

6 VICE CHAIR GOLD: A number of things I was going  
7 to say were already said by Trish and Diane. I do think  
8 it's important to reinforce the -- you don't want states to  
9 be doing a lot of things to deal with change, when what you  
10 really want them to do is be focusing on longer term  
11 change.

12 The only thing I would add to that is it seems to  
13 me that one thing we've seen, looking at Congress, is that  
14 it's hard to predict the specifics in some of the language  
15 and how things will come out, and I would think that it is  
16 useful to just say continue generally, rather than trying  
17 to anticipate which changes people might make and whether  
18 we're for or against them, so much as the general  
19 principle, and with that also a general sense of where  
20 we're going and that it's important.

21 I also would wonder, particularly -- it seems to  
22 me that part of what we're looking for is to reinforce the

1 point that there needs to be an extension because there are  
2 all these awful things that may happen if it doesn't in  
3 terms of coverage and things we've heard about, and that  
4 it's not -- just rolling it into the ACA now creates some  
5 real problems for children, as we've said.

6           On the other hand, ultimately, there may be  
7 reasons, important reasons that you can benefit all  
8 coverage for children by doing that. So I'm not sure. I  
9 wonder if -- I looked at this as a new Commissioner and  
10 said two years. I wonder. Really, the point is that it  
11 should be a short-term fix, and I think we certainly heard  
12 comments on that from a lot of people, and I wonder whether  
13 the point is more that where we're trying to go do, without  
14 sort of the specifics, it seems to me -- I'm not sure that  
15 this Commission wants to get into a fight with Congress  
16 about whether something is two years or four years versus  
17 what the extension is and that it be done quickly.

18           CHAIR ROWLAND: I think our goal ought to be to  
19 state that it's urgent that there be an extension, and that  
20 that extension be a sufficient time to not cause states to  
21 have to constantly reevaluate whether the program is going  
22 to be around.

1           I mean, I think two years or four years, but if  
2 it's a six-month extension, I think that is kind of  
3 inadequate, and so we need to say for planning purposes, it  
4 needs to be of sufficient duration, so that the states can  
5 actually continue to implement their programs.

6           But I also think we ought to be very careful,  
7 too, to remember that there are other recommendations that  
8 we had previously made that were not related to the pure  
9 extension that may also come up in this congressional  
10 review, and one of them specifically is that we recommended  
11 the elimination of the waiting period because of the new  
12 environment in which CHIP exists. And that is something  
13 that in the discussion draft put forth by the House and  
14 Senate under Hatch and Upton has called for extended  
15 waiting periods up to as long as 12 months.

16           So I think we should also reiterate some of those  
17 earlier recommendations that were just key to how the  
18 program should work.

19           I have Chuck. Then I have now Patty and Andy and  
20 Donna.

21           COMMISSIONER MILLIGAN: I think to me, the  
22 cleanest way, Diane, is what you said earlier, which is

1 we're talking about seven months from now, and I think the  
2 cleanest thing is to say that CHIP needs to be extended  
3 seven months from now and for a sufficient amount of time  
4 to work through some of the other programmatic and reform-  
5 minded changes that we can discuss -- we had discussed last  
6 meeting, and we can discuss further in this meeting.

7           But I think the short-term issue is that CHIP  
8 should be extended in a way that doesn't create budget or  
9 administrative uncertainty.

10           I do think there are some examples, like the  
11 contingency fund point that Patty made earlier, where you  
12 could say a state shouldn't get more than it needs, without  
13 that kind of change requiring a lot of administrative or  
14 budget uncertainty. I think, to me, the principle is it  
15 needs to be extended. This is an urgent issue, and until  
16 such time as the more programmatic reforms are really  
17 addressed in a meaningful way, it should be, as the  
18 Commission recommended last June, very much in line with  
19 the program as it exists now.

20           CHAIR ROWLAND: And it should be extended, so  
21 that the uncertainty for states is also not an uncertainty  
22 for families because obviously many of the families depend

1 on CHIP for their children's coverage right now.

2 I had Andy, then Donna, and I've got Peter.

3 COMMISSIONER COHEN: Just taking a little step  
4 back and thinking about our role here, I think it is very  
5 hard not to get into a discussion of what combination of  
6 provisions might delay an extension or what is some  
7 progress that we might like consistent with prior  
8 recommendations in a given package, but I do think we  
9 should take a step back here and say it's not probably  
10 really a MACPAC role, or at least this is my perspective,  
11 to be putting together packages or tradeoffs in a  
12 particular bill. And I would suggest more sort of along  
13 the lines of what Chuck said. I think we can both  
14 reiterate that we have recommended the elimination of  
15 waiting period and other things but not say or imply that  
16 we think any particular provision should or shouldn't be in  
17 any package, and then to address some issues around this to  
18 sort of prioritize what is the sort of biggest concern  
19 right now.

20 So along with Chuck, I would say right now, I  
21 would say our highest priority sort of recommendation  
22 should be around just making sure that an extension happens

1 at this point and happens timely, but I don't think we  
2 should be in a position of sort of recommending packages  
3 that make that more or less likely or that either undercut  
4 a recommendation we've made in the past. Unless we change  
5 our minds and recommend otherwise, we stand by the  
6 recommendations that we've made, but right now, our highest  
7 priority is extension, and whether or not that includes  
8 those other recommendations, I think we should be agnostic.

9 CHAIR ROWLAND: Okay. Donna.

10 COMMISSIONER CHECKETT: Listening to the  
11 discussion, of course, I go to what is our authorizing  
12 role, and the statutory authority is, as our Chair so often  
13 reminds us. So I think in the letter, in addition to the  
14 payment, we have to really focus on access, which is the  
15 other part of that to which the reason for which we are  
16 here.

17 And I was really struck by the list of states.  
18 You can read and read and read, and lots of it is very  
19 theoretically, and lots of it is very high policy-minded.  
20 When you see the states and you start thinking about the  
21 children and the families that are going to be affected by  
22 that, which to me is very powerful. So I would urge to the

1 extent that it is appropriate in our letter that we include  
2 that information, because I think that's going to start to  
3 people -- I mean, just look. Who didn't look to see where  
4 their state was on that? You all look for your state. It  
5 becomes very real, and so I just urge us, to the extent  
6 it's appropriate, to include that information in any  
7 letter. Thank you.

8 CHAIR ROWLAND: Peter.

9 COMMISSIONER SZILAGYI: Yes, just a couple of  
10 points. To piggyback on what Andy and Donna were saying,  
11 as a new Commissioner, I did want to go on record that I  
12 totally support what people have been saying around the  
13 table about urgently extending CHIP, not creating  
14 administrative and fiscal uncertainties at the state level,  
15 because children will be harmed. Many children will lose  
16 health insurance, and states will be forced to make  
17 decisions that they probably don't want to do.

18 I do think that one of our roles as  
19 Commissioners, perhaps it isn't to create an entire  
20 package, but I think it is to distill from our point of  
21 view, the evidence for what components can create  
22 improvements or perhaps harm in access or quality.

1           As a health services researcher, I have reviewed  
2 and participated in the research on waiting periods, and I  
3 do want to weigh in on that. Waiting periods cause harm.  
4 They don't help. Children lose health insurance, and they  
5 lose access and quality of care. So I wasn't here when the  
6 recommendations were made before, but I feel that the  
7 evidence totally supports that.

8           And similarly, the 12-month continuous  
9 eligibility causes good. It continues access to needed  
10 services for a very vulnerable population.

11           CHAIR ROWLAND: Okay. Patty.

12           COMMISSIONER GABOW: I just have a question for  
13 someone like Donna maybe to answer about just the  
14 operational feasibility. If CHIP is not done as a straight  
15 extension and a variety of new criteria come into play,  
16 from the fact that we've heard in this Commission how  
17 administratively strapped states are, what is the timeline  
18 for a state to be able, given computer programs, given all  
19 of this, to do education appropriately, educate and  
20 outreach?

21           The feasibility of doing major changes at a state  
22 level with limited administrative staff and limited

1 computer flexibility, every time we had to change something  
2 in our computer system, I had a migraine.

3 It is not turning on a dime. It's not a week.  
4 It's not a month. From a perspective of what it would take  
5 -- because I think that's important.

6 CHAIR ROWLAND: Well, there is also the issue of  
7 notifying beneficiaries --

8 COMMISSIONER GABOW: Yes.

9 CHAIR ROWLAND: -- of the fact that they are  
10 terminating coverage.

11 COMMISSIONER GABOW: I think thinking about what  
12 that timeline is, not just for budgeting purposes, but a  
13 check on administrative purposes, but delineating that  
14 maybe in some detail would be useful, I think.

15 I don't know, Donna.

16 COMMISSIONER CHECKETT: Well, I'll just comment.  
17 I'm sure others could, but I think I agree with you.

18 The other point, not that I think it has been an  
19 issue particularly that Congress has focused on, but the  
20 fact is in almost all states, you are going to have to have  
21 a statutory change, depending on how much the terms change  
22 and how the state statute is written. So you're point is a

1 good one as well, Patty, that it's not easy for states to  
2 jump in and change programs.

3 CHAIR ROWLAND: Okay. So I think that we agree  
4 that we are going to issue a policy brief on the earlier  
5 material, adding in some of the context about how difficult  
6 it is to do this in a short time period, but we are really  
7 going to focus in a letter to Congress, reiterating the  
8 importance and the urgency of moving now to provide an  
9 extension of the CHIP program. We are reinforcing our  
10 recommendation that a straight extension is the preferred  
11 way to minimize administrative disruption and hassle and to  
12 try to promote better continuity of care, that we're going  
13 to really add into that context some of the concern about  
14 the fact that Congress likes to do things in three- and  
15 six-month chunks, but this is really something where you  
16 need advanced planning, where it's a budget issue, it's an  
17 administrative issue, it's a family issue for families to  
18 know what they're having.

19 And I would add that as we wait to see what  
20 happens in King v. Burwell that we also are in a situation  
21 now where the general availability of help through the  
22 exchanges, through the marketplaces, may in fact be in

1 doubt after the Supreme Court ruling, so that it even adds  
2 more to let's make sure we don't disrupt the coverage  
3 children have now in the period when we're still in flux  
4 with some of the other provisions for the ACA.

5           And I think a strong letter dealing not with all  
6 the long-term changes to improve children's health, but the  
7 immediacy of the need to maintain children's coverage and  
8 the state's ability to provide that coverage.

9           And we can include a reference back to some of  
10 the key other provisions that we talked about, just because  
11 as those come up in the debate, we want to at least be on  
12 record, as Peter so well noted, that we don't think waiting  
13 periods, especially in the context of the new world of  
14 health insurance, are a provision that helps get children  
15 the coverage they need.

16           Okay. Well, I think short term, we've managed to  
17 get through this session, and now we have to go to long  
18 term, and I think Joanne is supposed to join us for long  
19 term.

20           It is always easier to deal in the immediate than  
21 in the long range, so let's go to the next level here where  
22 we really are going to look at some of the broader and

1 longer term issues in trying to address how to best provide  
2 coverage for our nation's children.

3 I do think that here, we really want to try and  
4 look at a view that is not a view that is kind of CHIP-  
5 narrow but that's children-wide, and that looks at for  
6 children at different income levels, what kind of services,  
7 protections, what kind of financial burdens can those  
8 families bear.

9 One of the things I think we need to really think  
10 through is what happens at different income levels and how  
11 well do the private plans cover children as well, because I  
12 think we want to be sure that we don't forget that there is  
13 the Medicaid coverage on one side, there is employer-based  
14 coverage on another side, and then there's been this bridge  
15 in the middle, which is CHIP, and how do we allocate those  
16 responsibilities, so that the bridge is more integrated  
17 into the coverage system. But I'll let our great staff  
18 kick off our discussion.

19 **### Session 2: LONG-TERM POLICY OPTIONS FOR CHILDREN'S**  
20 **COVERAGE**

21 \* MR. PETERSON: Thanks, Diane. Hopefully, I'm not  
22 going to be too redundant of what you just said, because

1 that's helpful. We now turn to long term --

2 CHAIR ROWLAND: Well, that's fine. If you agree  
3 with me, I like that.

4 [Laughter.]

5 MR. PETERSON: We now turn to possible long-term  
6 options to improve children's coverage, aiming to do so in  
7 a way consistent with your long-term vision of children's  
8 coverage, as articulated in last June's report to Congress.

9 That vision, which focused on the affordability  
10 and adequacy of children's coverage prompted you to call  
11 for an extension of CHIP in part to provide enough time to  
12 develop sound policy alternatives for children now served  
13 by CHIP if they could be integrated into other sources of  
14 coverage in the future, but it also raised the notion that  
15 this conversation should not just be about CHIP and  
16 children currently enrolled in CHIP, but also about  
17 coverage for low- and moderate-income children generally.

18 Based on the discussions that you had,  
19 particularly at the last meeting, we are bringing to you  
20 options that address some of your specific concerns. These  
21 options target exchange coverage. However, there are other  
22 coverage options that could also be considered, whether

1 it's affecting Medicaid or redefined CHIP, wraparound  
2 coverage. So while we are presenting some specific  
3 options, we don't want to limit your discussion.

4           We look forward to your feedback on whether the  
5 policy options we talk about today regarding exchange  
6 coverage adequately addressed the tradeoffs for improving  
7 children's coverage, and we would appreciate your thoughts  
8 on any other approaches you want to consider.

9           In last June's report, you noted that if CHIP  
10 went away, as under current law, there were going to be  
11 problems for children. In the report we're publishing next  
12 month, additional evidence has been brought to bear on each  
13 of these points. 1.1 million children would become  
14 uninsured. Compared to CHIP, premiums are generally higher  
15 for employer-sponsored coverage, sometimes for subsidized  
16 exchange coverage as well, and of course, that is a big  
17 contributor to the increased uninsurance if CHIP went away,  
18 those premiums. But even among those who obtain other  
19 coverage, what is the right level of premium contribution?

20           The same is also true of cost sharing. We know  
21 that deductibles and copays are higher in exchange coverage  
22 and employer-sponsored coverage than in CHIP.

1           In addition, moving from CHIP to other coverage  
2 could result in the loss of critical benefits, like dental  
3 coverage, and changes in provider networks could cause  
4 disruption, although how networks differ across sources of  
5 coverage is less clear.

6           So which of these are the most important issues  
7 to address, and how do you address them? We will talk  
8 about some options to address these affecting exchange  
9 coverage, and based on your comments, particularly in the  
10 last meeting, we are bringing back to you today these five  
11 issues you see here that you wanted to explore in greater  
12 depth with potential options.

13           Under each of these issues are specific options  
14 we will talk about shortly, and they represent a fairly  
15 broad range of options affecting an exchange coverage,  
16 generally from most expansive and, thus, potentially most  
17 expensive from the federal perspective to less.

18           Our goal for this session is to get your feedback  
19 on these potential options, and based on your feedback, we  
20 could then come back to you with more detailed policy memos  
21 on the options you want pursued. Those analyses would  
22 include initial indications of the effect of each option

1 and their interactions. Some will be based on modeling by  
2 the Urban Institute; however, there is limited capacity in  
3 the number of options that can be modeled, so we look  
4 forward to your comments on what specific information you  
5 would need additionally on these to make decisions on these  
6 options.

7           As you think about whether your preferred options  
8 are structured more broadly or narrowly, you might also  
9 want to consider what level of income should make one  
10 eligible, and we note this Commissioner is on the title  
11 slide of your table, which notes that income levels at 400  
12 percent of poverty, which for a family of three is \$80,360  
13 in annual income, all the way down to 150 percent of  
14 poverty, which is \$30,135 in annual income for a family of  
15 three.

16           Before we turn to the specific options and kind  
17 of go through them one by one, I want to point out  
18 generally the interactive effects of these. As we start  
19 from the top, for example, and talking about the family  
20 glitch, you, quote/unquote, fix the family glitch; that  
21 makes more individuals who are eligible for employer-  
22 sponsored coverage therefore eligible for exchange

1 coverage, but that does not necessarily mean all of them  
2 are going to enroll.

3           You may have to then go to the next step and  
4 address premiums, and that may not mean that kids are  
5 necessarily going to get the care. These come in stages,  
6 and the effects cascade, but then also the cost cascades,  
7 so these are some of the considerations that you need to be  
8 thinking about as we go through these on the interactive  
9 nature.

10           So, with that, I will turn to issue 1 about the  
11 family glitch, and just as a reminder, if employees'  
12 contribution towards self-only coverage for the employer-  
13 sponsored insurance is considered not affordable based on  
14 the definition of the ACA, then they and their family may  
15 obtain exchange subsidies. However, the employee's  
16 contribution to family coverage is not considered. That's  
17 why it's referred to, in shorthand, as the "family glitch."

18           So if the ACA's definition of affordable,  
19 accounted for family coverage, which means more families  
20 would be eligible for exchange subsidies.

21           COMMISSIONER COHEN: Can I interrupt for just  
22 one? Can you remind us, Chris, what we know about the

1 number of people and, by any chance, we know children who  
2 are caught in the family glitch?

3 MR. PETERSON: Remember the slide that we had  
4 from our last meeting, which is going to be in our March  
5 report? We looked at 3.7 million separate CHIP children in  
6 total. Half of those, if CHIP went away, would be eligible  
7 for employer-sponsored coverage.

8 Among those, half would have family coverage that  
9 is more than 9.5 percent of family income. In other words,  
10 you could say that half of kids eligible for employer-  
11 sponsored coverage are affected by the family glitch, if  
12 you look at it from this narrow issue of where we have  
13 numbers from the Urban Institute.

14 COMMISSIONER COHEN: Those coming from CHIP,  
15 which is about a million.

16 CHAIR ROWLAND: But those are of children in CHIP  
17 as opposed to children and families.

18 MR. PETERSON: Yes. That's a hard question.

19 CHAIR ROWLAND: Which is the broader effect.

20 COMMISSIONER COHEN: So we are talking --

21 MR. PETERSON: There have been --

22 COMMISSIONER COHEN: -- about a million.

1 MR. PETERSON: -- out there, but they vary a lot,  
2 and so this is one of the things that in our next meeting,  
3 we want to be able to bring to you how many children will  
4 be affected. So that, obviously, is critical information.  
5 So we can only provide you with the little narrow piece  
6 that I have given you at this point.

7 CHAIR ROWLAND: That is something to remember as  
8 we look at these options. We are not here talking about an  
9 option that just preserves coverage for children now  
10 participating in CHIP. We are talking about issues that  
11 affect children who are in family situations but were not  
12 taking advantage of the CHIP program.

13 MR. PETERSON: And in that vein, so these options  
14 even go potentially broader, and this is where we want your  
15 feedback. If you fix the family glitch and you change the  
16 affordability test -- let me say it like that, so it's more  
17 precise -- you could actually make the entire family  
18 eligible for exchange subsidies, not just the children.

19 But option 2 there is, well, the focus we've had  
20 is on children's coverage, and you could say do you want to  
21 narrow it down to just children's coverage or are you  
22 thinking more expansively. So that's the difference

1 between these first two is whether the whole family would  
2 be eligible for exchange subsidies or just the children.

3 COMMISSIONER ROSENBAUM: In other words, that the  
4 parent would also move at that point. The parent would  
5 forgo self-only coverage and buy the full package from the  
6 --

7 MR. PETERSON: Yes.

8 COMMISSIONER ROSENBAUM: Okay.

9 MR. PETERSON: That's right.

10 CHAIR ROWLAND: Which obviously increases the  
11 cost of the --

12 COMMISSIONER GABOW: Chris, these are all very  
13 specific ways of doing things, which expand them broadly.  
14 I guess I'm trying to think whether we need to pick one of  
15 them or whether we need to support any of them that would  
16 work, that can pass the political process or something to  
17 fix the family glitch, because it seems that the most  
18 important thing is to fix the family glitch. There are  
19 different ways to fix it, which have different costs and  
20 benefit more or fewer people, and we probably each have our  
21 own preferences as to which way it's done, but I guess I'm  
22 a little bit wondering how specific we're trying to be with

1 what we're recommending as the solution as opposed to this  
2 is critical, which it sounds like it is.

3 CHAIR ROWLAND: Well, I think what we're trying  
4 to say broadly is that the family glitch is an obstacle to  
5 getting affordable coverage for families, including many of  
6 their children, some of whom now qualify for CHIP and some  
7 of whom don't, but that fixing the family glitch is an  
8 important way to improve the affordability and availability  
9 of coverage for children and their families.

10 Sara.

11 COMMISSIONER ROSENBAUM: I also think that while,  
12 obviously, the most important message to convey, which we  
13 have done, is that the family glitch has effects both in  
14 terms of the relationship of the glitch to CHIP and CHIP's  
15 future, but also this broader question of children who  
16 should be able to rely on the exchange.

17 I do think we have to actually grapple with these  
18 choices because fixing the family glitch is not just bound  
19 up with CHIP. It's bound up with employer-sponsored  
20 coverage, and it is a very different thing for us to -- and  
21 we could put out two or three options and just simply point  
22 out the pros and cons, but I do think we want, if at all

1 possible, to see what the Urban Institute's estimates would  
2 be. We may decide in the end that we don't have a  
3 preferred option, that we would just want to show Congress  
4 some options, but whatever we have to say about fixing the  
5 family glitch, I do think we need to at least show some  
6 solid options and what the possible effects of different  
7 options are.

8 MR. PETERSON: In thinking again about the  
9 interaction of these effects, I've kind of teed up that we  
10 are going to be talking about the effect of the premiums  
11 and the cost sharing. The challenge is, like the two  
12 options here times multiple options for premium  
13 affordability times multiple options for cost sharing and  
14 you affect -- you want to vary this by FPL, the challenge  
15 is that it will be very complicated for Urban to produce  
16 those estimates. It is going to have to be a tradeoff in  
17 terms of can you go ahead and say, "Look, right now our  
18 focus is on children and the coverage long term for  
19 children, so we recognize that number 1 up here is a  
20 problem, but we're not focused on that," or are you saying,  
21 "No. We want to see all of these options as much as you  
22 can"?

1           COMMISSIONER ROSENBAUM: Well, the other  
2 complication, I should just note, is that --I was saying to  
3 somebody before, I think to Donna, that I am chair of our  
4 benefits committee for the university, and it is not just  
5 children and parents. There are 13 permutations on this.  
6 For example, there's spouses and children, and of course,  
7 in CHIP, we have spouses. We have women who are covered  
8 for their pregnancy in some states.

9           So I think you are absolutely correct that each  
10 one here then has a cascade of consequences on our other  
11 choices, but this issue is so foundational that, even  
12 though it produces a cascading effect, we might, one, ask  
13 for estimates on this one, with a clear point that just as  
14 -- we want to see as a threshold what the effects are, even  
15 though we may on the subsequent modeling choices narrow,  
16 begin to narrow down what we ask for, understanding that  
17 Urban has limits on what it can do. And we may decide that  
18 we really are only going to flesh out number 2 at this  
19 point because it bears most immediately, but we do, for  
20 example, in number 2 create situations in which potentially  
21 spouse and child coverage is not available, and then where  
22 does that leave us?

1           COMMISSIONER COHEN: I agree with the tenor of  
2 the conversation so far quite a bit.

3           I would make a comment about option number 3,  
4 though, which I see is quite different and just sort of  
5 raise the issues there that employer-sponsored insurance  
6 varies tremendously across the country. The ACA standards,  
7 like sort of minimum standards, are not very rigorous, in  
8 my view, in terms of what employer-sponsored insurance is.  
9 So without much further review and thinking about standards  
10 and things like that, I would be uncomfortable with  
11 pursuing option number 3 as a form of recommendation.

12           If we wanted to go much deeper and talk about  
13 what the limits or standards might be, that might be a  
14 different conversation, but I think as a general statement,  
15 to say that we want to start applying -- we would recommend  
16 applying exchange subsidies to employer-sponsored  
17 insurance, I think that is a huge leap kind of beyond where  
18 the ACA is and probably not an appropriate one for us to do  
19 without a lot of serious work.

20           COMMISSIONER MILLIGAN: I want to agree with  
21 Andy, and the other part about 3 that seems a little like  
22 going down the rabbit hole to me is that employer-sponsored

1 insurance is it is self-subsidized in the Tax Code for  
2 employers, so I'm not quite sure what the subsidies on top  
3 of the subsidies, how we even get out of that particular  
4 rabbit hole. So I would add that comment to Andy's  
5 comment.

6 COMMISSIONER ROSENBAUM: It is the case, though,  
7 that Medicaid and CHIP do option 3 today. So the irony is  
8 that 3 looks dramatic to us when we are looking at it in a  
9 vacuum, and yet we subsidize employer premiums with  
10 Medicaid funds and CHIP funds today.

11 COMMISSIONER COHEN: But although, Sara, in very  
12 tightly circumscribed situations, which is different.

13 COMMISSIONER ROSENBAUM: Absolutely. Absolutely,  
14 if it's a cost-effective investment, but it is not unheard  
15 of to use one federal subsidization to match another  
16 federal subsidization. It may be that we don't want to  
17 continue the practice, and so we don't do it. I just would  
18 point out that it's not a ground-breaking concept.

19 COMMISSIONER MILLIGAN: My point, though, may be  
20 coming at this conversation from a different direction is  
21 we could also just -- if we're going to go down this avenue  
22 of touching ESI, condition the employer receipt of tax

1 credits up on some of the other things instead of the  
2 subsidies on the subsidies, and that then is a bottomless  
3 pit.

4 CHAIR ROWLAND: I think we need to both move on,  
5 and I think that what we concluded here is that we really  
6 do want to look at the family glitch, which is much broader  
7 than our mandate, but it does affect how children would get  
8 their coverage and then think about whether there are  
9 lesser options, but let's at least get the numbers on the  
10 family glitch together.

11 And now we're going to move on to affordability.

12 Patty.

13 COMMISSIONER GABOW: I just wanted one  
14 clarification on 2. Are we saying that there would be a  
15 child-only plan then in the exchange? I mean, that's what  
16 we're supporting? Yes. Okay.

17 COMMISSIONER RILEY: But we are not supporting  
18 it. We are examining it, because I don't want us to -- I  
19 recognize the cost of number 1, but it strikes me that it's  
20 time to begin to talk about children and families. So if a  
21 child is healthy and returns to an uninsured, unhealthy  
22 family, what have we done to the kid? And it strikes me

1 that to broaden this conversation -- I know it's costly,  
2 and I know it's challenging, but it seems to me that we  
3 might want to broaden our conversation. I don't want us to  
4 forget one as we think about these options.

5 COMMISSIONER GABOW: Absolutely.

6 CHAIR ROWLAND: Excellent. Okay.

7 Issue 2. Since 1 was so easy, let's go to 2.

8 \* MS. JEE: So we have just talked about who would  
9 be eligible for the exchange subsidies; however, we do know  
10 that even with those subsidies, exchange premium  
11 affordability could still be an issue for some families.

12 Over the last several months, the Commission has  
13 considered the factors causing exchange premiums for  
14 children's coverage to be higher for those families.  
15 First, if parents are not already enrolled in the exchange  
16 plan, the family will not yet have paid its expected  
17 premium contribution for their exchange coverage, for  
18 exchange coverage. Thus, if the children enroll, the  
19 family would have to pay that expected exchange premium  
20 contribution.

21 As we discussed more fully at our last meeting,  
22 our analysis gives us a sense of what that means for

1 families. Take, for example, the family at 160 percent of  
2 the federal poverty level, which is just over \$38,000 for a  
3 family of four, which is what we looked at in our analysis.  
4 If the parents are not enrolled in the exchange plan, the  
5 family's average additional premium contribution for  
6 children's coverage would be 11 times higher than in CHIP.

7           At 210 percent of the federal poverty level,  
8 which is just over \$50,000 a year for a family of four, it  
9 would be five times higher.

10           Second, if families also enroll their children in  
11 a stand-alone dental plan, they could face additional  
12 premium contributions as well. Remember if stand-alone  
13 dental plans are offered on the exchange, the exchange  
14 health plans are not required to provide dental coverage.

15           For a family at 160 percent of the federal  
16 poverty level, the average additional premium contribution  
17 for a stand-alone dental plan is about \$242 a year.

18           CHAIR ROWLAND: But we did also discuss at the  
19 last meeting that the premiums under the CHIP program are  
20 not actuarially based premiums, and so we really need to  
21 make sure we know when we make those comparisons that we  
22 are really comparing apples to oranges to some extent.

1 MS. JEE: That's correct.

2 Okay. So let's move to some options for  
3 addressing exchange plan premium affordability. Remember,  
4 Commissioners, that the overarching question for these  
5 options, as Chris mentioned, is at what income level should  
6 they be applied, and again, I would just refer you back to  
7 the income levels that are described in the cover sheet to  
8 the table, which is in Tab 3 of your notebooks.

9 One option is to fully subsidize premiums for  
10 children's coverage in exchange plans, regardless of  
11 whether the parents are enrolled in the exchange or not.

12 A second option would be to provide some  
13 additional level of premium subsidy, but not a full  
14 subsidy, and still require some premium contribution from  
15 families.

16 And the third option would be to take into  
17 account the premiums paid for a family member's coverage  
18 outside of the exchange when calculating the amount of the  
19 premium tax credit. Currently, those premium costs are not  
20 included in that calculation.

21 So moving on to affordability of exchange plan  
22 cost sharing, as Chris said, you can address the premium

1 affordability. It doesn't necessarily address the cost  
2 sharing and the point-of-service affordability for  
3 families, and when we are talking about point-of-service  
4 cost sharing, of course, we are talking about things like  
5 copayments and deductibles.

6           The Commission's analysis, which we discussed in  
7 detail at last month's meeting, finds that cost sharing for  
8 children's exchange plans will be substantially higher than  
9 in CHIP. We estimate that the average annual cost sharing  
10 for children's coverage in the exchange will be about 6  
11 times higher than in CHIP for families at 160 percent of  
12 the federal poverty level and 13 times higher for families  
13 at 210 percent of the federal poverty level.

14           Of course, actual cost sharing will vary by  
15 service use, and certain children, such as those with  
16 special health care needs who require more frequent  
17 services are likely to have greater than average cost  
18 sharing.

19           So to turn to some options, again, just a  
20 reminder that these options could be considered  
21 independently or concurrently with the other options  
22 addressing the other issues.

1           The first option would be to provide children  
2 with exchange plan coverage with a 100 percent actuarial  
3 value. This means that there is no cost sharing for  
4 children for covered services, as is currently the case in  
5 12 states with separate CHIP programs. For this option,  
6 the Commission may want to consider an income eligibility  
7 range or level.

8           The second option is similar but would provide  
9 children's exchange coverage with an actuarial value of 98  
10 percent, which is the average actuarial value in separate  
11 CHIP programs now. This means that on average, families  
12 would pay for about 2 percent of the cost of covered  
13 services for their children, with the plans picking up the  
14 rest.

15           A third option would allow states to apply their  
16 current CHIP actuarial values to exchange plans. So the  
17 actuarial values and, thus, the cost sharing would vary  
18 across the states.

19           CHAIR ROWLAND: What's the range of state  
20 actuarial values?

21           MS. JEE: The range is 90 to 100 percent.

22           CHAIR ROWLAND: Sara.

1           COMMISSIONER ROSENBAUM: I just wondered whether  
2 we might, when we come back to this, add a fourth option,  
3 which is to use the platinum standard. Since all of this  
4 is tied to current CHIP practice, which is in some ways the  
5 ideal, but we can't say with certainty the current CHIP  
6 practices, current CHIP practice, another way to go would  
7 be to take another standard that has gained some acceptance  
8 in the context of discussing low income -- lower income  
9 families, and that is to think about either the current  
10 cost-sharing reduction subsidy model for families under 150  
11 percent or the platinum standard, so that we're sort of  
12 dealing with something that has a current -- may be a bit  
13 more current.

14           CHAIR ROWLAND: Yes. I think we are saying that  
15 the CHIP standard is not necessarily the gold standard, and  
16 really, here it would be both helpful on the premium issues  
17 as well as on the cost sharing to review the literature on  
18 what is financial burden for families at different income  
19 levels and to really begin to put this in a broader context  
20 than just we don't want to go backward from where CHIP is.

21           I have Andy, and then I have Chuck.

22           COMMISSIONER COHEN: Thank you. Clear

1 presentation. The issues that these two areas raise are  
2 just really huge and broad, and they range from things for  
3 which we really can have an evidence base to things that  
4 really are very, very much sort of value judgments. That  
5 makes it a little bit harder, I think, to talk about, but I  
6 wanted to just make a couple of comments and actually ask a  
7 question.

8           Let me start with my question. In thinking about  
9 the premium cost sharing, there can be multiple goals when  
10 we are talking about the issue of premium affordability.  
11 One is to not negatively impact family budgets in a  
12 potential change from the CHIP, and that certainly has  
13 impacts on children, moving from CHIP to exchange coverage,  
14 but the other is to ensure maximum coverage for children.  
15 So one is sort of looking at it from the perspective of  
16 family budget. One is like what will actually get the kids  
17 covered.

18           I did want to ask just the factual question. Can  
19 you just remind us what the underlying issue, what the sort  
20 of underlying rules about the mandate are and how they  
21 apply to children? Because that is a factor for us to sort  
22 of think about in this context unless it doesn't apply to

1 children. There is a requirement for families to cover  
2 their children, which has an impact, presumably -- and it  
3 may be a growing one -- on whether families will cover  
4 their children even if it is a hit on their budget.

5 So I think we just need to be clear about the  
6 impact of that. Can you just remind us what the sort of  
7 rules are and where they're headed?

8 Sorry. This is another classic multi-part  
9 question, but I apologize because this is only part one.

10 MR. PETERSON: So you are asking about the  
11 individual mandate.

12 COMMISSIONER COHEN: Yes.

13 MR. PETERSON: For an adult in 2015, it will be  
14 \$695 per person, and then for every kid, it's half that, so  
15 \$348.50, somewhere around there, up to some maximum. I  
16 think the maximum is up to just over \$2,000 a year for the  
17 penalty. Then it gets more complicated because there's  
18 actually another component that says, "Well, or 2.5 percent  
19 of your income if that's higher." That kind of gives you a  
20 range.

21 COMMISSIONER COHEN: In our modeling, in the  
22 modeling around -- have we taken that into account?

1 MR. PETERSON: Yes.

2 COMMISSIONER COHEN: Okay.

3 MR. PETERSON: That's actually a huge impact --

4 COMMISSIONER COHEN: Yes.

5 MR. PETERSON: -- that that has on families'  
6 decisions of whether to take up coverage.

7 If that individual mandate were not there, we  
8 would see a higher number of kids who would be uninsured  
9 post-CHIP.

10 COMMISSIONER COHEN: Okay. All right. Thank  
11 you. I did just want to -- so thank you for the answer,  
12 but I do think that we still need to sort of think about  
13 whether the end goal or the primary goal is around the cost  
14 or is around getting the kids covered.

15 Then I wanted to make a comment, obviously, in a  
16 perfect world where there weren't costs and demands. I  
17 would certainly prefer that both premiums and cost sharing  
18 were really affordable and make a decision to go to receive  
19 health care services as the parent believes that they are  
20 needed for the kid.

21 But as between the two, I have to say -- and in  
22 part, maybe because of the mandate and the growing sort of

1 push of the mandate, I am particularly concerned about cost  
2 sharing, and that is because -- and I think some review for  
3 us, as we go deeper into this in the literature that Peter  
4 mentioned last year about sort of the elasticity between  
5 sort of decisions to seek care and the cost at the point of  
6 service and how that relates to those decisions, I just  
7 think it's really critically important.

8           So I would just say I think there is a difference  
9 about sort of a budgeting decision that is made once a  
10 year. It's certainly an important one. I really have --  
11 but we have a variety of policies that can help to address  
12 that, and I am really concerned about the cost sharing at  
13 the point in time when a family has to decide whether to  
14 take a kid to a doctor or not. I think that that is an  
15 area for a particular concern, and I would say if we had to  
16 choose between where to relatively recommend spending more,  
17 I might go in that direction.

18           COMMISSIONER MILLIGAN: So I am going to have to  
19 learn to stop following Andy because I always have thoughts  
20 after you have thoughts, which is a good thing, but there's  
21 two points I want to make here.

22           The first is that I think this is an area where I

1 we definitely have to think outside of the CHIP framework,  
2 and if we were to pursue this analytic approach and  
3 eventually a recommendation, there's a lot of kids in  
4 existing qualified health plans who would be affected who  
5 are not part of the CHIP world. I am assuming we need to  
6 model that, but I just want to be very overt about that  
7 because what we're talking about is a longer term, sort of  
8 taking it back to the framework. We are talking about  
9 under what circumstances would the Commission be  
10 comfortable with CHIP not existing, and affordability was  
11 one of the pieces. But these principles or this framework  
12 that is on this slide would apply to a lot of other  
13 families too.

14           The other point I want to make, following Andy's  
15 point, is I agree about the cost sharing, and in  
16 particular, because it affects children with chronic  
17 illness and families with children with chronic illness  
18 disproportionately, which ties into benefits and other  
19 things, but I think that the utility of having insurance  
20 needs to address the chronic illness access issues that  
21 cost sharing in particular raises.

22           COMMISSIONER SZILAGYI: Yes. Actually, I had

1 raised my hand before Andy spoke, and I was going to say  
2 much the same.

3 To me, as I struggle with these issues, to me,  
4 the premium really affects the millions of families who are  
5 going to go into the pool, and so it's really important.

6 The cost sharing to me -- and I would support  
7 what Diane said, that it would be great to have you guys do  
8 a really good literature review, not only about cost  
9 sharing but how high up the income level does cost sharing  
10 change behavior, because the literature that I am familiar  
11 with is that children are highly sensitive to cost sharing.  
12 Children with special health care needs are a little bit  
13 less sensitive, but they need so much more care that it may  
14 impact them even more, and that cost sharing, it's also  
15 dependent on the type of services. So preventive services  
16 are highly dependent on cost sharing.

17 So if we have a program that has a fair cost  
18 sharing requirement, preventive services will go down. I  
19 mean, access and receipt of preventive services will go  
20 down, whereas --

21 CHAIR ROWLAND: Unless they're exempted.

22 COMMISSIONER SZILAGYI: Sure. Unless they're --

1 right, which gets into maybe the next discussion, whereas  
2 acute or emergent services may not change as much.

3 But some of the other studies that I see, people  
4 sometimes cut the income level at 200 percent and federal  
5 poverty level, but we have done studies which show that  
6 many families have a significant amount of unmet needs, all  
7 the way up past 300 percent of the federal poverty level,  
8 up to 400 percent of the federal.

9 So I would suggest looking at these issues all  
10 the way up to the federal poverty level and the types of  
11 services, because we are an access and I hope equality  
12 commission as well.

13 COMMISSIONER ROSENBAUM: When Jenny Kenney and I  
14 wrote an article for Health Affairs that came out last  
15 December, there was something that we reflected on, which  
16 we both agreed would require somebody asking for a much  
17 bigger study before we knew the answer, and this is  
18 obviously the possible opening.

19 One of the things that we pointed out was that in  
20 migrating children into the exchanges, of course -- and  
21 this has come up before for us -- especially if you, in the  
22 end, build a strong enough system to be able to migrate all

1 children into exchanges, that the effect on the pool might  
2 be significant enough in terms of the larger premium  
3 question by adding millions of children, that the difficult  
4 tradeoffs that we're now thinking about, which are hardly  
5 going to go away -- but some of the difficult tradeoffs  
6 might lessen a bit if there are salutary effects on the  
7 premiums as a whole.

8           I have to say I find this discussion so  
9 complicated because while I have spent almost 40 years now  
10 on the issue of cost sharing and children, I think we  
11 cannot overstate the seriousness of the premium problem  
12 because of not only the fact that families that find the  
13 coverage unaffordable end up with none, but because the  
14 recoupment is going to come for these families out of their  
15 earned income tax credits, by and large. And so the  
16 spillover effect is not just that their children are  
17 uninsured, but that their children are also losing other  
18 vital upstream investments in them that come through the  
19 EITC.

20           So anything and everything we can do to get  
21 Congress to see that while there are tradeoffs, when you're  
22 talking about tradeoffs in pediatrics, the tradeoffs in

1 pediatrics are a different kettle of fish from the  
2 tradeoffs that one might make for adults, assuming that  
3 they're competent to make decisions, bear a level of  
4 responsibility in the health care system here, we are  
5 talking about a group of people who do not bear legally or  
6 even functionally the same kind of decision-making  
7 discretion, and that in either way, the tradeoffs are  
8 really terrible things.

9           And that's why I'm also particularly focused on  
10 our playing out for Congress and for ourselves  
11 understanding what it means to migrate children into a  
12 pool. If you migrate children into a pool, what do you  
13 gain for populations that are not part of the children  
14 being migrated? And is it enough in terms of premium  
15 stabilization? Just like the question Arkansas is asking,  
16 is it okay to spend a little bit more on Medicaid if what  
17 we do is make a viable market for hundreds or thousands of  
18 people in the state? Is it a good idea to try and aim for  
19 a highly affordable system for families with children  
20 because of the salutary spillover effects? You can't do  
21 that until you have the system working properly for  
22 children, but it's an incentive to make the system work

1 properly for children.

2 I would just caution us about rushing too quickly  
3 to decide where we're going to trade until we really,  
4 really know the effects, the full effects of the migration.

5 COMMISSIONER GABOW: I think your point is really  
6 important, Sara, and I'd echo that, and we had that  
7 discussion here about Arkansas that if you increase the  
8 pool enough, the insurance rates for everyone go down. We  
9 shouldn't lose that in the context.

10 I wanted to make a point about providers in this  
11 for cost sharing. The idea that when you look at what the  
12 amount of cost sharing, if you're talking about a dollar or  
13 two dollars, from the provider perspective, collecting a  
14 dollar or two dollars and putting in place the structure to  
15 do that, I mean, the juice is not really worth the squeeze.  
16 So that thinking about the provider in this is also  
17 important.

18 The other thing that we saw happen, not  
19 infrequently at Denver Health, was when a poor person would  
20 come in -- and it was particularly with children, and they  
21 didn't have the copay for the medicine -- our providers  
22 would pay it for them. So it has this impact on the

1 delivery arm that shouldn't be forgotten.

2           There's some level where the amount of copay just  
3 doesn't justify the administrative process to collect it  
4 and send bills and get -- it's just --

5           VICE CHAIR GOLD: Yes. This is a really good  
6 discussion, and I think all the issues people raised are  
7 important ones. I am thinking of the staff and what I  
8 would do if I was a staff and had to take all this away.  
9 There's a lot of work here, and yet we want to move.

10           I think part of the challenge, the biggest  
11 barrier, which is not one that -- it's one everyone's faced  
12 in all these programs is figuring out what -- how to  
13 structure a benefit package.

14           So I am concerned on the lit review. I agree  
15 that it really needs to be done, but I also don't want you  
16 to have to feel like you have to reinvent the wheel. I  
17 know the IOM has looked at things. Peter can probably give  
18 you the list of mega reviews that children's literature has  
19 done, and some of this has been done. And it would be a  
20 real contribution, and I agree with Andy, it's really  
21 important to put it in. But I hope we can build on the  
22 existing literature, which I think is stronger here than in

1 many other areas, to sort of summarize it and then be able  
2 to spend the energy figuring out what some realistic  
3 options might be and why, how they differ from one another  
4 and what the rationale is.

5 CHAIR ROWLAND: Because we want our  
6 recommendations when we make them to be based on the  
7 available evidence. It doesn't have to be evidence we  
8 create. It can be evidence from the literature and from  
9 some of the states' experiences.

10 Okay. So now we'll move on to pediatric dental.

11 MS. JEE: I've got one more option. I don't know  
12 if we should run through it, but it's on the slide. Okay.  
13 This is the last one.

14 So this last option takes the same actuarial  
15 values that are used currently and providing the cost-  
16 sharing reductions for exchange plans, but just applies  
17 then at a different income level, so it basically just  
18 shifts them up on income.

19 Again, the table on page 4 in your meeting packet  
20 provides sort of which actuarial values would apply to  
21 which income level, so that's the last option here, and we  
22 can turn it over to Ben.

1           CHAIR ROWLAND: But I think what we're telling  
2 you is that we're not ready to look at these specific  
3 options. We want a broader framework, levels of cost  
4 sharing, financial burden, and the impact on access.

5           Ben.

6 \*           MR. FINDER: So I'll try to wrap this up a little  
7 bit more quickly.

8           For this issue, Joanne alluded to it earlier,  
9 pediatric dental benefits. In your consideration of  
10 affordability and benefits, it's become clear that some  
11 children in exchange plans may lack coverage for pediatric  
12 dental services.

13           In CHIP, pediatric dental services are covered.  
14 In exchange plans, pediatric dental services are one of the  
15 10 required essential health benefits. You'll recall that  
16 when pediatric benefits are not always embedded in exchange  
17 plans when stand-alone dental plans are available.  
18 Exchange premium subsidies do not reflect the additional  
19 cost of stand-alone dental plans.

20           So let's look at three options that could be  
21 considered independently or concurrently with other  
22 options. The first option is to require all exchange plans

1 to embed pediatric dental services. A few states have  
2 already moved to do this on their own. Secondly, premium  
3 subsidies could be augmented to include the cost of stand-  
4 alone dental plans, and thirdly, you could consider  
5 providing children with wrap-around pediatric dental  
6 coverage.

7 I should mention that for at least the last two  
8 options, you could also consider scaling these options in  
9 some way based on family income.

10 The story on other benefits is less clear. As a  
11 brief summary of our conversation on benefits, you will  
12 recall that most major medical benefits are covered in both  
13 CHIP and exchange plans, but our research has identified  
14 some areas in which benefits vary between programs and  
15 plans. For example, the March report found that audiology  
16 exams were covered by a separate CHIP in each state, but  
17 only by 37 percent of exchange plan benchmarks.

18 Covered services can vary within each source of  
19 coverage. For example, separate CHIP covered, supplied  
20 behavioral analysis therapy in some states but not others.

21 From those conversations on benefits, a couple of  
22 options have emerged that might address some of the

1 variation in covered benefits between programs. The first  
2 three options that I'll present revolve around how coverage  
3 is defined in exchange plans. All exchange plan benefits  
4 are based on the same essential health benefit benchmark  
5 established by the state. So policymakers could consider  
6 providing states the option of establishing a separate  
7 pediatric-specific benchmark.

8           The first option would allow states to establish  
9 a separate pediatric benchmark tied to Medicaid's EPSDT  
10 definition.

11           The second option would allow states to establish  
12 a separate pediatric benchmark tied to benefits generally  
13 available in each state's separate CHIP.

14           The third option is less prescriptive. We would  
15 just allow states the option of establishing a separate  
16 pediatric benchmark. Alternatively, you could consider  
17 changing how pediatric services are defined in the  
18 essential health benefits to include certain benefit  
19 categories; for example, audiology services.

20           The final option is to provide wrap-around  
21 benefit coverage for children through Medicaid.

22           So we presented a lot of options for your

1 consideration, options that generally reflect an exchange-  
2 targeted approach to addressing some of the concerns about  
3 affordability and adequacy that have surfaced in  
4 conversations about your long-term vision for children's  
5 coverage, but this list is by no means exhaustive.

6           Like Chris said, we look forward to your  
7 feedback, so that we can bring more detailed analyses for  
8 you to consider at a future meeting. We look forward to  
9 your feedback on these options and your feedback on the  
10 bigger policy decisions or choices. For example, what role  
11 should Medicaid play in your long-term vision for  
12 children's coverage, and what role can CHIP play or a  
13 Medicaid wrap-around or other more targeted approach?

14           And with that, I'll close.

15           CHAIR ROWLAND: Thank you.

16           Gustavo.

17           COMMISSIONER CRUZ: Thank you.

18           I want to comment on some of the options for the  
19 pediatric dental benefits. One of them is the option 3. I  
20 am going to start from the worst to the best. Sorry. I  
21 mean, the option 3 of the wrap-around Medicaid, it would  
22 create such administrative problems. We have some, which

1 I'm sure has been discussed here many times, sort of  
2 legendary issues in terms of access to care to children  
3 under the Medicaid program. Those issues of access are  
4 eased out under the CHIP program, so it would be sort of  
5 roll back to Medicaid. The only sort of positive aspect of  
6 that would be if these children would be covered under  
7 EPSDT, but they are not. So that would create added  
8 bureaucracy.

9           The second option in terms of the augment  
10 existing subsidies, that, in my view, will only work if you  
11 require to buy a stand-alone dental plan if it's not  
12 embedded within the plan, and there are four states that  
13 are already doing that. So if you go into the exchange and  
14 you choose a medical plan and you have children, you cannot  
15 get out of the exchange unless you buy the dental coverage.

16           The option number 1, which for me would be sort  
17 of the best, instead of providing comprehensive dental  
18 care. The only issue that we're finding is that in some of  
19 the states that offered embedded dental coverage within the  
20 medical plan, some -- not all, but some of the plans  
21 actually apply the full medical deductible to both children  
22 and dental. So if you have a deductible of \$3,000, let's

1 say, which is the average, you can be rest assured that the  
2 preventive services for those children are not going to be  
3 provided when parents have to sort of add and subtract  
4 their budgets. So that is a caveat that could be solved if  
5 you sort of exempt the deductible for pediatric dentists or  
6 create a separate deductible that many other plans have  
7 done.

8 Thank you.

9 COMMISSIONER RILEY: I just had a question on the  
10 benefits issue in item 4, expand the definition to include  
11 certain benefits, because I was stuck recently that  
12 mandates in insurance have been enacted in states for a  
13 very long time, and yet there's been a real rise of  
14 mandated benefits for kids. Thirty-seven states mandate  
15 services for Asperger's. Twenty-five, I think, are doing  
16 audiology. It would be interesting, a data point, to know  
17 how many dates for children services currently exist, so  
18 that we can think more about option 4.

19 COMMISSIONER GABOW: I wanted someone to clarify  
20 for me, and then I'll have a question.

21 My understanding is that the stand-alone CHIP  
22 plans did not have EPSDT as a mandate, and since there are

1 many stand-alone CHIP plans, do we understand what the  
2 impact of not having EPSDT included in stand-alone CHIP  
3 plans have been to access quality of care for children?

4 I mean, that's a pretty robust sample that is  
5 different.

6 COMMISSIONER ROSENBAUM: I was going to say that  
7 there are a couple of different studies. There's one,  
8 actually, that's in the materials that you are about to  
9 publish, I know from academic pediatrics, that suggest that  
10 special needs children -- it's sort of interesting -- do  
11 better than uninsured children, but it was not clear that  
12 there weren't specific services where they would do --  
13 these were in CHIP plans.

14 In a study that we did at GW about 12 years ago  
15 now, 12, 13 years ago, after the '97 CHIP enactment, we  
16 interviewed plan administrators in both Medicaid managed  
17 care plans that had to do the full complement as well as  
18 stand-alone CHIP plans. What we found was that the  
19 problems tend to cluster in certain very specific kinds of  
20 cases. It's children with very long-term, very severe  
21 physical and mental health conditions who need a very high  
22 frequency of care where, of course, the EPSDT benefit

1 mandate is important not so much for the covered class of  
2 benefits, although that is certainly a value, but it is the  
3 restriction on the use of amount, duration, and scope  
4 limits not related to medical necessity.

5           So even a good CHIP plan if it is separate -- at  
6 least this is what we found years ago, and it may be  
7 different today. A good CHIP plan would have some  
8 durational limits in it, 30 visits for X or X number of  
9 days of Y. Whereas, under the Medicaid program, in theory,  
10 there would not be a fixed day or durational limit, and so  
11 it's a very tiny, but very expensive, very costly sliver of  
12 children who are affected by this -- and in fact, in a lot  
13 of states under Medicaid managed care today, and that's why  
14 the discussion of wrap-around, I always find a little hazy,  
15 because there are states that have their managed care  
16 organizations handle the EPSDT benefit up to a certain  
17 level, and then they may do -- as an administering entity,  
18 they may handle all of the claims on a non-risk basis, but  
19 with the state kicking in beyond a certain level. So, in  
20 other words, there could be the equivalent of a wrap that  
21 goes on inside EPSDT today, which further complicates  
22 things.

1           COMMISSIONER GABOW:  If there is a small sliver  
2 of children where this -- not having the EPSDT coverage in  
3 the separate CHIP program, then it does have implications  
4 for our saying that EPSDT should be part of every benefit  
5 package, rather than focusing on the narrow group.

6           CHAIR ROWLAND:  Peter.

7           COMMISSIONER SZILAGYI:  Yes.  Just to embellish,  
8 I don't think anybody has or can do exactly that study that  
9 you were asking about, Patty, because enough of the  
10 separate CHIP plans have a lot of the essential benefits.  
11 There's a variability in those states, and there are other  
12 confounds or other things that affect those states.  So  
13 it's not completely, I think, answerable, although it's a  
14 really great question.

15           Regarding dental, do people realize that the most  
16 common chronic disease in childhood is dental caries?  It  
17 is actually more than -- some of the other things.  And  
18 secondly, do people realize that dental caries is almost  
19 completely a disease of the poor?

20           So if we can solve this issue in terms of  
21 adequate coverage and services for dental care for poor  
22 children, we will be able to potentially eradicate a major

1 chronic disease in this country.

2 CHAIR ROWLAND: But we need to look at that not  
3 just in the context of CHIP, but especially in the context  
4 of Medicaid.

5 COMMISSIONER SZILAGYI: Oh, absolutely. And by  
6 poor children, I don't mean that it stops at 100 percent of  
7 the poverty level because there's an awful lot of dental  
8 caries among children between 200 and 400 percent of the  
9 poverty level, but you just don't see it in high-income  
10 populations.

11 CHAIR ROWLAND: Chuck.

12 COMMISSIONER MILLIGAN: Yes. I guess I just want  
13 to raise a point. As I'm listening, I'm not getting a good  
14 sense of the sort of consensus of the Commission about  
15 whether what we're trying to solve for here is what do kids  
16 need as a national standard versus what should be done in  
17 terms of a potential bridge out of CHIP, where there is  
18 state variability.

19 There is state variability in EHB. There's state  
20 variability in the existing CHIP programs that would need  
21 to bridge to whatever the future might be. So I can't  
22 figure out listening to ourselves here whether we're trying

1 to solve for a national standard or whether we're trying to  
2 solve for a bridge where there would be probably  
3 variability in states.

4 CHAIR ROWLAND: I think one of the things we are  
5 looking at is what would a national standard be and then  
6 how do we measure up to it as we look at the bridge issue,  
7 because I think we've been struggling with -- is the  
8 national standard, CHIP, which has all of its variations,  
9 or is there a different level that we would say this is the  
10 minimum level of protection that children in America should  
11 have, and then how do we use the CHIP program as a bridge  
12 to try to get there.

13 COMMISSIONER MILLIGAN: I think even that  
14 statement would be helpful to confirm and then where is  
15 that foundation.

16 CHAIR ROWLAND: Marsha.

17 VICE CHAIR GOLD: I think that last discussion is  
18 a really important one. I am concerned that we are  
19 realistic in looking at these things because one can  
20 recommend everything, but it doesn't -- it may not come to  
21 pass.

22 The thing I wanted to suggest we also put on the

1 table is sort of access to providers and health plans and  
2 administrative simplicity. Some of these options are more  
3 consistent with the way health plans in the exchange work  
4 and the way providers work than others. In particular,  
5 some of the EPSDT things, if you're thinking about relating  
6 kids' coverage to Medicaid, it makes sense, but to provide  
7 plans and private providers, they are not used to dealing  
8 with them, and I think they probably don't like them too  
9 much because of the paperwork requirements.

10           So recalling, I would guess that one of our  
11 principles would be we want to give people access to the  
12 plans in the exchanges in a way that allows those plans in  
13 the exchanges and the providers they contract with to be  
14 interested in serving children, and so I think the kind of  
15 solutions we come up with may want to sort of reflect what  
16 the common practices are there.

17           COMMISSIONER COHEN: Great points and questions,  
18 and I just figured I would take my personal crack at sort  
19 of answering them.

20           I think that what we are looking at is something  
21 that we could have looked at in the absence of a cliff on  
22 CHIP. This is the question of whether coverage for low-

1 income children and potentially low- and middle-income  
2 children across the country, whether it should be  
3 reexamined in some way or another, the financing, the  
4 benefits, or otherwise. As it so happens, this question is  
5 forced by the potential cliff in CHIP, but I do think that  
6 our frame should be looking at coverage for low- and  
7 potentially low- and moderate-income children across the  
8 board and not just those who might be in CHIP at a point in  
9 time when it expires because there's lots of moving in and  
10 out.

11 I would also say that while we don't need to be  
12 terribly -- it's one thing for us to say what we think is  
13 an important goal and we don't have to be terribly specific  
14 in all cases about what we recommend, I am really not  
15 excited about wrap-around options in this context.

16 I think one of the principles that we mentioned  
17 in saying that for all the good that CHIP has done, that  
18 it's the long-term future we think is in a different  
19 program that has better sort of -- a better continuum of  
20 financial support for health coverages was because of  
21 simplicity and then the costs, not just financial, but all  
22 sorts of costs of having multiple programs interesting with

1 each other, and I think that the wrap-around, I personally  
2 would be inclined to take it off the table and personally  
3 would support a look at a separate children's EHB  
4 benchmark.

5           Again, I always come back to this. I would love  
6 to get a little bit more clinically oriented sort of  
7 research summaries around the extent to which that is  
8 necessary and in what areas, but that is my orientation at  
9 this point.

10           COMMISSIONER MILLIGAN: Yes. Just a really quick  
11 point. I do think contextually, if and when this gets  
12 written into a chapter down the road, we need to keep in  
13 mind that in this time frame, we're talking about the  
14 Section 1332 waivers under the ACA would be available,  
15 which could alter EHB, alter subsidy levels, alter cost  
16 sharing, and so I think we will need to contextualize this  
17 in the time frame in which that waiver would be available,  
18 since we're getting into QHP land.

19           COMMISSIONER ROSENBAUM: I realize I've raised  
20 this earlier, and I certainly appreciate the complexities  
21 of some of these options, but again, I think it's important  
22 to note that we use something called "wrap-around." I've

1 never understood exactly what wrap-around is. What I  
2 understand is that you might be eligible for some  
3 supplementary coverage, and I think we underestimate the  
4 degree to which actually today we have a fairly sizeable  
5 number of children with dual enrollment.

6 And I'm not sure that it's so much --

7 COMMISSIONER GABOW: But, Sara, is it good? Does  
8 it work well for them?

9 COMMISSIONER ROSENBAUM: Oh. If you ask a parent  
10 of a child with cystic fibrosis if the extra Medicaid  
11 coverage is working for the child, they would trade their  
12 lives before they would give up the extra coverage. Their  
13 employee benefits do not cover the drugs they need, the  
14 therapies they need.

15 I'll never forget one hearing we had a few years  
16 ago, actually, on the Hill that was held to do a briefing  
17 around children's coverage, and we had three families with  
18 cystic fibrosis come and testify, all of whom had workplace  
19 coverage. And this was before. Actually, it was in  
20 relation not to CHIPRA per se. It was in relation to  
21 Medicaid.

22 And so I couldn't agree more, Andy, that there

1 are issues in making supplemental coverage work, but I  
2 think before we tackle this issue in theory, we need -- and  
3 I've actually asked MACPAC staff this question once before  
4 and got a totally startling answer. I mean, the number was  
5 high -- asked how many children showed up in Medicaid who  
6 also had private insurance coverage because, of course,  
7 Medicaid does not have a crowd-out provision, and the  
8 number is significant.

9 So I find --

10 CHAIR ROWLAND: We are sure that MACPAC staff  
11 will produce that number.

12 COMMISSIONER ROSENBAUM: Right. And I find it  
13 particularly compelling, going back to the priori exchange,  
14 when in fact we can identify with some certainty which of  
15 the benefits it is. It's drugs. It's extra mental  
16 therapy. It's extra speech and occupational therapy. It's  
17 not sort of just this crazed agglomeration of services.  
18 There are distinct places where commercial benefits fall  
19 short, and that is because of the norms underlying  
20 commercial benefits.

21 So I just want to be sure that we're having this  
22 discussion with the benefits of a lot of information on

1 dual enrollment today, among children especially.

2 CHAIR ROWLAND: Well, and there is another big  
3 wraparound in the Medicaid program, which is the dual-  
4 eligible Medicare and Medicaid population. That works  
5 fairly well.

6 COMMISSIONER COHEN: May I just -- so, Sara,  
7 point extremely well taken, and perhaps taking the option  
8 off the table is a little strong at this point.

9 I would say we are in the maybe privileged  
10 position of not thinking about what might -- I mean, the  
11 question of whether additional benefits might be necessary  
12 is -- on top of commercial coverage, I think we understand  
13 that there are times when commercial coverage does not  
14 provide what some children need. I think the question is:  
15 In a design phase of a new opportunity, would you design it  
16 as the wraparound, is a solution to do that. And if you're  
17 thinking about, say, dental coverage, you are talking not  
18 just for kids with illness, but every child needs that  
19 benefit in particular.

20 So the idea that you want to design the program  
21 with a Medicaid wraparound for virtually every child, for,  
22 you know, tens of millions of children, I just think as a -

1 - it would not be a preferred design.

2 CHAIR ROWLAND: It depends on what the wraparound  
3 is.

4 COMMISSIONER ROSENBAUM: And we could give  
5 everybody EPSDT benefits, but I think that actual is more  
6 jarring than thinking about a situation where a child is --  
7 there is a tiny number, and Peter's really one of the great  
8 experts on this, a very small number of children for whom  
9 normative coverage standards are not going to be  
10 sufficient, and --

11 CHAIR ROWLAND: Okay. I think we're getting --

12 COMMISSIONER ROSENBAUM: -- we need to think  
13 about them --

14 CHAIR ROWLAND: -- too stuck on wraparound  
15 benefits here and sort of getting into the weeds before we  
16 get to the top of the mountain to be able to look down.

17 Is it about wraparound benefits, Donna?

18 COMMISSIONER CHECKETT: Let me assure you I  
19 wouldn't dream of raising that issue after those strong  
20 words of caution from our Chair.

21 [Laughter.]

22 COMMISSIONER CHECKETT: I actually am going to

1 really take this discussion in another direction, which is  
2 to say I don't feel that -- I think as we're moving into  
3 the exchange population, that I would like to have more  
4 facts about what the real needs are instead of kind of a  
5 gut reaction that it's not enough. And so I know that  
6 we've done some analysis in that regard, but I am stating  
7 the need for more data and facts around that. And I don't  
8 want us to just assume that it's not good enough. That  
9 would be my concern.

10 CHAIR ROWLAND: Great contribution.

11 Patty, did you have another comments or was it  
12 about wraparound benefits?

13 COMMISSIONER GABOW: It was about wraparound, and  
14 I'm willing to defy the Chair.

15 [Laughter.]

16 COMMISSIONER GABOW: I think that as we look at  
17 long term -- as you all know, I'm in favor of simplicity  
18 and administrative ease. But I think as we think about the  
19 long term of the country, it's not -- and the future of  
20 Medicaid in general, it is not unrealistic, I don't think,  
21 to think about saying that we're going to have coverage  
22 that is, you know, in an exchange, whether it's commercial

1 or subsidized coverage, and we're going to have Medicare,  
2 and in both those instances Medicaid will wrap around what  
3 no basic insurance plan would ever offer. And if you make  
4 every insurance plan offer everything that anyone could  
5 possibly need, it rapidly becomes unaffordable.

6 So I think as we think about long term and the  
7 future of Medicaid, it is not unrealistic to think, Is  
8 Medicaid's long-term future a wraparound for extraordinary  
9 services that the average person would not need?

10 CHAIR ROWLAND: I think it's important to  
11 recognize, as Sara pointed out earlier -- so I'll talk  
12 about wraparound --

13 [Laughter.]

14 CHAIR ROWLAND: -- that Medicaid has in its  
15 history been designed as a wraparound program. There was  
16 no crowd-out provision. It was intended to either fill the  
17 void for those who had no other source of Congress or to  
18 provide wraparound services, whether that would be for  
19 long-term-care services, whether that would be for  
20 additional coverage for people who had skimpy private  
21 insurance plans. So that we really need to think about the  
22 Medicaid context, but I also think as we go forward in

1 looking at these options, we have to remember what the  
2 coverage is for those under 138 percent of poverty who are  
3 on the Medicaid program, what their cost sharing is, what  
4 their benefits are, and then try and figure out how to not  
5 create a notch as you go forward with kids at slightly  
6 higher and higher income levels. And for that I think it  
7 would be very helpful if for our next discussion the staff  
8 brought in a table that really shows us what the Medicaid  
9 eligibility levels are by state so that we know how many  
10 states actually cover kids on Medicaid above 138 percent of  
11 poverty and how many kids are affected at what income  
12 levels in what states so that we have some sense of how  
13 many kids are falling under CHIP and Medicaid and to which  
14 income groups.

15           And then I think we really need to think through,  
16 starting back at the family glitch, I mean, so what's the  
17 family glitch and how many are affected there, but how are  
18 we really structuring premiums and cost sharing up the  
19 entire income scale and not just starting at 138, and then  
20 looking at kind of the choices, as you've laid out, between  
21 the coverage in the exchange that provides some special  
22 cost-sharing help to families at lower-income levels, well,

1 maybe that needs to be changed. But I think there's a  
2 range of options there that we ought to look at, but we  
3 need to wed it in keeping the Medicaid end of it part of  
4 our discussion.

5           COMMISSIONER CARTE: Having administered a  
6 separate CHIP program, I would just say that the separate  
7 CHIP benchmark I think has been highly satisfactory for  
8 states. I know in my state and in looking at surveys that  
9 NASHP has done, I don't think you see lots of demand for  
10 wraparound. I think it really is a great standard that has  
11 satisfied the needs of most families, and you don't see a  
12 big cliff. Of course, there have been exceptions, like for  
13 special populations like children with autism, but also  
14 that has been changing rapidly as those mandates have come  
15 into the commercial market.

16           CHAIR ROWLAND: One of the options we might want  
17 to consider is to look at having a provision for children  
18 with special needs who -- it's not every child would have  
19 access to wraparound Medicaid benefits, but if there's a  
20 child with special needs and those services are best served  
21 within the Medicaid program, to have them have that as an  
22 option, and I think that's one thing we might look at and

1 put on the table.

2 MR. PETERSON: To follow up on the factoid that  
3 was mentioned, 3 percent of children in Medicaid/CHIP also  
4 have private coverage -- 3.3. Percent. That's based on the  
5 National Health Interview Survey.

6 CHAIR ROWLAND: Okay.

7 COMMISSIONER ROSENBAUM: [off microphone] --  
8 generally, you wouldn't go looking -- you might -- there  
9 might be children who start as public and end up picking up  
10 employer coverage. But my guess would be -- and maybe we  
11 can find out more -- that the opposite is true, that these  
12 are -- whatever group this is, somewhere between a million  
13 and 2 million children, whatever the number is --

14 COMMISSIONER SZILAGYI: About a million.

15 COMMISSIONER ROSENBAUM: Yeah, are -- start off  
16 with employer coverage exhausted. They're essentially  
17 Grassley children, and people, you know, don't remember the  
18 Grassley children who Senator Grassley created in 2006 who  
19 were designed to deal with this problem of parents  
20 exhausting their employer benefits.

21 MR. PETERSON: So to that point, if you look at  
22 just children with SSI or who do not have SSI but are

1 qualified as children with special health care needs, 6  
2 percent have private coverage versus 3 percent if they are  
3 neither SSI nor children with special health care needs.

4 VICE CHAIR GOLD: And I would suggest, Chris that  
5 maybe you could talk with -- I don't know if it's the  
6 people at AHRQ or people at NCHS. Some of that has to be  
7 reporting error, because people -- these come from self-  
8 reports of whether people have coverage. And when you're  
9 talking such a low percent, it does not take that much  
10 reporting error, I would think, to have one of the 3  
11 percent be people who have something odd or something they  
12 think they had or maybe they had it last month but they  
13 don't have it now.

14 So I'm not sure I would agree they're all people  
15 who were double, and I think those groups may be able to  
16 provide you some -- the issue is how accurate is the  
17 reporting of private insurance data or Medicaid coverage  
18 and could that explain some of it, and then how much is  
19 left for what Sara's saying.

20 CHAIR ROWLAND: Okay.

21 COMMISSIONER ROSENBAUM: One last point. Just  
22 one last point, which is an important analogy in all of

1 this, is the medically frail exception to the benchmark  
2 plan. And so one of the things -- I mean, there, going  
3 back to Diane's point, it's just a decision at the  
4 threshold that certain people don't go into a benchmark,  
5 i.e., don't go into a plan modeled on an employee benefit  
6 plan at all. And so one variation, going to Andy's point  
7 of administrative problems or Patty's point, is to think  
8 about sort of this variability, right? You can do it as a  
9 supplemental insurance plan. You can do it as a voluntary  
10 choice for families or even a screening tool to make  
11 Medicaid the primary insurer for certain services with  
12 financial adjustments to go along with that. But, I mean,  
13 you know, it's sort of two ways to get at the problem.

14 CHAIR ROWLAND: So what we're asking the staff to  
15 do is to continue to look at the family glitch and the  
16 implications of it more broadly and then potentially just  
17 looking at it on a children basis. We're asking you to  
18 really comb the literature for what we know about financial  
19 burden for premium and cost sharing and especially its  
20 impact on access. And we're looking at then trying to  
21 figure out what levels of skin in the game are going to be  
22 problematic for families and how that would change as one

1 goes up the income scale. So obviously what is a burden  
2 for someone at 150 percent of poverty isn't at 300.  
3 Finding out where we are today with regard to levels of  
4 coverage for children and their income eligibility.

5           On the benefit side, I think we've also  
6 identified in much of our work that there's a very slim set  
7 of benefits -- not slim, but a very limited set of benefits  
8 that are outside of what the normal scope is. So let's  
9 think about special needs children and what benefits they  
10 need, and then let's have a special focus on availability  
11 of dental care. And I'd like that to be looking at kind of  
12 how we merge Medicaid problems with problems outside of the  
13 Medicaid program.

14           And, finally, I think we ought to really be  
15 sensitive to the fact that what kids get if they qualify  
16 for Medicaid and they are under 138 percent of poverty or  
17 another state is at a higher level, and what kids get if  
18 they are outside of the Medicaid program, so that we don't  
19 create a big notch where \$1 of income that puts you out of  
20 Medicaid throws your kids into a totally different  
21 situation. And I think all of that is perfectly doable by  
22 our next meeting.

1 [Laughter.]

2 CHAIR ROWLAND: So I want to thank our team, and  
3 obviously the Commission has been well engaged in this  
4 discussion, and I know we will continue to be. And I'm  
5 going to take the Chair's prerogative of moving our next  
6 discussion on an update of Medicaid expansions to post-  
7 lunch. But I'm going to ask if there are public comments  
8 on the morning session before we adjourn for lunch.

9 **### PUBLIC COMMENT**

10 \* [No response.]

11 CHAIR ROWLAND: Seeing and hearing none, we will  
12 stand adjourned, and we will reconvene at 1:00 instead of  
13 1:15.

14 [Whereupon, at 12:15 p.m., the Commission  
15 recessed, to reconvene at 1:00 p.m., this same day.]

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1 AFTERNOON SESSION

2 [1:03 p.m.]

3 CHAIR ROWLAND: Okay. If we can please  
4 reconvene, we will finish up our morning business before we  
5 get to our afternoon session, and we are asking Martha and  
6 Sarah to give us an update on the Medicaid expansion which  
7 it's at Tab 4 in your briefing books.

8 **### Session 3: Update on Medicaid Expansions**

9 \* MS. MELECKI: Good afternoon.

10 With most state legislatures currently in  
11 session, there's been a lot of recent activity and news  
12 coverage surrounding Medicaid expansion discussions, and so  
13 we felt that this would be a good time to update you on the  
14 state of Medicaid expansion decisions in the states.

15 So I'll begin today by providing a brief update  
16 on state expansion decisions. Martha will then provide  
17 more information on expansions by waiver and traditional  
18 expansions, followed by the most recent Medicaid enrollment  
19 data available. We will conclude with an overview of  
20 future MACPAC work in this area.

21 As of today, 28 states and the District of  
22 Columbia have chosen to expand Medicaid, and this includes

1 states who have chosen to expand traditionally and those  
2 who have used Section 1115 demonstration waiver authority.  
3 Currently, 22 states have not expanded Medicaid.

4 The map in this slide shows expansion decisions.  
5 Dark green states are those that have expanded  
6 traditionally. The light green states have expanded by  
7 waiver authority, and red states have not expanded.

8 Given that most legislatures are currently in  
9 session, we're monitoring movement closely. Examples of  
10 states we're monitoring include Idaho where the Governor is  
11 interested in expansion and has convened a work group to  
12 study a possible expansion. The work group has released a  
13 plan which they've presented to a House committee.

14 In Utah, the legislature is currently debating  
15 three different proposals for a waiver application,  
16 including one from the Governor. Just yesterday, one of  
17 those proposals passed the Senate, and it's unclear if it  
18 will be considered in the House.

19 In Alaska, the newly inaugurated Governor favors  
20 expansion and released an expansion proposal in early  
21 February.

22 Turning to Florida, the state currently has a

1 low-income pool, or LIP, funding waiver, which provides  
2 federal money to help hospitals treat low-income and  
3 uninsured patients. CMS officials have said that they will  
4 not approve a continuation of the waiver, and so some in  
5 the state are proposing Medicaid expansion as an  
6 alternative to help balance the state's budget in lieu of  
7 the LIP waiver.

8           Finally, looking at Ohio, the state expanded  
9 Medicaid through the legislature's seven-member controlling  
10 board in October of 2013. The Governor wants to continue  
11 the expansion, but it's unclear what steps would need to be  
12 taken in order to do so.

13           There's also been recent activity in several  
14 states. In Pennsylvania, the newly inaugurated Governor is  
15 in favor of a traditional expansion and has begun work to  
16 move the state from the 1115 waiver that was approved by  
17 CMS last year to a traditional expansion. The waiver  
18 program has been implemented, and so the move to  
19 traditional expansion will have a transition period.

20           In Indiana, CMS approved the state's 1115 waiver  
21 on January 27th, and eligible persons began to be enrolled  
22 on February 1st.

1           In Arkansas, the waiver stipulates that the  
2 legislature must vote to extend funding each year, and the  
3 current legislature has voted to extend funding through  
4 2016. They also voted to create a work group to look at  
5 options for years beyond 2016.

6           In Tennessee, the Governor released a plan last  
7 year to expand by waiver authority. The legislature did  
8 not pass such an expansion during a special session that  
9 was called specifically to address expansion, and the  
10 legislature is currently in regular session.

11           In Virginia and Wyoming, proposals were brought  
12 before both legislatures, and both legislatures failed to  
13 pass expansion legislation, which effectively ended  
14 expansion efforts in the current legislative session. Both  
15 Governors favor expansion.

16           MS. HEBERLEIN: So moving on to the traditional  
17 versus Section 1115 waiver expansion.

18           As Sarah mentioned, 5 of the 29 states that have  
19 expanded have chosen to do so through Section 1115 waivers,  
20 which give them the option to try out different approaches  
21 to benefit and cost-sharing design than would be available  
22 to them under their traditional Medicaid expansion.

1           So I'm going to give you some highlights of these  
2 waivers as I go through them.

3           Arkansas, which is also known as the "private  
4 option," and you've heard a lot about it, is using a  
5 premium assistance approach to purchase qualified health  
6 plans on the exchange for enrollees. A recent amendment to  
7 this establishes health savings accounts that require  
8 monthly contributions for enrollees beginning at 50 percent  
9 of the FPL.

10           Iowa is actually two waivers. One, which is very  
11 similar to the Arkansas model, is using premium assistance  
12 for enrollees, but it's just for those who have income  
13 between 100 and 138 percent of the FPL. There are those  
14 who are under 100 percent, are covered through managed  
15 care, and that's a separate waiver.

16           Premiums are charged for those starting at 50  
17 percent of poverty, but they are waived in the first year  
18 of enrollment and in subsequent years if you complete  
19 certain healthy behaviors.

20           Just as a reminder for returning Commissioners,  
21 you may recall that I presented a chapter at the December  
22 meeting that will appear in March that talks more about the

1 Arkansas and Iowa premium assistance approaches.

2           So, as Sarah said, Indiana was just recently  
3 approved and is probably the most complex. I won't go into  
4 all the details, as we are still trying to sort all of it  
5 out, and this is a continuation of an existing program that  
6 they already have that relies on health savings accounts as  
7 well.

8           Those with income at or below 100 percent who  
9 don't make monthly contributions to these health savings  
10 accounts actually get a lower benefit package that doesn't  
11 include dental or vision while those above 100 percent who  
12 don't make contributions are locked out of coverage for six  
13 months.

14           Michigan is using managed care plans to expand  
15 Medicaid. They also are using sort of a health savings  
16 account approach where all enrollees will make  
17 contributions based on the prior six months of utilization,  
18 and again, contributions are reduced through healthy  
19 behaviors. Enrollees above 100 percent also pay premiums.

20           Pennsylvania is also covering their expansion  
21 population through managed care. They charge monthly  
22 premiums of about 2 percent of income for enrollees above

1 100 percent, and there, again, are incentives for healthy  
2 behaviors. As Sarah mentioned, the Governor is in favor of  
3 more traditional expansion, and so they're transitioning  
4 from their waiver coverage to a traditional expansion.

5           Finally, in New Hampshire they have a pending  
6 waiver that looks very much like Arkansas as well where  
7 they are going to use premium assistance in the exchange  
8 beginning in January 2016. Their waiver has been in since  
9 the end of November, so we expect something shortly on  
10 that. Currently, they are covering the expansion  
11 population in a bridge program and as well as through  
12 premium assistance with employer-based coverage.

13           CHAIR ROWLAND: Martha, when we look at the  
14 waivers and the waiver experience, I am going to channel  
15 Patty for a minute, and I think one of the things that we  
16 haven't always looked at is we've described the features of  
17 the waivers, but we haven't thought through kind of the  
18 administrative complexity of much of what is in the  
19 waivers, and I think that's a criteria we should also look  
20 at because just having reviewed some of the terms of the  
21 Indiana waiver, I think it adds more complexity to the  
22 program than one really anticipates it would.

1 MS. HEBERLEIN: And I will give more on our work  
2 on waivers in a minute.

3 We also wanted to give you the latest update on  
4 the enrollment figures. These are hot off the presses.  
5 These came out on Monday. They show that as of December  
6 2014, nearly 69.7 million people were enrolled in full-  
7 benefit Medicaid in CHIP. This is an increase of 18.6  
8 percent or about 10.75 million enrollees from the July-  
9 through-September-2013 baseline.

10 As you would expect, expansion states reported  
11 increases much higher than those states that have chosen  
12 not to expand Medicaid. Expansion states saw increases of  
13 over 27 percent compared to over 7 percent in non-expansion  
14 states.

15 Fifteen of the 26 reporting expansion states saw  
16 an increase of enrollment of 30 percent or more. This  
17 includes Arkansas, California, Colorado, Kentucky,  
18 Maryland, Minnesota, Nevada, New Hampshire, New Jersey, New  
19 Mexico, Oregon, Rhode Island, Vermont, Washington, and West  
20 Virginia.

21 Also, at the end of January, CMS released data  
22 that looks at the Medicaid enrollment in the new adult

1 group for the first time. These data are a bit older, so  
2 we have data as of March 2014, but it shows us that 4.8  
3 million expansion adults were enrolled in the program. And  
4 it's important to note that this excludes California, D.C.,  
5 and North Dakota, and because California is such a big  
6 state, it's probably significantly larger than that.

7           It's also important to note that since March,  
8 that quarter, four additional states have expanded,  
9 including Indiana, Michigan, New Hampshire, and  
10 Pennsylvania. So as data come out more, that number is  
11 expected to increase.

12           Two-thirds or so of the new group qualify for the  
13 100 percent matching rate, while the other third do not.  
14 As a reminder, the 100 percent match is available only for  
15 non-elderly, non-disabled adults, with income up to 138  
16 percent of the FPL who would not have been eligible as of  
17 December 1st of 2009. So the vast majority of those 1.5  
18 million of new adults that are ineligible for the 100  
19 percent match are in states that expanded coverage prior to  
20 the ACA, and so if they are adults without dependent  
21 children, they would be eligible for a transitional match  
22 rate that is higher than the state's traditional FMAP.

1 Enrollment in the new group represents about 9  
2 percent of all Medicaid enrollees in the 48 states  
3 reporting data and about 18 percent of enrollees in 22  
4 expansion states.

5 COMMISSIONER ROSENBAUM: Can I just ask one  
6 question about the data? Do we know, of the expansion  
7 adults, what proportion are, as you know, adults who are  
8 neither caretakers nor people with disabilities nor  
9 Medicare beneficiaries, and how many are parents who got  
10 picked up because of the exceedingly low eligibility  
11 standard for parents? Because I think people talk about  
12 them as childless adults.

13 MS. HEBERLEIN: Yes.

14 COMMISSIONER ROSENBAUM: In fact, this expansion  
15 has helped a huge number of parents of children.

16 MS. HEBERLEIN: And I know we looked a little bit  
17 at the data when they were more preliminary. They're not  
18 in the report that CMS released at the end of January. It  
19 doesn't break down where -- it breaks down whether you're  
20 newly eligible for the 100 percent match or not, but it  
21 doesn't break down what category you might be in.

22 I know that we looked at those data when they

1 came out, but they were still sort of preliminary. But  
2 that's something we can certainly look at more.

3 CHAIR ROWLAND: Sara, among the potentially  
4 eligible, it was about two-thirds childless adults and one-  
5 third parents, but that was in all the states. And so the  
6 southern states, which are not expanding, you would have a  
7 much higher proportion there of parents in the mix. So I  
8 think there's been a -- the parents are more affected by  
9 the non-expansion states than by the expansion states.

10 \* MS. HEBERLEIN: So just to give you a little  
11 preview of what we are working on, are continuing to work  
12 on, Sarah and I -- Sarah Melecki -- will continue to track  
13 the Medicaid expansion decisions in the states on a daily  
14 basis, and we'll be sure to look at states that are going  
15 the traditional route versus the waiver route and track  
16 what CMS is -- what they are actually asking for and what  
17 CMS is approving in those waivers.

18 Sarah and I are also working on a brief that  
19 summarizes the features of the existing expansion waivers  
20 in more detail as well as looks at trends across states,  
21 and we will certainly add in administrative complexity to  
22 that list.

1           We also will continue to provide updates through  
2 MACStats and other means on the enrollment data as they are  
3 released.

4           And finally, we talked a little bit about this at  
5 the last meeting, but under contract with the Urban  
6 Institute, we are using data from the Health Reform  
7 Monitoring Survey to get characteristics of the new adult  
8 group, and so some of those data that Sara was just asking  
9 about, we'll get a little bit more from the HRMS.

10           Just to remind you, it is a quarterly Internet-  
11 based survey that was designed to track implementation of  
12 the ACA and the impact on coverage, and so we are working  
13 with Urban now actually to pull the data on the new adult  
14 group to get their demographic and socioeconomic  
15 characteristics as well as their access utilization to the  
16 services and hope to present those at an upcoming meeting.

17           COMMISSIONER MILLIGAN: If you are open to  
18 another, maybe, ongoing activity, it might be worth  
19 capturing how different states do the administrative side  
20 of the medically frail adult piece of this and  
21 identification, transition, and so on to really back to the  
22 morning conversation, but to see from a process point of

1 view, how different states manage that activity.

2 COMMISSIONER RETCHIN: Going back to the group of  
3 adults that were part of the expansion but were not newly  
4 eligible, was that the woodwork phenomenon or not? Because  
5 you said that it was different than the organic FMAP but  
6 not as much as the expansion. I didn't really follow that.

7 MS. HEBERLEIN: So a number of states had  
8 expanded Medicaid eligibility prior to the ACA, and so in  
9 order to sort of equalize, because they wouldn't be  
10 eligible for the 100 percent match rate, there is a  
11 provision in there that says they get this transition match  
12 rate, and so over the years, as the 100 percent FMAP goes  
13 down for the new group, their FMAP goes up, and they become  
14 sort of equal. So it's to try to compensate the states  
15 that were early expansion.

16 CHAIR ROWLAND: Yes. It was basically a provision  
17 that said you shouldn't be disadvantaged because you  
18 already expanded coverage to these groups, and yet they  
19 didn't give them the full 100 percent, but then they phased  
20 together at the 90.

21 Chuck.

22 COMMISSIONER MILLIGAN: I think I might want to

1 just build on the point you made a minute ago about parents  
2 and the non-expansion states. Correct me if I'm wrong,  
3 anybody.

4           But I think part of what we're talking about here  
5 is when welfare reform happened and states were required to  
6 sort of stick with old AFDC kinds of standards and states  
7 could then have some income disregard in other rules to  
8 deal with how to cover parents, a lot of the really lower  
9 parent thresholds as a percent of poverty tended to be  
10 states that aligned with the states that chose not to  
11 expand Medicaid. So you might see a state covering parents  
12 up to 20 or 25 percent of FPL pre ACA more aligned with  
13 states that chose not to expand, and states that chose to  
14 expand the parent coverage pre ACA might have been 45 or 50  
15 or 70 percent of poverty.

16           So I just wanted to elaborate a little bit on the  
17 point that you had made, Diane.

18           VICE CHAIR GOLD: Yes. I can't recall what  
19 subgroups the Urban study lets you do, whether it has state  
20 estimates or types of characteristics of states, but as you  
21 get the information on the characteristics of the new adult  
22 group, whatever you can do to sort of put people in buckets

1 by the type of state programs they're in, it may help you  
2 make sense of some of that stuff people were talking about  
3 because depending upon what their underlying existing  
4 program was, that may affect the characteristics of the new  
5 eligibles. And to the extent you can talk about that, it  
6 may help talk about, a little bit, the effect of the states  
7 that are not in and what they might look like or something  
8 like that to try and help make sense of the data, because I  
9 have a feeling, the total aggregate may not be as  
10 interpretable as if you can get some of those buckets.

11 CHAIR ROWLAND: I think the real difficulty on  
12 the parent side here is the variability in where states  
13 were covering parents to begin with, and the expansion  
14 states, as Chuck noted, often were covering parents at  
15 higher, sometimes even at the poverty level than the non-  
16 expansion states. So that the benefit to parents is going  
17 to be greater if the non-expansion states expand than it  
18 was to the expansion states, but we'll track it all and  
19 have numbers.

20 I think it's also important that there's two ways  
21 here that enrollment is being counted. The first one was  
22 really looking at the number of people enrolled in

1 Medicaid, without necessarily teasing out how many of them  
2 were just the normal turnover, to add people onto Medicaid  
3 versus the people who were newly entitled to Medicaid  
4 coverage.

5           The second one does reflect newly entitled  
6 because it's where the states are claiming the 100 percent  
7 match, but that one is one in which I'm sure a lot of  
8 states haven't even turned in some of their match, since  
9 this is part of what's going on, the administrative  
10 material, and so, certainly, we should not go out and say  
11 that only 4.8 million people benefited from the expansion.  
12 And when California comes in, that will be even higher, but  
13 it's just a caution that this is a very incomplete number,  
14 although it will ultimately be the number that reflects how  
15 many people were covered under the 100 percent match.

16           Chuck.

17           COMMISSIONER MILLIGAN: I'm sorry. Just one  
18 other point. I think having lived through a lot of this in  
19 the Maryland side, I think a population we shouldn't lose  
20 sight of is former foster care kids up to age 26, because  
21 that -- to create equity with kids covered through their  
22 parents under employers. It may not be a big number, but

1 it's an important part of the expansion.

2 CHAIR ROWLAND: And we'll see in some later data  
3 that it could also be a costly part of the expansion.

4 Thank you.

5 And, reflecting the other part of our name  
6 besides "payment" is "access," and, obviously, we have  
7 tried to look at gaps in access, at where Medicaid  
8 beneficiaries and others get their access to care, and so  
9 Anna is going to present to us with some of the analysis  
10 that she has been conducting on site of care. Thank you,  
11 Anna.

12 **### Session 4: SITES OF CARE SERVING MEDICAID ENROLLEES**

13 \* MS. SOMMERS: In the context of many different  
14 discussions you have had, you have raised the question,  
15 where do Medicaid enrollees receive care? Is it the most  
16 cost efficient place? Is it the most appropriate place of  
17 care? So, this presentation is intended to set the stage  
18 for future dialogue about access and payment policies  
19 related to sites of care.

20 First, I'll briefly place this topic in policy  
21 context, and then I'll present some preliminary data  
22 identifying the sites where major populations of enrollees

1 receive care. And, then I'll wrap up with some of the  
2 potential areas for future work.

3 Medicaid services are provided in over 30  
4 distinct sites of care reflecting a wide spectrum in  
5 service capacity, facility types, and payment incentives.  
6 Encouraging broad access to lower cost sites can help to  
7 meet program objectives related to cost efficiency and  
8 economy of care. However, higher cost providers are needed  
9 to provide more intensive and specialized services, when  
10 appropriate.

11 So, looking at where enrollees get their care is  
12 an important first step in a discussion of whether  
13 enrollees are getting care in the most cost efficient  
14 places and in the settings most appropriate for their  
15 needs.

16 To set the stage, we conducted a preliminary  
17 analysis using the 2011 Medicaid Statistical Information  
18 System, or MSIS, data. We estimated the percentage of  
19 enrollees having contact with each site of care  
20 identifiable in the MSIS at any point in 2011 for major  
21 eligibility categories and age groups. Contact with a site  
22 is defined as having any service at that site. That

1 includes non-practitioner services, case management,  
2 imaging, and lab tests. We used both fee-for-service  
3 claims and managed care encounter data to derive these  
4 estimates.

5           So, of course, we had to exclude some populations  
6 known to have incomplete data on utilization in the MSIS,  
7 individuals dually eligible for Medicare and Medicaid, and  
8 also those eligible for limited benefits.

9           In addition, individuals enrolled in  
10 comprehensive managed care plans in 11 states were excluded  
11 due to known problems with completeness and quality of  
12 their encounter data.

13           So, the analysis population reflected in your  
14 tables is non-dual, full benefit enrollees.

15           CHAIR ROWLAND: But, it does include people with  
16 disabilities.

17           MS. SOMMERS: Yes. So, your handout includes  
18 four tables showing these estimates in detail, and I'll  
19 just give you the highlights here.

20           Overall, 83 percent of enrollees had contact with  
21 at least one site of care in 2011. That includes  
22 ambulatory care sites, inpatient hospital, psychiatric

1 facilities, substance abuse treatment centers, residential  
2 and long-term care facilities, and the patient's home.

3           Individuals enrolled for just part of the year  
4 are included in these estimates and they have much lower  
5 contact rates than full-year enrollees. So, this is one  
6 reason the overall percentage of contact is only 83  
7 percent. For most full-year enrolled groups, the  
8 percentage with any contact is between 92 and 95 percent,  
9 whereas part-year enrolled groups have contact that is 20  
10 percentage points lower.

11           Non-disabled adults are an exception to this  
12 pattern. Even for the full-year enrolled, only 86 percent  
13 had contact with any site. And, among part-year non-  
14 disabled adults, this rate was only 66 percent, lower than  
15 all the other part-year groups. On the other hand,  
16 disabled children had the highest overall contact rates.

17           So, let's look briefly at institutional and home-  
18 based settings. The percentage of enrollees accessing  
19 inpatient acute care hospital services ranged from one  
20 percent to 29 percent. Part-year non-disabled adults had  
21 the lowest rate, at one percent, and part-year disabled  
22 adults had the highest rate, at 29 percent.

1           Very few non-dual full-benefit enrollees accessed  
2 any non-psychiatric residential or long-term care facility,  
3 less than one percent overall. Among groups with higher  
4 than average rates -- that means disabled groups and the  
5 elderly -- the percentage receiving care in their home was  
6 much higher than the percentage receiving facility-based  
7 long-term care. For example, among disabled children, one  
8 percent received care in a residential or long-term care  
9 facility, whereas 27 percent received services in their  
10 home.

11           Now, we'll look at ambulatory care. Overall, 82  
12 percent of enrollees accessed at least one ambulatory care  
13 site. This is broadly defined. It includes contact with  
14 community health centers, school-based clinics, state and  
15 local public health clinics, ambulatory surgery centers,  
16 independent laboratories, and other sites. Of these, more  
17 enrollees accessed office-based settings than any other  
18 site. The lowest contact with offices occurred among part-  
19 year enrolled adults, about 49 percent, and the highest  
20 contact with offices occurred among full-year enrolled  
21 children, at 84 percent.

22           The percentage of enrollees accessing emergency

1 departments on an outpatient basis varied widely based on  
2 eligibility category and age, but there were three patterns  
3 consistent for all groups. First, a lower percentage of  
4 enrollees accessed EDs than hospital outpatient clinics in  
5 every eligibility group. Two, a higher percentage of  
6 people in disabled eligibility groups than in non-disabled  
7 groups accessed EDs. And, three, a higher percentage of  
8 full-year enrolled individuals than part-year enrolled  
9 accessed EDs.

10 Health centers -- health centers served 16  
11 percent of enrollees. These include federally qualified  
12 health centers as well as the services provided by FQHCs in  
13 other places off-site that qualified for the enhanced  
14 payment as an FQHC service, rural health clinics, and  
15 community mental health centers. FQHCs amount for most of  
16 this contact. Eleven percent of enrollees accessed FQHCs.  
17 A higher percentage of disabled adults, 25 percent,  
18 compared to other enrollee groups received care at health  
19 centers.

20 So, those were the data highlights and there are  
21 just a few things to keep in mind when considering these  
22 results. Where we could compare our estimates to those

1 from other data sources, we did, and for the most part, the  
2 MSIS is consistent with these data sources. National  
3 household surveys also found, as we did, a small percentage  
4 of individuals reporting no ambulatory care at all, and  
5 they show this -- the surveys show this in all insurance  
6 categories and socio-economic groups.

7           The MSIS does not capture services provided to  
8 Medicaid patients and billed to another payer or provided  
9 free of charge to Medicaid patients.

10           And, services through limited benefit plans,  
11 meaning plans providing only mental health, dental, or  
12 transportation services, are known to under-report  
13 encounter data.

14           So, just a few ideas of future work that could be  
15 undertaken with these data or with other data. The  
16 analysis could, of course -- the data set could be used to  
17 explore in greater depth selected groups of interest and  
18 their service patterns between sites. And, some other  
19 questions that could be explored are what explains low  
20 ambulatory contact by some groups? Would a different mix  
21 in sites yield cost savings? Which trends are important to  
22 track? Do certain payment policies explain certain

1 patterns of service use? And, how does the availability of  
2 sites vary geographically, and what are the implications  
3 for state planning?

4           So, we look forward to hearing your ideas about  
5 future work that we could conduct around sites of care to  
6 assist you in developing recommendations related to access  
7 or payment.

8           COMMISSIONER GABOW: Thank you. I have four  
9 questions, and it's not even Passover.

10           [Laughter.]

11           COMMISSIONER ROSENBAUM: We are getting close.

12           COMMISSIONER GABOW: I know. So, my first  
13 question is, what group are pregnant women included in when  
14 you break down these groups, because I suspect if you  
15 looked at pregnant women as a discrete group, you might  
16 find some different data. That's the first question.

17           The second is, when you take out managed care,  
18 are there providers that would be differentially impacted?  
19 For example, are you likely to have more health centers who  
20 are in an HMO, Medicaid HMO, than office-based practice,  
21 and, therefore, if you exclude the large volume of managed  
22 care data, this could significantly skew the outcome.

1           The third issue is there are some providers that  
2 do not take Medicaid, so that also would skew results. For  
3 example, I don't know, but my -- I thought I had some data  
4 that some urgent care centers, the for-profit urgent care,  
5 won't take Medicaid payment. It's cash on the barrelhead.  
6 And, we certainly have had experience in Colorado with non-  
7 public psychiatric and substance abuse providers not taking  
8 Medicaid. So, if you already have a barrier, this will  
9 affect the data.

10           And, as you look at -- the last comment is, one  
11 of your questions was about cost efficiency. It would be  
12 useful, if you could ever get the data, when you compare an  
13 office visit to an FQ visit, since FQs are cost-based, is  
14 there a difference? So, that turns out to be significant  
15 in payment. Those are my questions and/or comments.

16           COMMISSIONER ROSENBAUM: So, my question actually  
17 is on the residential finding, and I just wonder, out of  
18 curiosity, whether you can go back in time to look at the  
19 distribution, because I think it would be incredibly  
20 educational for Congress and the administration to see how  
21 far we've come in where we are delivering services to  
22 people with extreme disabilities that previously might have

1 landed them in an institution. I mean, I assume that the  
2 drop since the mid-1990s has been quite notable. So, I  
3 think that what Congress has done over the past, now, 15  
4 years or so to make it easier for states to design  
5 community-based programs and then couple that with whatever  
6 recommendations we might have on building on past reforms.

7           But, you know, basically, residential care has  
8 disappeared from the Medicaid program. I mean, it's  
9 phenomenally, at least to a lay eye like mine, I would say  
10 there's a very, very modest level of residential care for a  
11 program that had nursing home care as one of its mandatory  
12 services 50 years ago -- and still does, but the numbers,  
13 I'm sure, are dramatically different. So, I think that  
14 would be incredibly useful to do.

15           And, I also wonder, going back to the point that  
16 Patty was raising as sort of having the same issue -- same  
17 thought -- whether we can do some apples-to-apples  
18 comparisons. So, if it is, in fact, the case that people  
19 with disabilities are more likely to end up visiting health  
20 centers, if we can try and start to figure out the extent  
21 to which that might bear into their -- on their high unit  
22 cost as well as the mix of services, you know, are there

1 underlying cost drivers because health centers are, in  
2 fact, absorbing more people with disabilities in their care  
3 systems. I have long suspected it, but, I mean, this  
4 jumped out at me as interesting.

5 COMMISSIONER COHEN: Thanks, Anna. That's so  
6 interesting. I think this presentation is like a  
7 Rorschach's test because you can see so many things in it  
8 depending on what you are focused on when you first hear  
9 about it. But, I thought it was really interesting.

10 So, my angle on this is I am really interested in  
11 seeing if we can tell or learn how this sort of site of  
12 care analysis would line up with different populations,  
13 like a Medicare population, commercially insured, and  
14 actually -- this might be hard to do -- dual-eligible,  
15 because I have always wondered, does the dual-eligible  
16 population in general use a Medicaid sort of set of  
17 providers or a more mainstream Medicare set of providers.  
18 So, I am really interested in it from the comparative  
19 perspective, in part to just sort of understand, and I  
20 understand there is not one answer to this nationwide, but  
21 to what extent are Medicaid beneficiaries, are they using a  
22 different set of safety net providers than other insured

1 populations, and to what extent is it really integrated and  
2 in what context.

3           And, I think that matters both from the  
4 perspective of thinking about Medicaid's role in the larger  
5 health care system. It matters in terms of thinking about  
6 sort of segregation of Medicaid beneficiaries and where  
7 that might be particularly problematic. But, I was also  
8 thinking that while the rest of the health care system, I  
9 think, is very focused on some issues around, say,  
10 transforming primary care and moving to more patient-  
11 centered medical homes and other sorts of things, it is  
12 important to understand that if the Medicaid sort of  
13 primary care provider base looks different than, say,  
14 mainstream commercial insurance or Medicare provider base.

15           So, are people, you know, the extent to which  
16 they are mostly being seen in clinics and large sort of  
17 OPDs, and people -- I think that has been a perception.  
18 Certainly, in New York, it is commonly assumed that that's  
19 mostly where Medicaid beneficiaries are seen. But, I  
20 actually think the data suggest that there's lots that are  
21 actually going to small practices. And, what are the  
22 implications for that in thinking about transformation

1 towards better primary care and other things like that.

2           So, anyway, I think it's a great analysis. I'm  
3 very interested in how it really relates on sort of some of  
4 these comparative issues.

5           CHAIR ROWLAND: Andy, I'd just point out that  
6 this analysis is only based on Medicaid --

7           COMMISSIONER COHEN: Oh, no. I mean, I  
8 understand --

9           CHAIR ROWLAND: -- you're asking for a totally  
10 broader study.

11           COMMISSIONER COHEN: Well, I'm saying it is to me  
12 particularly interesting as sort of a baseline from which  
13 maybe comparative work could be done if perhaps -- perhaps  
14 there are analyses, similar ones in other -- for other --

15           CHAIR ROWLAND: -- using MSIS --

16           COMMISSIONER COHEN: Right. No, but I do  
17 understand that this is not that.

18           COMMISSIONER RETCHIN: Building on the Medicaid  
19 provider population that Andy just referenced, I've been  
20 concerned for some time that there is an out-migration of  
21 physicians from the inner city for a variety of reasons  
22 that don't need to be expanded on here, but it would be

1 interesting -- I don't know how you would find that, maybe  
2 through ARF or something, but to look and see -- because  
3 you have two things working against you there. One is the  
4 falling, rapidly falling interest in primary care from  
5 graduates of medical schools, now down to, I think, in  
6 terms of their interest, about 22 percent of medical  
7 students. And, then, those who go into primary care are  
8 actually locating their practices increasingly in the  
9 suburbs, even those who 20 years ago would have located in  
10 underserved areas.

11           So, I think, most definitely, these are different  
12 providers who take Medicaid. I'm astonished when I meet  
13 with -- or I've met with community providers who -- they  
14 don't take Medicaid at all, and I've wondered in terms of  
15 the expansion how they've been able to accommodate that in  
16 a network for adults, particularly in states that really  
17 had no coverage before.

18           COMMISSIONER MILLIGAN: I wanted to mention a  
19 couple things, I think. One is we did a study in Maryland  
20 about site of care and we looked at CPT Code 99-213 and 99-  
21 214, the two most frequently coded things, and we looked  
22 over time for Medicaid, and it was done at the Hilltop

1 Institute, where Anna and I first met. What we saw is a  
2 couple of important trends -- in one state, but a couple of  
3 important trends.

4           The first is that the physician office site of  
5 care was about -- we paid about \$48, as I recall. The  
6 weighted average for FQHCs, because each of them has a  
7 separate rate, was about \$150. And, then, the weighted  
8 average for a hospital OPD, if you include the facility fee  
9 piece -- and, again, Maryland is unique because of the all-  
10 payer hospital rate setting system -- but, on a weighted  
11 average basis, one 99-213, established patient, routine  
12 visit, was almost \$400. So -- and, we saw that the trend  
13 was moving toward hospital OPDs because hospitals were  
14 increasingly employing physicians, and I want to stay on  
15 that point for a second and then come back.

16           There has been a huge trend toward employment of  
17 physicians for reasons that are very understandable for new  
18 physicians about schedule predictability and coverage, but  
19 also for covering, really, the costs of practice, like EMRs  
20 and other things that are very hard to sustain in a small  
21 office. So, there's a lot of reasons that things are  
22 moving toward hospital OPDs, but we saw the percentage

1 shifting very dramatically and almost all of the new visits  
2 going to the most expensive site.

3           We then had conversations with other payers in  
4 the state about whether they were seeing the same thing and  
5 they were typically not seeing that trend because they were  
6 using co-payment, a co-payment on the facility and not the  
7 professional fee, and raising the co-payments to try to  
8 influence decision making about site of care, which was a  
9 tool we didn't have in Medicaid.

10           So I just want to kind of raise some of those  
11 broader themes about employment, the cost to practice,  
12 facility fee and professional fee co-payment issues, and  
13 the very significant difference in cost that Medicaid was  
14 paying a lot.

15           But I guess the other point I want to make about  
16 this is it's going to be very hard to look at site of care  
17 because it's changing so fast, and I will tell you from  
18 what I'm observing in my current work, the demand for  
19 convenience care models, the Minute Clinics and the  
20 pharmacy-based clinics, the demand for telehealth models,  
21 the demand for workplace-based clinics is disaggregating  
22 sites of care in many, many ways, and co-payments again on

1 the commercial side are influencing those decisions. We  
2 just launch January 1st where I work now that there's no  
3 co-pay for a telehealth visit to try to keep some of the  
4 volume out of physician office urgent care or urgent care  
5 settings.

6           So I think this is really important work, and I  
7 guess I'll conclude with this point. I think we have to be  
8 careful that we not emphasize efficiency so much that we  
9 indirectly encourage the kind of Medicaid mills that are  
10 anathema to where we want Medicaid folks to be able to  
11 receive care.

12           So those are my comments.

13           VICE CHAIR GOLD: Hi, Anna. I want to sort of  
14 bring the conversation up a level and down a level at the  
15 same time and sort of suggest sort of what's new here and  
16 maybe what some of the constraints are, because I think one  
17 of the key questions is: What's most important looking  
18 forward? That's what you asked us.

19           I think -- this is claims data. It's probably  
20 one of the -- I haven't seen a lot of analyses like this  
21 that look within service, within claims, so it's new that  
22 way. It's different than the survey data. The survey data

1 have information that's a whole-person focus. Their  
2 advantage is they have things that you don't have on claims  
3 to adjust, like health status, age, things like that. So  
4 you have this and you don't have that, and so two things  
5 from a technical perspective, and then I'll talk more  
6 broadly.

7           When you look at some of the disabled or other  
8 people, people who use more care have a greater likelihood  
9 of using more settings of care just because they use more.  
10 So you haven't looked at the denominator of the total care  
11 used by the person, so I'd be cautious in drawing  
12 conclusions about the disabled using this more than the  
13 other. I mean, yes, they use everything more, maybe, or  
14 something like that.

15           The second is when you're comparing it to the  
16 survey data on the share that use a visit, you might want  
17 to pay attention to what the denominator is of the  
18 population, because I don't know on yours whether it's  
19 month of eligibility, people who are eligible months, the  
20 survey data is people reporting for a year. It may be that  
21 they're reporting different things and the numerator and  
22 denominator aren't the same, because I think it would be

1 important, because people focus on it a lot, to sort of see  
2 what's similar and different about the share that make a  
3 visit in a year.

4           My other set of questions, you know, it's sort of  
5 funny to see this. This goes back to my earliest research,  
6 I mean my master's thesis in 1971 -- I shouldn't say that,  
7 it ages me -- was on use of the emergency rooms. And in  
8 the 1970s -- '80s, I guess, I look at substitution of  
9 inpatient and outpatient care. You've got a lot of stuff  
10 going on here, and it seems to me what's really most  
11 critical looking forward, some of these things are  
12 substitutes, some of these things are complements. What's  
13 the question?

14           I mean, I guess the question is: You want to  
15 sort of figure out what's important to look at and what you  
16 can look at with these data, or you can't and what data to  
17 use. And I'm not sure what it is. I don't know that even  
18 if you answered any of the questions you had here you'd  
19 take it anywhere further to understanding from a policy  
20 sense what some of the issues might be. Ultimately I think  
21 what you want to do is look at patterns versus need.

22           Now, you have a hard time with that because you

1 don't have data on the demographics and other things.  
2 Maybe you can look at some by states or state  
3 characteristics or there's some controls you have. But I  
4 think bringing it back -- and some of the questions people  
5 have had here have sort of brought up problems that people  
6 know exist. Some of them can be looked at with these data,  
7 some can't, and maybe thinking a little more about the why  
8 and what the question is that this is answering might be  
9 helpful as you sort that out.

10           COMMISSIONER RILEY: Well, I would just echo  
11 Chuck's points, most of which I won't repeat, I was going  
12 to make. I think they're really important ones. It seems  
13 to me that one of the issues is also the issue that you  
14 raised about geography. Supply drives demand, so do we  
15 really know anything about population behavior, or is it  
16 more that there happens to be these services in this  
17 service mix in this community.

18           The others are on payment reform, to Chuck's  
19 point about all the variation and change in delivery  
20 systems and payment. It would be sort of intriguing to me  
21 to think about the medical home movement within Medicaid,  
22 and we certainly have seen the data that it appears not be

1 saving money, but has it driven people to different sites  
2 of practice into more primary care sites? And could we cut  
3 the data that way to take a hard look at whether these  
4 payment reform models are really driving changes in patient  
5 behavior?

6 COMMISSIONER SZILAGYI: Just a couple -- I  
7 actually had a question, and then a couple points  
8 piggybacking onto what Chuck and Marsha said.

9 My question has to do with the population that  
10 was not covered for the full 12 months. Did you analyze  
11 the data for the full -- of visits for the full 12 months  
12 even though they weren't covered for the full 12 months?  
13 Or did you control for the number of months that they were  
14 covered?

15 DR. SOMMERS: No, we didn't control for --

16 COMMISSIONER SZILAGYI: Because if it was the  
17 former, then I don't think that data is really valid,  
18 because if somebody was covered for six months out of the  
19 12 but you looked at visits for the whole year, you know,  
20 you can -- there's ways to adjust for that. So I guess my  
21 general theme is to be careful about over interpreting data  
22 on utilization and certainly the partial months. So I

1 would kind of go back and rethink that.

2           The point that Chuck was making I think was  
3 really important, and I want to do kind of a counterpoint,  
4 that I would be really careful in overinterpreting data  
5 simply based on costs or visits, and the reason is that the  
6 population that visits community health centers or  
7 outpatient clinics, even though they're both on Medicaid,  
8 is different from the Medicaid population that visits  
9 private offices. So the Medicaid population -- what you  
10 haven't done, because it's partially impossible to do it,  
11 although you can get there if you start looking for ICD9  
12 codes, is you haven't done risk adjustment or looked at the  
13 risk of the population attending outpatient departments.

14           For example, just as a very concrete example,  
15 many, probably most outpatient clinics have social workers.  
16 Virtually zero primary care practices out in the community  
17 have social workers. So the population that visits those  
18 two places is different. The needs are different. And  
19 just looking at costs to the system isn't the entire  
20 answer, because there's different populations and different  
21 levels of services that are delivered. And I'm not against  
22 trying to save costs, but we shouldn't over interpret

1 trying to drive this population out of outpatient  
2 departments or community health centers because they appear  
3 to be more costly.

4           COMMISSIONER MILLIGAN: Peter, I just -- first of  
5 all, I want to say I agree with -- that the cost in some of  
6 the cost data I presented isn't meant to say that those are  
7 all identical services, because I do think there's  
8 definitely more supportive services in an FQHC than in  
9 other settings, so I wasn't trying to make an apples-to-  
10 apples comparison. But I want to maybe -- a friendly  
11 amendment to what you just said. The population that seeks  
12 services in a hospital OPD may be different, not certainly  
13 is different, because one of the things that we observed in  
14 Maryland was hospitals hired groups that previously were  
15 independent and brought them inside their clinics, and so  
16 the patients followed their physicians into a facility-  
17 based model. But I don't -- and a lot of what I was  
18 observing wasn't an academic medical center delivered OPD.  
19 It was community hospital OPD. So I just think it may be  
20 different, it may not be different.

21           VICE CHAIR GOLD: It varies by state.

22           CHAIR ROWLAND: Anna, you noted that you excluded

1 individuals in managed care in 11 states. What do you  
2 think that -- that really does change, I think, potentially  
3 some of the conclusions one can draw from this, because if  
4 those 11 states are really big states with high penetration  
5 of managed care, you're mainly picking up people who may be  
6 more in the disability population than in the children and  
7 families population.

8 DR. SOMMERS: Just quickly, the percentage of  
9 enrollees that the remaining states represents is still  
10 pretty high, I think 88 percent of all enrollees. I can  
11 tell you the states that were excluded.

12 CHAIR ROWLAND: Did you include California?

13 DR. SOMMERS: California was not excluded. D.C.,  
14 Illinois, Maryland, Massachusetts, Mississippi, Nevada,  
15 Pennsylvania, Ohio, South Carolina, Utah, and West  
16 Virginia.

17 CHAIR ROWLAND: Well, I think one of the  
18 interesting things in this analysis is really the  
19 differences in the array of sites of care by the different  
20 eligibility groups. I totally agree with Peter's comment  
21 that you really need to look at the full-benefit, full-year  
22 people because the partials, it's too hard to tell what

1 they had before, what they had later, or how long they were  
2 on.

3           But I was thinking that there's a theme here that  
4 we might want to also pick up about foster care, because we  
5 pick up foster care here. In the work Amy is going to  
6 present, we're going to pick up foster care again. In the  
7 psychotropic drugs, we're going to pick up foster care  
8 again. And I think some of what we can learn from this  
9 kind of data and from the next sets of reports is how  
10 within Medicaid there are some special needs populations  
11 and what happens to them, because I think the thing that  
12 jumps out is just the real difference often with the foster  
13 care and the disabled children versus the non-disabled.

14           So I think really looking at this by population  
15 is one of the ways that we can get some insight.

16           COMMISSIONER SZILAGYI: Actually, I forgot to  
17 make another point, and it's related to what we just said.  
18 We might consider an entire chapter on foster care since  
19 it's, you know, not just focusing on their mental health  
20 but on -- because they are all on Medicaid. There's some  
21 interesting changes now with the post-foster care period.  
22 There's legislation right now being considered by Congress

1 about making some other changes with the foster care  
2 population. So it's one of the populations that may be  
3 worth a separate chapter.

4 VICE CHAIR GOLD: Diane, has the Commission --  
5 when it did their broad overview of Medicaid, did the  
6 Commission's report ever summarize the issues with foster  
7 care? Because I know I've been in health care for ages,  
8 and this is not a population I know well. And I'm  
9 wondering, if it hasn't been done, whether that would be a  
10 contribution as to what we're learning about where this  
11 population fits within the Medicaid --

12 COMMISSIONER ROSENBAUM: I would just add to that  
13 special needs adoptions, which are a distinct Medicaid  
14 eligibility category, and it's one of the places where --  
15 you know, we were talking before about the 1 percent cases.  
16 I mean, Medicaid has probably done more to promote special  
17 needs adoption than almost any other policy you can think  
18 of, and very little is known about it. So I would raise  
19 the same thing.

20 CHAIR ROWLAND: We obviously discussed it since  
21 one of our previous Commission members was a foster care  
22 parent -- Robin -- but we really have never dealt in any

1 depth with it in terms of a chapter. It's occasionally  
2 woven in, and I think that's an excellent suggestion  
3 because I do think as you read the next three sets, you  
4 begin to say foster care has a particular difference here  
5 or really why shouldn't we examine it.

6           Okay. Thank you, Anna.

7           [Pause.]

8           CHAIR ROWLAND: And now just because we've been  
9 talking about eligibility and enrollment issues, and we  
10 always love data, we're going to ask April to join us and  
11 to talk a little bit about reviewing Medicaid eligibility  
12 and enrollment issues.

13 **### Session 5: REVIEW OF MEDICAID ELIGIBILITY AND**  
14 **ENROLLMENT ISSUES**

15 \*           MS. GRADY: Thank you, Diane. I seem to have a  
16 technical glitch. Well, I'll just go ahead and start while  
17 we're waiting for the slides to come up.

18           You've been hearing a lot obviously about  
19 eligibility and enrollment issues in many of our  
20 presentations. For example, we've clearly devoted a lot of  
21 time to the current status and future of CHIP. You also  
22 heard an update this morning on the adult group expansions.

1 And you're going to hear more about the Medicare savings  
2 programs in the session directly following this one.

3 But based on those examples I just gave, you can  
4 see that our discussions tend to be about very specific  
5 populations, and the current session is intended to bring  
6 us back to the big picture of Medicaid eligibility and  
7 enrollment. And we have a few purposes here in taking a  
8 step back. One is to review the basic eligibility  
9 pathways, not because you're not already familiar with them  
10 -- clearly you know them very well -- but to emphasize the  
11 fact that Medicaid currently has a very bifurcated system  
12 of eligibility methods and rules, one that applies to non-  
13 disabled children and adults and one that applies to  
14 seniors and people with disabilities. So we really want to  
15 highlight that in this presentation.

16 Another purpose is to highlight the issue of  
17 full-benefit eligibility versus Medicare savings program  
18 eligibility within the population of seniors and people  
19 with disabilities. And this is a key distinction, and it's  
20 an important one for the presentation you're going to have  
21 from Katie Weider right after me, so please be sure to  
22 grill me here if there's any questions that you have about

1 the Medicare savings program pathways and how those  
2 interact with full-benefit Medicaid eligibility pathways.

3           And the final purpose is to give a preview of  
4 some of the eligibility and enrollment work we're planning  
5 or have in progress that you haven't necessarily heard  
6 about already.

7           I keep doing that, pushing the wrong button.  
8 Here we go.

9           Historically, coverage of Medicaid was tied to  
10 receipt of cash welfare for families with children, people  
11 with disabilities, and those age 65 and older. And when  
12 the Medicaid program was enacted, there were grant programs  
13 to states, and Medicaid was directly tied to your receipt  
14 of assistance under one of those programs.

15           Of course, there were many expansions and changes  
16 over the years, and Medicaid has really evolved to cover  
17 specified low-income groups for the most part without  
18 regard to welfare receipt. So your eligibility is based on  
19 your income level, not because you participate in another  
20 program.

21           That being said, there are two important  
22 exceptions there, and one is the Supplemental Security

1 Income program for low-income seniors and people with  
2 disabilities. In most states, if you receive SSI benefits,  
3 you are automatically eligible for Medicaid. And foster  
4 care and adoption assistance is another category of  
5 programs where, if you receive those benefits, generally  
6 you are automatically eligible for Medicaid.

7

8           And, of course, the most recent expansion,  
9 income-based expansion, was to adults without dependent  
10 children.

11           General requirements for Medicaid eligibility,  
12 I'll just go through these very quickly. Only citizens and  
13 qualified aliens can receive full Medicaid benefits, and  
14 "qualified alien" is a very technical term that was defined  
15 in the Welfare Reform Act of 1996. And generally speaking,  
16 most legal permanent residents, people who are qualified  
17 aliens, have a five-year bar on their Medicaid eligibility,  
18 and during that time they can only receive emergency  
19 benefits that I'll cover in just a minute.

20           Some groups only receive limited benefits.  
21 Again, you're very familiar with the Medicare savings  
22 programs that provide assistance with Medicare costs.

1 There are some people who only receive family planning and  
2 related services. In some states that's actually a very  
3 large number of enrollees. California, for example, I  
4 believe has about 2 million people who only receive family  
5 planning assistance under Medicaid. And there is also a  
6 population of non-qualified aliens who only receive  
7 emergency services. And the largest group of these folks  
8 are unauthorized people, folks who are illegally present,  
9 but it also includes students and other legal non-  
10 immigrants who have been admitted for a temporary purpose.

11 They can only receive emergency benefits. They  
12 have to meet all of the other financial and eligibility  
13 criteria for the program.

14 In addition, for people who are seeking long-term  
15 services and supports under Medicaid, a functional  
16 assessment may be required that demonstrates your need for  
17 assistance. Usually, these functional assessments look at  
18 your ability to do activities of daily living, things like  
19 bathing, dressing, feeding yourself, but there's a range of  
20 things that states look at, and we have a project on that,  
21 that I'll talk a little bit about later on.

22 Here, I just want to point out the major

1 eligibility groups for nondisabled adults and children. Of  
2 course, we have parents, pregnant women, and the new adult  
3 group. And for children under age 19, what I want to point  
4 out, of course, is the maintenance of effort that you're  
5 familiar with through fiscal year 2019, and the fact that  
6 some Medicaid coverage is financed with CHIP funds. So  
7 they are Medicaid-eligible children who happen to be  
8 financed with CHIP dollars.

9           In terms of enrollment, nondisabled adults are  
10 about 30 percent -- or were about 30 percent of Medicaid  
11 enrollment in fiscal year 2011. Of course, as Martha just  
12 presented on, there's increased enrollment in 2014 as a  
13 result of the new adult group in expansion states, so that  
14 share of the Medicaid population may increase somewhat.

15           With regard to nondisabled children under age 19,  
16 that's nearly half of all Medicaid enrollees, and in 2014,  
17 we might also expect to see a little bit of an increase in  
18 that enrollment because of an increase in CHIP-financed  
19 Medicaid that I'll touch on in the next slide.

20           Some of the relevant changes to nondisabled  
21 adults and children, eligibility for those groups, include  
22 the Modified Adjusted Gross Income standards and methods

1 and the fact that the asset test has been removed for most  
2 of these eligibility groups.

3           The thing I want to emphasize here is that prior  
4 to the move to modified Adjusted Gross Income, or MAGI,  
5 states had a lot of flexibility in the way that they  
6 counted income and assets for nondisabled adults and  
7 children. So even if two states appeared to have the same  
8 income eligibility level, say 100 percent of poverty, one  
9 of them might use income disregards that effectively reduce  
10 the amount of income that's counted in an eligibility  
11 determination, so people above 100 percent of poverty could  
12 actually end up being covered.

13           In contrast, a state that had no income  
14 disregards would be only covering people up to 100 percent  
15 of poverty, and the reason I'm telling you this is that  
16 situation still exists for the seniors and people with  
17 disability populations, and that's an important thing to  
18 understand for our discussion of the MSP pathways, but  
19 again, I'll cover that when we get there.

20           We've covered a lot of these. I'll just focus on  
21 the former foster care children until age 26 because that's  
22 something that came up in your previous discussion. As I

1 mentioned, there are child welfare programs, including  
2 foster care and adoption assistance, where Medicaid  
3 eligibility is automatic, but generally, children are only  
4 eligible for that assistance until age 18. Some states  
5 actually cover them at older ages, but they do eventually  
6 age out of the child welfare system. And this is a new  
7 pathway that will allow coverage for those children up to  
8 age 26 if they were in foster care when they aged out of  
9 the program.

10           In terms of our work here that you may not have  
11 heard about, you will recall that last September, we gave  
12 you an update on eligibility and enrollment in the new  
13 adult group and noted that application backlogs were still  
14 a problem in some states. It seems that since that  
15 presentation, things have been pretty quiet on that front,  
16 and for the most part, it seems that states have been able  
17 to work out a lot of the problems and the issues that were  
18 leading to their application backlogs. There still are  
19 some issues, but now what we're tracking is renewals rather  
20 than those initial applications.

21           As you will recall from the previous meeting, our  
22 focus groups with newly enrolled adults revealed that many

1 of them were unaware of the need to renew their coverage  
2 and were concerned about the possibility of losing that  
3 coverage. So it's something that we want to pay attention  
4 to.

5 Other than tracking news from the states on this  
6 front, one of the things we're going to see if we can learn  
7 anything from is the enrollment data. Only a handful of  
8 states have opted to extend their renewals for nondisabled  
9 children and adults into 2015. Many of them should have  
10 wrapped up that process by now.

11 Martha presented data from, I believe, November  
12 of last year, so we haven't seen any big decreases in  
13 enrollment that could indicate a potential problem with  
14 renewals, but we'll keep an eye on the December and the  
15 January data to see what might be happening on that front.

16 As I noted earlier, previous income counting  
17 rules could lead a state with an income level of 100  
18 percent of poverty to actually be covering people at  
19 effectively a higher level. So when there was a conversion  
20 to the MAGI rules that no longer allowed income disregards  
21 and state flexibility, states were required to convert  
22 their income eligibility levels to reflect the disregards

1 that they had previously been using. So if you were at 100  
2 but you had disregards that really brought you up to 110 or  
3 120, that is your new MAGI-converted eligibility level.

4 And the effect of that conversion has been to increase the  
5 stated Medicaid eligibility levels in some cases, and if  
6 you increase the Medicaid eligibility level, that creeps up  
7 into separate CHIP territory in some states.

8           So what you have is a little bit of a shift from  
9 separate CHIP eligibility to Medicaid eligibility, and what  
10 we're seeing from some preliminary data is that there has  
11 been a reduction in separate CHIP eligibility in some  
12 states, and a portion of that reduction may be owing to the  
13 MAGI-converted levels, so that's something we're going to  
14 be analyzing a little bit more closely and reporting back  
15 to you on.

16           This last point here about transitions between  
17 Medicaid, CHIP, and exchanges, I won't go on about that.  
18 You've heard many presentations about the work we're doing  
19 with the Urban Institute to model what could happen with  
20 CHIP in the future and the interactions between those  
21 programs with regard to eligibility and enrollment.

22           Okay. Now I will move on to major eligibility

1 groups for seniors and people with disabilities. Here, I  
2 am going to break this up into two slides. This slide here  
3 is talking about full-benefit Medicaid eligibility  
4 pathways. Most people age 65 and older or those who are  
5 eligibility on the basis of disability are coming in  
6 because they are receiving Supplemental Security Income  
7 benefits, and most of these people are at or below about 75  
8 percent of the federal poverty level. As I mentioned, in  
9 most states, this is a mandatory eligibility group. You  
10 are automatically eligible for Medicaid by way of receiving  
11 SSI benefits.

12           Additional options for states include the poverty  
13 level pathway where they can cover folks up to 100 percent  
14 of poverty, medically needy pathways where your income may  
15 exceed the regular levels for Medicaid eligibility in your  
16 state, but you have high health care spending that is  
17 deducted from your countable income to bring you down to a  
18 lower income level that's counted for Medicaid eligibility.

19           And then the other major pathway is the special  
20 income level and the related home and community-based  
21 waiver pathways for people who need an institutional level  
22 of care, and there's some overlap between this special

1 income level and the medically needy concept, but these are  
2 also higher income people who spend a large proportion of  
3 their income on medical expenses, either in a nursing home  
4 or in the community if they are receiving home and  
5 community-based waiver services.

6 I'll also point out here that there's a  
7 disability determination that applies to people under age  
8 65, and those are based on federal rules that are used for  
9 the SSI and the supplemental -- I'm going to get this one  
10 wrong -- Social Security Disability Insurance, SSDI rules,  
11 so those are uniform rules that generally apply in the same  
12 way across states. Again, there's always an exception with  
13 Medicaid, but generally speaking, the disability  
14 determinations use the SSI and the SSDI rules.

15 Once you turn 65, your income is really the  
16 determining factor. There is no longer a disability  
17 determination being done. That being said, as I mentioned  
18 earlier, if you do need and are seeking coverage for long-  
19 term services and supports, you may have a functional  
20 eligibility assessment that looks at the need for services,  
21 but that doesn't affect your eligibility for Medicaid per  
22 se. It's once you get onto Medicaid, we give this

1 assessment of your need for long-term services and supports  
2 within Medicaid.

3           So now I want to talk about the Medicare savings  
4 programs because separate from your determination of  
5 eligibility for full-benefit Medicaid, we have the Medicare  
6 savings programs, and we've got the acronyms up here. But  
7 the point is that these are separate from full-benefit  
8 Medicaid, and if you are a dually eligible beneficiary, you  
9 can qualify under the MSP-only pathways, and those are the  
10 people we generally refer to as partial duals.

11           You can qualify for an MSP and for full-benefit  
12 Medicaid -- and there are several million people who do --  
13 or you can qualify for full-benefit Medicaid only. And  
14 most of the full-benefit dually eligible beneficiaries are  
15 the higher income, medically needy folks, special income-  
16 level folks who are living in nursing homes or otherwise  
17 receiving long-term care in the community, who may have  
18 higher incomes but again are spending most of that income  
19 on their health care. So I say they're higher income, but  
20 effectively, their net income is still low because of their  
21 health care expenses.

22           The other thing I want to point out here is that

1 the income and asset counting rules for the MSPs are  
2 generally similar to what's done for full-benefit Medicaid  
3 pathways within a state, and those rules build off of the  
4 rules for the Supplemental Security Income Program because  
5 of the historical link to SSI eligibility for these  
6 populations. Those are pretty complex. There's all kinds  
7 of disregards and other special provisions, but within a  
8 state, you generally have consistency in the way income is  
9 counted for MSP and full-benefit Medicaid.

10           The issue here that Katie will talk to you more  
11 about is that the rules for MSP eligibility determinations  
12 within a state, which again are linked to those SSI rules  
13 that I talked about, those may differ from the way that  
14 Medicare Part D counts income for the low-income subsidy.  
15 So when it comes time to talk about aligning the rules for  
16 the Part D low-income subsidy with the MSPs, you have to  
17 remember that there's an interactive effect here because  
18 the MSPs are doing what full-benefit Medicaid does. If you  
19 then make the MSPs do something different and you're  
20 aligning it with LIS, you are misaligning it with full-  
21 benefit Medicaid. So simplification and alignment sounds  
22 great until reality hits. We'll talk more about that in

1 the next session, but if you do have any questions, let me  
2 know.

3 In terms of enrollment, people age 65 and older,  
4 people with disabilities are about a quarter of total  
5 Medicaid enrollment, and many of these people are dually  
6 eligible for Medicaid and Medicare, and the dually eligible  
7 beneficiaries account for about 15 percent of total  
8 Medicaid enrollment.

9 Getting back to the full-benefit versus MSP only,  
10 about a quarter of the dually eligible beneficiaries are  
11 MSP only. So for those folks, you don't need to sort of  
12 worry too much about how their income is counted. If we  
13 changed that, there's no effect on full-benefit Medicaid  
14 eligibility. They're only getting MSP benefits, but the  
15 remaining three-quarters of duals do receive full Medicaid  
16 benefits, so a change in the way that the MSPs count income  
17 would have an effect on those folks.

18 Just briefly covering some work that we have  
19 going on this front, in last year's June report, we had a  
20 chapter on long-term services and supports that provided  
21 some information on financial eligibility for people who  
22 require long-term services and supports, and we're

1 currently updating and expanding that information.

2           As you might remember, the income and asset  
3 counting rules, the requirements for documentation are  
4 quite complex, and it's actually a big undertaking to go  
5 and try and gather that information from the states. But I  
6 think we're close to bringing that to you in a future  
7 Commission meeting.

8           We also have a contractor who is researching and  
9 reporting on the LTSS assessment tools that determine  
10 functional eligibility status and the level of services  
11 that you might receive in Medicaid, and of course, as part  
12 of that, but it's not listed on the slide -- but staff are  
13 also researching some states that are using presumptive  
14 eligibility for LTSS. Before the formal assessment is  
15 completed, you might receive services in the interim based  
16 on a presumptive eligibility determination.

17           And then finally, of course, we are presenting  
18 some policy options and discussion around MSP eligibility  
19 and enrollment.

20           One last thing I want to mention is some data  
21 analysis that is still in the planning stages, so we'd like  
22 your feedback on the particular issues of interest that you

1 all might have here.

2           The first issue is about how people become dually  
3 eligible beneficiaries. In the joint data book that we  
4 published with MedPAC back in January, there's some  
5 information there showing that close to 40 percent of  
6 people who have become dually eligible in a given year, so  
7 we looked back two years, they were new to dual eligible  
8 status.

9           About 40 percent of those people were Medicaid  
10 beneficiaries who gained Medicare coverage, so those are  
11 people who had either aged onto the Medicare program. They  
12 were Medicaid enrollees, low-income people who then turned  
13 65 and gained Medicare coverage. There could also be some  
14 people in there who were receiving Social Security  
15 Disability Insurance and were in their two-year waiting  
16 period for Medicare coverage, who had Medicaid in the  
17 interim. So we could look a little bit more closely at  
18 those people.

19           I think one of the issues is, with this  
20 population, some of them are very long-term Medicaid  
21 enrollees, and what we found in the analysis with MedPAC is  
22 that many of them, their receipt of Medicare benefits is

1 actually based on them being the dependent of someone who  
2 receives Medicare benefits. So many of them have been  
3 disabled since childhood or they're spouses who became  
4 disabled at some point, so there's sort of a long-term need  
5 for care in this population.

6           The other portion of folks are those who were  
7 Medicare beneficiaries who gained Medicaid eligibility, and  
8 this is where we think of the people who are spending down,  
9 people who require nursing home or extensive home and  
10 community-based services. So those are two very different  
11 groups of people that you might want to consider  
12 differently, and that's why we're going to look a little  
13 bit more closely at their characteristics.

14           I will mention that Hilltop at the University of  
15 Maryland does a lot of work for Maryland Medicaid, has  
16 published a lot on this, and we've looked at that work to  
17 sort of see where we might go with ours.

18           We're also -- for the overall Medicaid population  
19 and for subgroups, so this is moving on from the dually  
20 eligible work -- going to be looking at fee-for-service and  
21 managed care spells to inform our encounter data work. The  
22 issue here is that for people in managed care, even where

1 we have good encounter data, it may not reflect the  
2 entirety of their service use for a couple of reasons.

3           One is that if you need long-term services and  
4 supports, for example, you may be getting your acute care  
5 through managed care, but fee-for-service is handling the  
6 additional long-term care benefits you receive.

7           The other issue is that there may be people who  
8 enroll in Medicaid because they went to a hospital, so they  
9 have a very intense period of fee-for-service use before  
10 they get into a managed care program, and then maybe  
11 there's almost nothing happening in managed care, so that's  
12 something we want to be aware of when we're trying to  
13 characterize the managed care encounter data.

14           And then the opposite can be true. You could  
15 have someone who enrolls in Medicaid and sits in fee-for-  
16 service for a few months until they get enrolled in a  
17 managed care plan, so they don't have any fee-for-service  
18 use, but then once they get into their managed care plan,  
19 they have this intense period. So there's sort of  
20 countervailing things here that we want to be aware of when  
21 we're doing our encounter data analyses.

22           Then finally, here the idea is to look at the

1 person-level Medicaid Statistical Information System data  
2 where we can to look at transitions between Medicaid  
3 programs and separate CHIP. Separate CHIP data has been  
4 optionally reported by states in MSIS for many years. More  
5 of them are now reporting it -- and so we want to sort of  
6 assess where they're at on that front -- and also see where  
7 Mathematica and other people have done some work here to  
8 look at gaps in coverage when children transition between  
9 Medicaid and separate CHIP programs within the same state.  
10 And knowing that, one of the things we'd like to look at is  
11 the service use that was happening under Medicaid and what  
12 happens when they eventually end up in the separate CHIP  
13 programs.

14           The good thing is we do have longitudinal data  
15 here, so we can look across a period of months or years to  
16 get an idea of what's happening.

17           So I will end there and take any questions you  
18 might have.

19           CHAIR ROWLAND: You have the first comment.

20           EXECUTIVE DIRECTOR SCHWARTZ: Yes, which is I  
21 want to let Commissioners know that there will be a test on  
22 this material.

1 [Laughter.]

2 EXECUTIVE DIRECTOR SCHWARTZ: It will be either  
3 multiple choice or fill in the blank. And for those of you  
4 who are visual learners, we will accept a diagram of these  
5 pathways.

6 COMMISSIONER CRUZ: I was wondering if any of  
7 this data -- and I was thinking that on the previous  
8 presentation -- can be broken down by race and ethnicity.  
9 We have these tremendous disparities and inequities in  
10 health, and we know a lot about the epidemiology of it, but  
11 not really sort of the health services research aspect of  
12 it. I mean, who's eligible? Who enrolls? Who utilizes  
13 the care? What sites of care do they utilize? And  
14 eventually what are the outcomes? I think that would be  
15 really very interesting and will fill a gap in research.

16 MS. GRADY: That's a very timely question because  
17 we are going to be coming to you in the near future on that  
18 issue. But in the data we have in particular, we are able  
19 to identify race and ethnicity to the extent that states  
20 report it. So we do have a lot of missing information in  
21 their eligibility records.

22 The other thing is it's not always clear how that

1 information is getting from the beneficiary to the record,  
2 whether it's self-reporting or whether a caseworker is  
3 filling something in. But the ACA did have a number of  
4 provisions that were intended to standardize the collection  
5 of race and ethnicity data in Medicaid, CHIP, and other  
6 programs, and I believe they just issued a report on those  
7 provisions that we're going to be coming back to you on to  
8 talk about.

9           So the answer is yes, but I think we sort of view  
10 the data with a cautious eye at this point in time.

11           COMMISSIONER CRUZ: I do remember the ACA did,  
12 you know, try to standardize all of the data collection,  
13 but I haven't seen anything since then.

14           VICE CHAIR GOLD: I assume you know the people  
15 who have used that data with CAHPS, like Alan up at  
16 Harvard. And I would check with them on any tricks they've  
17 developed to deal with that messiness, because they've been  
18 dealing with it for a while, and I know there's some  
19 surname stuff -- well, I guess you can't use that, but  
20 there's zip code stuff. There may be some other things  
21 that they've developed that can help you apply this the  
22 right way, because I think the data are getting better.

1           COMMISSIONER ROSENBAUM: So I always explain to  
2 people that I went prematurely gray because 40 years ago  
3 this year, basically, I went through my first training as a  
4 legal services lawyer, and the first thing we went through  
5 was Medicaid eligibility at Vermont Legal Aid, and it was,  
6 like, "Oh, my God, I quit." And it was so much easier  
7 then. It's really horrendous now. But everything here is  
8 for a reason, and that is -- you know, you have to remember  
9 that.

10           A couple of issues, one minor -- not minor, one  
11 sort of micro and one is more macro.

12           So there's an issue buried in people with  
13 disabilities policy that we've not really ever looked at,  
14 but given our name and given our mandate for children, I  
15 think we might want to, and that is -- and it's also an  
16 issue for adults, and that is the large number of states --  
17 I think it's still about 15 -- that are classified as  
18 209(b) states, and those states can depart from the  
19 definition of disability as it was adopted in 1972. And  
20 some of those states actually today I believe still do not  
21 recognize children as a group of people with disabilities.  
22 And for adults, some of those states may use a disability

1 test that is even more restrictive than the Social Security  
2 Act disability test.

3 Now, for children, the poverty level expansion  
4 mitigated some of the damage, but not completely, because,  
5 of course, there are children with disabilities who have  
6 incomes well above the 138 percent of poverty test, and if  
7 they can't be considered disabled, then they have no  
8 attachment potentially to Medicaid.

9 Those states may have either altered their  
10 definition or they may have through home and community-  
11 based waiver programs at this point essentially negated the  
12 effect of the definition. But it may still be an issue for  
13 children and adults on Medicaid, and I think, you know, a  
14 really important question for us is how much is poverty a  
15 proxy and how much do you really still need a disability  
16 definition? Who gets left out when you either have none or  
17 have a restrictive -- an even more restrictive test?

18 Which brings me to the other point that's more  
19 macro, and it's an issue that I've raised before at MACPAC.  
20 You cut the information in lots of ways that are really  
21 important, but I think given what has happened since 2010,  
22 we have to do a very clear job explaining to Congress and

1 other policymakers who the greater than 138 percent of  
2 poverty group is, because beginning January 2014, of  
3 course, the maintenance of effort provision in Medicaid for  
4 adults is presumably gone, although there was never a big  
5 flag waving around it. The Justice Department has noted in  
6 all of its King briefs that the MOE period is over.

7           For children, we are closing in on it, and I have  
8 been concerned for a long time that we will start to see  
9 erosion in this population, and it has, you know, of  
10 course, a lot of eligibility implications for the  
11 population, but also it has risk implications for the  
12 exchanges in states. And it's everybody from women with  
13 breast and cervical cancer to people with disabilities and  
14 alternative arrangements. I mean, it's everybody in the  
15 world who has a special need, as you pointed out. But I  
16 think that giving policymakers a clearer picture of who are  
17 we talking about here, and that, of course, feeds over to  
18 this question we've circled back to any number of times,  
19 which is should there be -- I don't want to go down this  
20 road again, but I'll flag it. Should there be a formal  
21 mechanism that would enable a state to do some  
22 supplementation of commercial coverage, or do we really

1 want to treat these folks as medically frail under a much  
2 bigger umbrella and keep them separate? What are some of  
3 the options? As opposed to just letting them slowly get  
4 sort of thrown off the program because the MOE period is  
5 over, and we don't even really know whom we've missed.

6           People have alluded now a few times to the fact  
7 that states have begun to start coming back on their adult  
8 coverage, and, you know, it could be that it's just the  
9 demo stage, they were covering some people who were low-  
10 income adults now eligible for subsidies. But I think we  
11 need to watch this carefully.

12           CHAIR ROWLAND: You know, April, when we next  
13 return to look really in-depth at the disability  
14 population, the working disabled, who, of course, would fit  
15 perfectly into Sara's analysis of who's above 138, and the  
16 whole role of the substantial gainful activity test, since  
17 most people think the disability test is based on your  
18 disability, but it's also based on your inability to earn  
19 substantial gainful activity, which we touched on only  
20 minorly in the past in our work on disability, but I think  
21 it's an increasingly important thing to look at given that  
22 everyone assumes that Medicaid is now just going to cover

1 everyone under 138 percent of poverty.

2           COMMISSIONER RILEY: I've been thinking in the  
3 discussion of CHIP about children with developmental  
4 disabilities, and now I think more about it when I look at  
5 the long-term care assessment tools. It seems to me that's  
6 a population we need to spend more attention on anyway, but  
7 it strikes me that -- and it's not an area I know a lot  
8 about, but there's a new SIS assessment tool to look at DD  
9 eligibility and what kind of services they get, and I  
10 wonder if we could add that into our work.

11           VICE CHAIR GOLD: April, I have two suggestions  
12 on the work you have on slide 13 on longitudinal data. One  
13 is that it gets -- you know, when you start talking about  
14 the duals, they're so complicated and you start talking  
15 about this -- and I was intrigued by this, you know, stock  
16 and flow, where they come from, what they stay, and it  
17 seems to me you might think as you do this about how to  
18 visually lay some of these out over time, over like a life  
19 cycle of, you know, the ages of people or whatever, so we  
20 understand a little bit how people are coming in, and maybe  
21 differences across subgroups and similarities in their age  
22 or their needs or their service patterns, to help us sort

1 out who this dual-eligible population is and sort of how  
2 they relate to the Medicare and Medicaid programs.

3 CHAIR ROWLAND: I have a little comment to add to  
4 that. We always talk about how Medicaid is taking care of  
5 Medicare's population. But there's a little twist in this  
6 in that Medicare is now taking care of some of Medicaid's  
7 population. And I think that's a very important story.

8 VICE CHAIR GOLD: And the other question I had, I  
9 just wondered how you were dealing with defining managed  
10 care in your analysis. Are you looking at just  
11 comprehensive managed care? Are you distinguishing the  
12 types of managed care? Because, as you know, that gets  
13 really messy in understanding who these people are and what  
14 the situation is with using fee-for-service and managed  
15 care.

16 MS. GRADY: So the answer is yes, we are looking  
17 at the different types of managed care. With regard to the  
18 encounter data analysis we've done thus far, it has just  
19 been focused on comprehensive managed care.

20 VICE CHAIR GOLD: Then at least you know what  
21 you're talking about there. Sort of.

22 MS. GRADY: Right. It seems that from work your

1 former colleagues have done, the other limited-benefit  
2 plans, for example, behavioral health plans, don't have a  
3 lot of information that's being submitted right now. We  
4 have anecdotal reason to believe that the stand-alone  
5 dental plans also probably are not providing good  
6 information or we're not getting good information on those.

7           The other major type of limited-benefit plan is  
8 transportation, and that's one where it's highly variable  
9 in terms of the contracting arrangements that states are  
10 using and what we would even expect to see if we had data.  
11 But we do have a contract that I didn't mention on that  
12 right now, on non-emergency medical transportation, so  
13 hopefully we can get at some of those issues and understand  
14 what we can know from the data. But to date, the analysis  
15 has focused mostly on comprehensive managed care.

16           VICE CHAIR GOLD: That's fine. You have to focus  
17 somewhere --

18           CHAIR ROWLAND: Non-emergency transportation is  
19 very important because that's one of the main things  
20 they're trying to waive in most of the waivers, so that  
21 would be useful to have.

22           VICE CHAIR GOLD: But one other comment. When

1 you're doing this, it's not just this presentation and  
2 others. It seems that the staff are learning stuff about  
3 the completeness of the encounter data, which states are  
4 more complete, which programs are more complete. It would  
5 be nice to track that across your different results and  
6 actually, you know, produce a brief or something on it,  
7 because everyone is very interested.

8           For example, those states you left out, it wasn't  
9 clear which ones or what you knew, and I know that gets a  
10 little sensitive, probably, because no state wants to be  
11 viewed as having provided poor data. But as users of data,  
12 it's really good to know.

13           And the only other -- Alan Zaslavsky is who I  
14 meant from Harvard. He's a guru on this stuff.

15           CHAIR ROWLAND: Well, on the data, one of our  
16 charges from the statute is to report on what data we need  
17 and what data others need to actually manage and evaluate  
18 the program, so that's a good point.

19           COMMISSIONER SZILAGYI: Just a simple point. By  
20 the way, I will flunk your test, Anne.

21           [Laughter.]

22           EXECUTIVE DIRECTOR SCHWARTZ: I don't think I

1 would get a passing grade either.

2           COMMISSIONER SZILAGYI: So as I -- I'm learning  
3 about all these adult populations, and as I try to  
4 understand the forest, one of the things that would be  
5 helpful, at least for me, with all of these different  
6 populations, is if kind of consistently we could talk --  
7 you know, if you could present information about how many  
8 people are in this group and what is the total cost and  
9 what percentage of all Medicaid does this cover. Because  
10 where the access and cost -- you know, we're trying to  
11 figure out how best to optimize access and reduce costs, if  
12 possible. So, you know, it would help me in terms of where  
13 to prioritize and what to focus on. You know, if something  
14 is a relatively small population but an enormous part of  
15 the cost, that would be certainly worth focusing on.

16           CHAIR ROWLAND: One of the things you'll find out  
17 is that that also varies tremendously by state.

18           COMMISSIONER SZILAGYI: I meant more at the  
19 national level.

20           CHAIR ROWLAND: What else is new about our  
21 Medicaid work?

22           COMMISSIONER MILLIGAN: I'm sort of late to the

1 party. So I need to ramble for a second. Working in  
2 Maryland through a lot of the ACA launch and a lot of ELE,  
3 express lane eligibility, and some of the CHIPRA bonus and  
4 all of those pieces, there was a lot of discussion about  
5 other programs, TANF and SNAP, and how to align the  
6 eligibility pathways and what it meant for systems, what it  
7 means for caseworkers, what it meant for data transfer,  
8 because Medicaid at a state administrative level isn't --  
9 the eligibility pathway isn't isolated from those other  
10 means-tested programs.

11           And so just in the context of how we think about  
12 this in terms of simplification, in terms of retaining  
13 people from churn, I think we also have to be mindful of  
14 the context in which -- a couple things. One is express  
15 lane eligibility doesn't work in both directions. Somebody  
16 still has to come back in if they want their TANF cash  
17 assistance; they have to come back in if they want their  
18 SNAP food assistance. And some of the asset and income  
19 tests vary a little between programs. And so I think that  
20 we're going to need to contextualize some of this work  
21 around -- from a family's perspective dealing with food  
22 security, dealing with cash, is part of what they might be

1 pursuing.

2           And so I just want to make sure that we don't  
3 lose sight of the entry points and what drives entry in  
4 those other senses as well.

5           MS. GRADY: One thing I would point out on that  
6 issue is that one of the things that was in the President's  
7 budget was an indication that the 90 percent match for  
8 eligibility systems is going to be extended, and in  
9 particular, integrated eligibility systems where Medicaid,  
10 TANF, SNAP, other programs are being determined at the same  
11 time. There's been a waiver in place actually that's  
12 allowing the 90 percent match to be used for those  
13 integrated eligibility systems. Whereas the other programs  
14 would normally have to pay, they don't currently, so there  
15 is funding available -- if not to align the actual  
16 eligibility standards and processes, to at least have a  
17 system that works well with Medicaid.

18           COMMISSIONER MILLIGAN: Waiver of OMB Circular A-  
19 87. Sorry.

20           But one of the points I would want to make about  
21 that is if you look at SNAP, which I think it's 135 percent  
22 of poverty, it aligns pretty closely, like within margin of

1 error, of 138 percent MAGI. But food nutrition services at  
2 USDA, you know -- so the ELE pieces don't work both  
3 directions.

4 CHAIR ROWLAND: Okay. Well, I think that we've  
5 managed to all flunk Anne's quiz, but not because April  
6 didn't do a great job of walking us through a program that  
7 has been built one layer on another layer on another layer  
8 over the last 50 years that ends up to be as complex as it  
9 is today. And we will work as a Commission toward how we  
10 can try over time to simplify and to integrate the coverage  
11 in a better manner.

12 But April has given us a good start, and now  
13 we're going to turn to Katie to give us a little bit of an  
14 update on the Medicare savings programs that April has just  
15 alluded to. And what we want to do here is to understand a  
16 little more about how they work, about some of the gaps in  
17 them, and about kind of the broader world in which we may  
18 be seeing and hopefully implementing at some point in the  
19 future reforms that help to smooth out the way in which  
20 these programs work with Medicare and Medicaid.

21 **### Session 6: IMPROVING ELIGIBILITY AND ENROLLMENT FOR**  
22 **THE MEDICARE SAVINGS PROGRAMS**

1 \* MS. WEIDER: Okay, great. Thank you. So, the  
2 purpose of my presentation today is to revisit the Medicare  
3 Savings Program (MSP) eligibility and enrollment issues.

4 At our October and December meeting, we discussed  
5 barriers to MSP enrollment and opportunities to improve the  
6 MSPs. However, during these previous conversations, the  
7 real focus was on Medicaid payment of Medicare cost  
8 sharing. And, as a result, we didn't include MSP  
9 enrollment issues in our March report. However, now that  
10 we've addressed cost sharing, we can turn our full  
11 attention to MSP eligibility and enrollment.

12 Today, I'll briefly highlight barriers  
13 surrounding MSP enrollment. And you'll notice in the  
14 background paper provided, in Tab 7, we provide examples to  
15 improve the MSPs. But, in today's presentation, I'll  
16 discuss their benefits and challenges at a higher level.  
17 Today, we're seeking your feedback on the presentation and  
18 identifying if you need additional evidence to move  
19 forward.

20 So, now to focus on the issue. Enrollment in the  
21 MSPs has been historically low. In 2004, the Congressional  
22 Budget Office estimated that only 33 percent of individuals

1 who were eligible to enroll in the Qualified Medicare  
2 Beneficiary program, that is the QMB Program, were actually  
3 enrolled in the program. As a reminder, the QMB program  
4 covers Medicare Part B premiums and cost sharing to  
5 individuals with incomes between -- or, excuse me, up to  
6 100 percent of the federal poverty line. And, in 2004, CBO  
7 also estimated that only 13 percent of eligible  
8 beneficiaries were enrolled in the SLMB program. And, as a  
9 reminder, the SLMB program covers Medicare Part B premiums  
10 for individuals with incomes between 101 and 120 percent of  
11 the federal poverty line.

12           Now, there are a number of reasons why people  
13 don't enroll into the MSPs, and here, we highlight four  
14 major barriers, and the first is lack of program awareness.  
15 Research suggests that people don't know about the program  
16 and, as a result, don't apply or enroll into the program.

17           Second, there's also a complicated application  
18 process which can be too long, too difficult to understand,  
19 or require extensive documentation. Additionally, some  
20 states do not make MSP applications readily available to  
21 applicants. For example, some states do not allow  
22 applicants to submit an application electronically, while

1 other states require authorized representatives to be  
2 physically present with the applicant in order to submit an  
3 application.

4           And, third, we have financial eligibility. Not  
5 only do states have varying income and asset standards for  
6 the MSPs, they also have varying methods in how they count  
7 assets. Additionally, there is also a misalignment between  
8 the MSPs and the Part D Low-Income Subsidy Program. These  
9 factors create confusion regarding the programs and  
10 differences in eligibility levels.

11           And, finally, we have the expiration of the  
12 Qualifying Individual program, the QI program. The QI  
13 program is currently only funded through short-term  
14 Congressional authorizations and periodic reauthorizations.  
15 It is set to expire on March 31, 2015, and I'll discuss  
16 this issue in greater detail in an upcoming slide.

17           So, what's the rationale for fixing these  
18 barriers? Here, we have three major reasons. One, the  
19 MSPs can improve access to care. Two, MSPs can reduce out-  
20 of-pocket costs for low-income beneficiaries. And, three,  
21 simplifying the MSP application could reduce administrative  
22 burden to states and also beneficiaries.

1           So, with that being said, there have been methods  
2 to improve MSPs for potential enrollees. Some of these  
3 methods have been used in past efforts to increase MSP  
4 enrollment.

5           One such effort is support of MSP education and  
6 outreach. As previously noted, one of the major reasons  
7 people don't enroll in the program is due to a lack of  
8 knowledge regarding the program. So, in 2006, the State  
9 Health Assurance Assistance Programs received about \$30  
10 million from CMS to support MSP and Part D LIS education  
11 and outreach. And, in 2008, MIPPA provided approximately  
12 \$18 million to the SHIPs, Area Agencies on Aging, and Aging  
13 and Disability Resource Centers towards MSP education and  
14 outreach. Since 2009, SHIPs and these other agencies  
15 submitted nearly 900,000 applications to the Part D LIS  
16 program and the MSP programs, which equaled approximately  
17 \$2.3 billion in benefits.

18           There have been recommendations and efforts to  
19 continue the support. In 2008, MedPAC recommended  
20 increasing funding to the CHIP -- to the SHIPs, excuse me -  
21 - to support outreach to low-income Medicare beneficiaries  
22 for MSP and Part D LIS enrollment. And, recently, the

1 Protecting Access to Medicare Act of 2014 provided  
2 additional funding to support the SHIPs and these other  
3 agencies on MSP education and outreach for fiscal year 2014  
4 and 2015. For 2015 -- for FY 2015, excuse me -- this  
5 funding totaled approximately \$13 million, but at this  
6 time, there is no other appropriations to continue this  
7 funding.

8 Another effort to improve MSP enrollment is  
9 examining the QI program funding. The QI program provides  
10 Medicaid coverage of Medicare Part B premiums to Medicare  
11 beneficiaries with incomes between 121 and 135 percent of  
12 the federal poverty line. Unlike the other three MSPs, the  
13 QI program is entirely federally funded. However, this  
14 program is only funded through short-term Congressional  
15 appropriations and periodic reauthorizations.

16 Most recently, the Protecting Access to Medicare  
17 Act of 2014 extended the program to March 31, 2015. If the  
18 program is not continued, almost 600,000 QI beneficiaries  
19 could lose coverage of their Part B premiums. The FY 2016  
20 President's budget proposes to extend the expiration date  
21 of the QI program to December 31, 2016. And OMB estimates  
22 that this extension would cost the federal government

1 approximately \$975 million.

2           Additionally, states have made individual efforts  
3 to improve the MSP application availability. However, not  
4 all of these efforts have trickled down to all the states.  
5 As I previously noted, not all states allow applicants to  
6 submit an application electronically and there are also  
7 barriers for some authorized representatives to submit  
8 applications on behalf of potential MSP enrollees.

9           Now, attention has been paid toward aligning the  
10 MSP eligibility with Medicare policy, specifically, the  
11 Part D LIS program. Aligning these programs could  
12 potentially: one, increase enrollment to the MSPs and the  
13 Part D LIS program; two, simplify the application process  
14 for MSP-only beneficiaries; and three, could shift  
15 responsibilities for MSP administration from the states to  
16 the federal government.

17           Now, I'm raising this issue because the  
18 Commission has been continually interested in simplifying  
19 the Medicaid program, but I want to highlight that MIPPA  
20 did make efforts to align these programs in the past, but  
21 it did not completely align the programs as income and  
22 asset counting methodologies are different between the

1 programs. And, some of the reasons why MIPPA didn't  
2 completely align these programs is because they have ripple  
3 effects outside of the MSPs that can harm beneficiaries and  
4 also increase costs to the states and federal government.

5           And, April alluded to some of these, so I'll go  
6 through them right now, and the first one is the loss of  
7 medically needy Medicaid eligibility. As a result of  
8 gaining MSP eligibility, beneficiaries will have their  
9 Medicare Part B premiums paid for. And because their Part  
10 B premiums are now covered through an MSP, they may no  
11 longer have enough medical expenses to qualify for Medicaid  
12 under the medically needed Medicaid eligibility pathway.

13           Two, the program does not -- aligning the  
14 programs do not change full benefit Medicaid eligibility  
15 determination processes or its eligibility standards. For  
16 individuals who want to qualify for full-benefit Medicaid,  
17 aligning the MSPs with the Part D LIS program would also  
18 require these applicants to submit two separate  
19 applications, one for the MSPs and another for Medicaid.  
20 This could also result in states conducting two methods of  
21 counting income and asset testing, which could increase  
22 their administrative burden.

1           And, three, some states have expanded their MSP  
2 income and asset levels beyond the Part D LIS thresholds.  
3 And if states adopted the Part D LIS income and asset  
4 levels and they were not able to keep the expanded  
5 thresholds beyond the Part D LIS program, then aligning the  
6 MSPs and the Part D LIS Program could actually decrease MSP  
7 eligibility for individuals in those states.

8           And, finally, aligning the programs would  
9 increase the number of people enrolled in both the MSPs and  
10 the Part D LIS program, which would lead to increased costs  
11 to the states and federal government.

12           So, now, we're seeking your feedback on this  
13 information, and we can provide additional evidence, as  
14 needed, in the upcoming meeting. And, at this point, I can  
15 answer any questions.

16           CHAIR ROWLAND: Thank you. Patty, and then  
17 Chuck.

18           COMMISSIONER GABOW: If this doesn't convince us  
19 that we need to simplify the whole program, then there is  
20 absolutely nothing in the world that will convince us that  
21 we need to simplify it.

22           CHAIR ROWLAND: Chuck.

1           COMMISSIONER MILLIGAN:  Patty, what are you  
2 trying to say?

3           [Laughter.]

4           COMMISSIONER MILLIGAN:  So, I want to go up to  
5 the, like, a problem statement level, and I think a problem  
6 statement is there is an affordability issue regarding Part  
7 B premiums and that sort of thing.  From that problem  
8 statement to the remedy, there's a couple of options that I  
9 want to just ask maybe a question or two.

10           For a lot of the individuals who we're talking  
11 about, they increasingly have access to and are taking up  
12 Medicare Advantage, where there might be a zero premium and  
13 there might be very low copayments for physician visits and  
14 pharmacy and so on.  Do we have any data on take-up of SNPs  
15 or just traditional Medicare Advantage plans for the cohort  
16 of individuals who would be eligible for MSP to find out  
17 if, in some way -- or the markets nationally who are served  
18 by zero premium Medicare Advantage plans, because I'm  
19 trying to figure out if, in some ways, the problem is  
20 getting solved because people are choosing to join MA plans  
21 where there is a zero premium and relatively low copayments  
22 for physician visits and so on, separate from a kind of a

1 Medicare fee-for-service model that MSP is really built  
2 around.

3 MS. WEIDER: Dual enrollment in a Medicare  
4 Advantage plan is about 20 percent. The specific  
5 breakdowns on the no premiums, I can -- we can look into  
6 that. I don't have that off the top of my head.

7 COMMISSIONER GOLD: But, even a no premium plan -  
8 - few of them subsidize part of the Part B premium. So,  
9 even if someone is in an MA, the regular Medicare Part B  
10 premium still applies, so that issue would still remain  
11 regardless of that. And, I'm not sure how they counted.  
12 The data in this area is pretty crummy. But, if they are  
13 partial duals and not full duals, then they don't get the  
14 extra benefit -- they only get what the Medicare Advantage  
15 plan pays. They don't get Medicaid benefits. So, it's a  
16 little bit complicated.

17 CHAIR ROWLAND: Obviously, it's a complicated  
18 population as well as a complicated issue, and it could get  
19 more complicated as some of the discussions that are now  
20 underway about restructuring the Medicare coverage and  
21 looking at alternative ways of combining Parts A and B and  
22 introducing new low-income subsidies. So, I think what,

1 really, we need to tease out of this is what are the  
2 lessons for who this population is? What are the  
3 differences between those who are getting full benefits and  
4 those who are just getting the premiums and the cost  
5 sharing, which is where Patty started it, saying why are  
6 they in Medicaid in the first place. But, I think it's  
7 important to recognize that some of the full benefit  
8 beneficiaries also get the premiums and the cost sharing  
9 and you wouldn't want to have them lose that if you sent  
10 the partials back to Medicare.

11 But, I think, really understanding more about who  
12 the population is, how much they are using -- and, I'm  
13 struck by the fact that we really don't know -- 2004 was a  
14 long time ago. It was before the implementation of the  
15 Medicare drug benefit. So, do we have any sense of how  
16 many people are actually benefitting from these programs  
17 now, what the real counts are? And, I would think that CMS  
18 ought to know that, because aren't they collecting those  
19 premiums? So, at least they should know how many people  
20 from each state have states paying premiums for them.

21 MS. WEIDER: Yeah. I haven't seen too much data  
22 out there regarding this. Most recently, GAO did a report

1 on examining what MIPPA did to increase MSP enrollment and  
2 they saw that the overall program expanded about five  
3 percent in the first three years of MIPPA, but, also, those  
4 first three years were also during the recession, so that's  
5 also something to keep in mind, just what was going on in  
6 the economy. But, overall, I haven't seen any new data on  
7 potential enrollees who aren't enrolled, or what that  
8 number looks like.

9 CHAIR ROWLAND: Well, I would suggest that the  
10 Commission ask the Department to provide us with some of  
11 that information, that we do have the right to request  
12 information to inform our deliberations, and certainly  
13 putting together a data request to HHS, especially since  
14 they're engaged, as well, in the dual demonstrations and  
15 there is an Office of Duals, perhaps that office could  
16 respond, because I do think that we need more information  
17 about how many people are benefitting, about what some of  
18 the lessons are, are there states where this is more of a  
19 problem and states where there is less of a problem, and  
20 how to proceed.

21 Sara.

22 COMMISSIONER ROSENBAUM: I'm curious. I mean,

1 usually, things don't happen for completely irrational  
2 reasons. So, why -- why is the application process  
3 burdensome in a number of states? What's the logic behind  
4 not -- no, I mean, I'm asking the question. I'm trying to  
5 ask the question, you know, in a serious way. I mean, I  
6 realize it's a cost. That, I realize. There are a lot of  
7 things in Medicaid that are a cost. So, is it a more -- is  
8 there something about this part of the program that is more  
9 cumbersome? This is not having to supplement on all the  
10 benefit front. This is just the premium and the cost  
11 sharing. And, I --

12 CHAIR ROWLAND: Don't you have to apply for the  
13 whole elderly and disability eligibility under the state?  
14 There's no federal streamlined form for just the MSP, is  
15 there?

16 COMMISSIONER ROSENBAUM: Well, I'm sort of trying  
17 to get to the bottom of why hasn't the process of entering  
18 gotten further along. The way we've thought about all  
19 these issues in the case of families with children, no  
20 wrong door and this and that, and yet we sort of -- we seem  
21 to be in the stone age when it comes to the group, and I'm  
22 wondering if you could talk a little bit about what we

1 know.

2 MS. WEIDER: Yeah. So, I don't know exactly why  
3 states have more burdensome process than others, but I know  
4 of at least one state that does not have the MSP  
5 application on their website. You have to call or go to a  
6 local Medicaid office to get the actual application.

7 Other issues about electronically submitting the  
8 form. What I mean by that is an applicant cannot fax in a  
9 form or e-mail a form in. And, what I think there is --  
10 it's two separate reasons why they don't allow that. One,  
11 it's just technology. They don't have the technology. And  
12 two is on the physical signature, so -- I just did my  
13 taxes, so when I did my taxes on TurboTax, I typed in my  
14 name and that was my signature, whereas they need the  
15 actual physical signature. I don't know why.

16 And, on the authorized representatives, I do not  
17 know why that some of that --

18 COMMISSIONER ROSENBAUM: And, does CMS not -- I  
19 mean, CMS has done so much work around simplifying  
20 enrollment, and I realize the ACA pushes in that direction  
21 from a broad policy point of view, but does CMS have sort  
22 of a counterpart thinking machine that has sort of tried to

1 come up with best practices and models and working groups  
2 and everybody around simplification? I know about the  
3 SHIPs, of course, but other than sort of -- we have one at  
4 the law school, and other than empowering lawyers and law  
5 students to sort of try and overcome all this for people,  
6 it doesn't sound like there's a lot of enrollment  
7 streamlining going on.

8 CHAIR ROWLAND: Well, part of that, I think, is  
9 that this is the same form being used if you need home and  
10 community-based services and if you need long-term care,  
11 and it also retains an asset test which is not there in the  
12 children and families. And, so, the asset test requires  
13 yet another level of documentation. Even the Medicare Low-  
14 Income Subsidy program still retains an asset test, which,  
15 you know, we've eliminated for families in most states.

16 Okay. Well, thank you, Katie.

17 Now, we'll take a ten-minute break and then  
18 return, since I think after going through Medicaid  
19 eligibility, everyone needs a break.

20 [Laughter.]

21 [Recess.]

22 CHAIR ROWLAND: If we could please reconvene. We

1 are going to reconvene to take back up our discussion of  
2 Medicaid behavioral health services, and Amy is going to  
3 report to us on some of the analysis we requested that she  
4 has now completed, and I think this is really going to  
5 speak to the many issues that we raised and wanted to know  
6 more about in terms of the Medicaid eligibility system.

7           So, Amy, kick it off.

8 **### Session 7: USE OF BEHAVIORAL HEALTH SERVICES BY**  
9 **MEDICAID BENEFICIARIES**

10 \*           MS. BERNSTEIN: Thank you very much. Good  
11 afternoon. Welcome back.

12           So at our last meeting, as Diane said, you  
13 requested more analysis of utilization expenditures,  
14 diagnoses, and issues by population group, including age  
15 group and basis of eligibility, so we have very busily  
16 tried to do that for you in the interim.

17           What I'm going to present to you today is a very  
18 high-level overview to inform your discussion of where we  
19 might go in this area, and I will give you some overall  
20 information on use expenditures, diagnoses, and sort of  
21 issues or targeted concerns for different age and basis of  
22 eligibility groups.

1           We used 2011 Medical Statistical Information  
2 System expenditure and claims data and encounter data. We  
3 looked at all services, including behavioral health and  
4 medical and long-term care services. So when you see  
5 estimates of expenditures, they are total expenditures.  
6 They are not expenditures for behavioral health conditions,  
7 which is a more complex analysis, but we could do that in  
8 the future if you're interested.

9           Again, we used both encounter and fee-for-service  
10 data, and just a few caveats, we did include all states,  
11 even the ones that had issues with their encounter data,  
12 because the purpose of this was to give you sort of a  
13 broad-level overview. So the numbers, we're not making  
14 them public yet, and they may underestimate or even in some  
15 cases overestimate the true number of enrollees with  
16 service use for a couple reasons. One is, again, some of  
17 the encounter data are questionable. Two, again, we don't  
18 have utilization for services that were not provided by the  
19 Medicaid system, and three, Medicaid or any sort of  
20 behavioral health diagnoses may be subject to  
21 underreporting due to stigma and other underreporting  
22 issues. So there are some services for which a diagnosis

1 that was considered a behavioral health diagnosis was not  
2 reported, or there were many diagnoses, and there was not  
3 sufficient space to record that diagnosis.

4           The way we defined a person with treatment for a  
5 behavioral health condition was we looked at all of their  
6 service use, using claims and encounter data, except for  
7 behavioral health drug data. We did not include the drug  
8 data, and I'll talk about that in a minute, and Chris Park  
9 will talk about that in his presentation on behavioral  
10 health drug estimates.

11           We looked at all of the diagnoses that were  
12 associated with that claim, and if any of the diagnoses  
13 were considered to be behavioral health diagnoses based on  
14 the chronic illness and disability payment system  
15 classification, then we considered that a person with a  
16 behavioral health diagnosis. So if that is not clear, I  
17 can try to clarify that further at some point.

18           The tables are at Tab 8 in your binder. There is  
19 no paper associated with it, just the tables.

20           The first table gives you sort of a broad  
21 overview of who these different classes of enrollees are.  
22 Looking at all of the Medicaid enrollees that we could

1 identify that had a behavioral health diagnosis based on  
2 what I just described, there were about 13 million  
3 enrollees, which is about 18 percent of all Medicaid  
4 enrollees had some behavioral health diagnosis. That  
5 constituted about \$170 billion, and again, this is total  
6 expenditures, not just expenditures on behavioral health  
7 conditions or behavioral health treatment. This accounted  
8 for almost half of total Medicaid expenditures, so people  
9 with one of these diagnoses accounted for almost half of  
10 total Medicaid expenditures, and total spending for  
11 enrollees with a behavioral health diagnosis was about four  
12 times as high as for those with people without behavioral  
13 health diagnosis.

14           Again, you asked for everything to be broken down  
15 by age group and basis of eligibility, so I am just going  
16 to go through each of them sort of one slide for each and  
17 give a high-level summary.

18           Starting with children, we divided children into  
19 foster children, children who qualified on the basis of a  
20 disability, and children who did not qualify either on the  
21 basis of being a foster child or having a disability, so  
22 three different groups.

1           The first group that I will talk about is the  
2 nondisabled non-foster children. This is most of the  
3 children with a behavioral health diagnosis, which is 3.9  
4 out of a total of 5.2 million children. There are a total  
5 of 5.2 million children we identified as having a  
6 behavioral health diagnosis. Three quarters of them did not  
7 qualify on the basis of being a foster child or on the  
8 basis of a disability.

9           The most common behavioral health diagnoses were  
10 hyperkinetic syndrome of childhood, which includes the ADD,  
11 attention deficit disorder and attention deficit  
12 hyperactivity disorder, and learning disorders, but it's  
13 important to note that although this was not a large  
14 percentage of children who had a behavioral health  
15 diagnosis, there were an additional 500,000 nondisabled  
16 children who had episodic mood disorders, which includes  
17 bipolar disorder, and another 500,000 with anxiety  
18 dissociative or somatoform disorders, which is basically  
19 anxiety disorder. This is the largest group of children  
20 with a behavioral health diagnosis.

21           Concerns that have been raised for this group  
22 related to behavioral health treatment includes appropriate

1 prescribing of psychotropic drugs, particularly ADHD and  
2 antipsychotic drugs or atypical antipsychotic drugs, and  
3 also appropriate and timely screening for behavioral health  
4 problems under EPSDT and in general and providing  
5 appropriate referrals and treatment, which is sort of  
6 related to the whole issue of integrating behavioral health  
7 into primary care. You want to try to catch conditions  
8 early through screening, so those are again very, very  
9 summary level.

10           So children eligible on the basis of a  
11 disability, we identified about 900,000 of these children  
12 who had a behavioral health diagnosis, which is almost half  
13 of children who qualified on the basis of a disability.  
14 They had the highest total Medicaid expenditures of all of  
15 the child eligibility groups, and the most common diagnoses  
16 were, again, the hyperkinetic syndrome of children, but  
17 also specific developmental delays and pervasive  
18 developmental disorders, including autism spectrum  
19 disorders. So these are very functionally or otherwise  
20 limited children, which is why they qualified on the basis  
21 of a disability. I should also note that about 5 percent  
22 of them, although many of them had autism spectrum

1 disorders and other developmental -- also had or had  
2 instead of episodic mood disorders, including bipolar  
3 disorder or anxiety and other dissociative disorders.

4 I should also note -- and I forgot to say this --  
5 that disorders are not mutually exclusive, so you could  
6 have more than one. Many of these children had more than  
7 one disorder.

8 As far as behavioral health-targeting programs  
9 for these children, many of them are under waiver  
10 specifically for their behavioral health disability. There  
11 are many states that have waivers for children with autism  
12 spectrum disorder to serious emotional distress, and many  
13 of these waivers and other special programs concentrate on  
14 integrating medical and behavioral health in order to  
15 provide services more effectively and to have better  
16 outcomes for this sort of functionally and high-cost, high-  
17 need population.

18 Foster children is the smallest group of children  
19 that we identified with behavioral health disorders. It's  
20 about 42 percent of them have a behavioral health disorder  
21 out of all foster children, which is about 400,000  
22 children, and the children with behavioral health disorders

1 account for about three-quarters of total spending for  
2 foster children.

3           They have, as you discussed at the last meeting,  
4 a high percentage of traumatic and emotional disorders, and  
5 the most common diagnoses were again the ADHD syndromes and  
6 adjustment reactions, but many of them also had conduct  
7 disorders, episodic mood disorders, and other behavioral  
8 health diagnoses.

9           You spoke a lot this morning about various issues  
10 related to foster children, and behavioral health drug  
11 prescribing has been raised, and Chris Park, again, is  
12 going to be talking more about that in the next session.

13           So moving on to adults, non-elderly adults -- and  
14 let me just highlight this is the group to which the  
15 Institutions for Mental Disease Exclusion does apply. Just  
16 keep that in the back of your mind, but I will not mention  
17 it again. About two-fifths of this group had a behavioral  
18 health diagnosis, which is about 3.5 million people, and  
19 that accounted for about 58 percent, more than half of  
20 total expenditures for this group.

21           This is a large portion of the SSI population. I  
22 believe about, according to my notes because I haven't kept

1 up with myself, about one-third of SSI recipients qualify  
2 on the basis of a mental health condition, which includes  
3 depressive disorders, but also adults with autism spectrum  
4 disorder and intellectual and developmental disabilities.  
5 This is where a lot of the SSI population is. The most  
6 common diagnoses were depression, anxiety, and again,  
7 episodic mood disorders.

8           This group has the highest prevalence of  
9 diagnosis of psychotic and personality disorders. It is  
10 only about 8 percent of the group, but it's higher than in  
11 other groups because, in general, those conditions are  
12 relatively rare but also very expensive.

13           Concerns have been raised here, and you raised  
14 them at the last meeting as well, about the lack of  
15 coordination between behavioral health and medical care  
16 resulting in possible inefficient use and suboptimal  
17 treatment and outcomes.

18           You look like you want to say something.

19           Again, this is very high level, so there are many  
20 other activities targeted to all of these groups, but just  
21 to sort of show the difference.

22           Nondisabled adults age 21 to 64 are a

1 heterogeneous group. There are about 2.9 million of them  
2 that we identified as having a behavioral health disorder,  
3 which is about 16 percent of them, but this includes  
4 pregnant women, parents with very low income, and people  
5 who are basically eligible on the basis of something that  
6 is not a disability-related pathway.

7           The most common diagnoses were anxiety,  
8 dissociative and somatoform disorders, and depressive  
9 disorders, which are very common in the population at  
10 large, and also nondependent abusive drugs.

11           One other thing that I again probably should  
12 mention is this doesn't get at the severity of any of these  
13 conditions. So this is anyone with a behavioral health  
14 diagnosis, regardless of sort of how severe it is.

15           Here again, the concerns have been raised about  
16 inadequate screening and referrals for primary health  
17 conditions and as diagnosed through primary care providers,  
18 and other initiatives have been to identify and treat  
19 behavioral health conditions in pregnant women in  
20 particular to help improve perinatal outcomes. Many of the  
21 pregnancy special programs have been targeted to women with  
22 behavioral health, both substance use disorder and

1 behavioral health and mental health conditions.

2 COMMISSIONER MILLIGAN: Amy, I'm sorry. Can I  
3 just stop you there for a second? This is 2011 data?

4 MS. BERNSTEIN: 2011, yes.

5 COMMISSIONER MILLIGAN: So I think with the  
6 expansion population, this information would change quite a  
7 bit.

8 MS. BERNSTEIN: Yes. And I should mention that  
9 this is the group, as with the new expansion, you will have  
10 more adults who have interactions with the criminal justice  
11 system, for example, that we talked about last time as  
12 well, and possibly adults or homeless adults that hadn't  
13 been in before, and yes, substance abusers who are not  
14 otherwise qualified but who can come in through the  
15 expansions, so yes. Thank you. I had it written down.

16 CHAIR ROWLAND: It's good to not say everything,  
17 so we have something to say.

18 [Laughter.]

19 MS. BERNSTEIN: Adults aged 65 and older, it was  
20 harder to get information on use for them because, again, a  
21 lot of their care is Medicare care. Since we identified  
22 them based on their use and the conditions that were

1 associated with their use, I actually took these numbers  
2 from the dually eligible Medicare and Medicaid data book.  
3 Based on that, if you look just at the dual eligibles, 20  
4 percent of dually eligible Medicare and Medicaid enrollees  
5 65 and over -- and they used 2010 data -- had a diagnosis  
6 of depression. Eleven percent had an anxiety disorder, so  
7 there is a high prevalence of behavioral health conditions  
8 in this population as well.

9           Several of the financial alignment demonstrations  
10 have attempted to integrate behavioral health care with  
11 medical care, and concerns have also been raised in this  
12 group in particular, and there have been national CMS and  
13 SAMHSA and other initiatives to try to address issues of  
14 inappropriate psychotropic drug use with elderly people  
15 with dementia in particular where these drugs have been  
16 shown to be harmful, and also with the need to screen older  
17 people for depression and other behavioral health  
18 conditions in primary care settings to improve overall  
19 health care outcomes.

20           So, in summary, the groups are different. All  
21 age and eligibility groups include a substantial number  
22 and/or percentage of enrollees with behavioral health

1 diagnoses, and for every age and eligibility group, which  
2 the audience doesn't have, but which you have in your  
3 tables, enrollees with a behavioral health diagnosis have  
4 higher total expenditures per person than those with no  
5 behavioral health diagnosis. In some groups, that is four  
6 times or five times as many, and in some, it's about half  
7 as much, again.

8           These differ in terms of their diagnoses of the  
9 services provided, of expenditures, treatment concerns, and  
10 programs targeted to each group, and as we begin our  
11 investigations into behavioral health, we would welcome  
12 your direction as to which of these groups, which of these  
13 interventions, what you are most interested in pursuing, as  
14 you discussed at the last meeting.

15           So I welcome your discussion.

16           CHAIR ROWLAND: Okay. Thank you.

17           Marsha.

18           VICE CHAIR GOLD: I wasn't here at the last  
19 meeting, although I read your paper, and I enjoyed it.

20           I really liked the tables you had, especially the  
21 first two tables. I think the way you have laid this out  
22 here really helps to sort of bring to life some of the

1 behavioral health issues and who these people are, and I  
2 think that's important in its own right because unless  
3 something is described, it's invisible, and so I think  
4 that's great.

5           I had two areas where I think I might suggest you  
6 go a little further. One is that your tables look at  
7 means, and it would be very useful to understand the shape  
8 of the distribution of people and expenditures, so that the  
9 big issue is there a chronically ill population among these  
10 cohorts or these subgroups that is different from a sort of  
11 not-that-sick population, because they get cared for in  
12 different systems. So I don't want to complicate your  
13 charts, but I think to the extent you can look at some  
14 medians and look at some quartiles and things and just come  
15 to a conclusion as to whether maybe some of the diagnoses  
16 you have in the subgroups are associated with the big fat  
17 part of the distributions, and others are the tail that  
18 counts for a lot of expenses -- or anything you could do to  
19 just see if there's a chronically ill and others within  
20 these subgroups would be useful.

21           The other is more a caveat. I was surprised when  
22 I looked at the dually eligible that they had almost as

1 much spending as the non-dually eligible. I think that's  
2 probably for the under-65, and I was surprised because,  
3 obviously, Medicare spending isn't in your numbers.

4 I think your numbers are probably right. I mean,  
5 you know how to do numbers, but I think there's probably a  
6 case mix issue, and maybe you have even said that somewhere  
7 that there's different people who are dually eligible for  
8 non-dually eligible adults. And you just may want to look  
9 at it, so you can flag it, because it was only about \$1,000  
10 less, I think, that they used.

11 The other thing, I was sort of thinking about  
12 where you go with this. To my mind -- and I don't know  
13 what's feasible and what makes sense with what the work  
14 flow of the Commission staff is, but I think that the first  
15 part, especially the first two tables and the description  
16 of the population with a little bit of work could be ready  
17 to get out, either in the June report or as a stand-alone  
18 brief.

19 But I think I am not sure that from the policy  
20 perspective -- and I think that's important in itself.  
21 From the policy perspective, I am still not quite sure that  
22 one understands enough about where the Commission's

1 interests are best applied, so that I don't know -- and I  
2 would think it's where are the federal issues here because  
3 that's what we focus on and where are the people issues or  
4 something like that, but that can be done later. It seems  
5 to take a little more work, because I'm not sure we've  
6 gotten in the sort of how does care work for each of these  
7 subgroups, now that you've defined them, and what are the  
8 major barriers or facilitators at the federal level that we  
9 need to be aware of and where might we productively focus,  
10 but others may have some other comments on that.

11 CHAIR ROWLAND: Donna.

12 COMMISSIONER CHECKETT: Amy, thanks. I really  
13 enjoyed the analysis, and your pithy synopsis was just  
14 helpful. So I step back -- this is an area of great  
15 interest I think to all of us who are in a role of  
16 providing and managing care for highly complex  
17 beneficiaries. So I asked myself looking at this, because  
18 I think you said, well, where would you like to take this?

19 So I think one of the big issues for states and  
20 for people running these programs is for people who have  
21 serious mental illness and in designing programs that are  
22 going to help manage costs and get these people as healthy

1 as they can be, understanding that may be very different  
2 than what we might hope it to be.

3 I hear quoted a lot people who have dual  
4 diagnoses are going to live 25 years -- they have 25 years  
5 less in their life span than, quote, the rest of us. And  
6 you hear things tossed around that they're 50 percent more  
7 expensive. And I know we've looked at those numbers or  
8 variations of that in the past.

9 But what would really be helpful for me, to get  
10 to my point, I guess, is if we're going to pick a  
11 population or sort one out, that would be the one I would  
12 really like to go to, because, in fact, they are very, very  
13 expensive, they are very, very ill, and I think states have  
14 a lot of questions about do we do carve out, do we do  
15 special -- like Arizona just did a special integrated  
16 program just for SMIs. But what is really the best way to  
17 manage these folks? Should they never be in managed care  
18 because they're so sick that you could never possibly get  
19 managed care to take care of them well?

20 These are the policy questions that I see states  
21 struggling with, and I think to really understand, you know  
22 -- so if the behavioral health diagnosis is the driving

1 diagnosis, what are the physical health care costs that  
2 need to be addressed and how can we best address those?

3 I guess I'm at this point rambling, but picking  
4 out all these areas, I just think that's the one that  
5 probably is the greatest need.

6 My thoughts. Thank you.

7 COMMISSIONER RILEY: I would wholeheartedly  
8 endorse Donna's sense here, and the bigger question is:  
9 Access to what? You know, as much as we struggle with what  
10 are the quality metrics and what are the metrics of  
11 performance and outcome on the pure health side, it's a  
12 much more complicated arena with less data. So what kind  
13 of services? Where are we seeing successful interventions?  
14 What works, what doesn't with these populations? And it  
15 seems to me we have a natural sort of data set here that's  
16 going to be quite useful. I would love to be able to track  
17 the expansion group. There's so much discussion in the  
18 states, particularly those states that haven't expanded,  
19 and the discussion we had about what is the future of  
20 Medicaid.

21 You know, the discussion is these adults are  
22 able-bodied and ought to be in an employer system and ought

1 not to be on Medicaid. I would love to be able to look and  
2 drill down on the expansion group in the new coverage  
3 populations and see their behavioral health diagnoses,  
4 their service use, and get a better handle on who they are  
5 and how they compare to a traditional Medicaid population.  
6 And I think it could inform a bigger access decision.

7 DR. BERNSTEIN: Can I just clarify? So not  
8 necessarily for the SMI population, just for the new  
9 expansion group population.

10 COMMISSIONER RILEY: The expansion group and how  
11 many of them are behavioral --

12 DR. BERNSTEIN: Okay. But separate from SMI,  
13 okay.

14 COMMISSIONER MILLIGAN: Amy, thanks. I think  
15 this is really helpful information. When I think about  
16 areas of focus, I do want to reiterate, I think, that the  
17 foster care side is really important, and I think one of  
18 the complexities in the foster care world is how frequently  
19 judges get involved because of the state custody issues,  
20 and a lot of times the social supports and housing supports  
21 get kind of interwoven with behavioral health supports when  
22 it comes to meeting a foster child's needs. So I think

1 that's an important group.

2           But I want to focus on the other end of the age  
3 spectrum, actually. The life expectancy of people with  
4 behavioral health needs is increasing. There are more  
5 people with behavioral health needs aging into Medicare,  
6 and there's a lot of complexity in terms of the Medicare  
7 piece and the Medicaid piece. You know, with the physician  
8 side and some of the pharmacy side in Medicare, a lot of  
9 the actual specialty behavioral health service is not in  
10 Medicare but in Medicaid. A lot of age bias because people  
11 perceive that depression is a part of getting older and  
12 it's treatable. And so I do think that there's a dual-  
13 eligible piece here that is often overlooked in discussions  
14 about duals.

15           COMMISSIONER GABOW: I think that as we look at  
16 this and think about the policy issues, understanding the  
17 physical health needs that are so tied with behavioral  
18 health needs, and it goes both ways. People with serious  
19 medical illness have much more behavioral health issues,  
20 and people with serious behavioral health issues have more  
21 medical needs, and that data is well available.

22           So the policy issue that has bothered me for a

1 long time is Medicaid is in general separating the delivery  
2 model from the behavioral health and the physical health,  
3 which takes -- particularly when you're talking about the  
4 seriously mentally ill, asking people who are the most  
5 vulnerable to navigate two complex systems that don't talk  
6 to each other because of the often HIPAA rules about  
7 communicating behavioral health diagnosis.

8           And so I think thinking about how we can increase  
9 the coordination of this group that's expensive, complex,  
10 and has big needs in both, so to the extent that we can  
11 demonstrate their medical cost as well as their behavioral  
12 health cost and make an argument for integrating these  
13 delivery models, I think that's a key policy question.

14           The other comment I would just --

15           CHAIR ROWLAND: Maybe just looking also at what  
16 the co-morbidities are so that you have a better sense of,  
17 you know, is it diabetes and mental health, or is it other  
18 things.

19           COMMISSIONER GABOW: Well, in our study, even the  
20 simplest thing, which I would say is not a disease,  
21 pregnancy, when you have a behavioral health diagnosis and  
22 you're pregnant, the cost and the complications go up

1 amazingly. So as you get more complex chronic disease, you  
2 can imagine how it's exaggerated.

3 I was surprised by the overall number of 18  
4 percent because in our experience, when we looked at our  
5 Medicaid managed care population, the percentage of people  
6 with behavioral diagnosis was significantly higher than  
7 that. So I was wondering how that 18 percent compares  
8 overall with the number that you see in the literature,  
9 because it seems low to me. And the substance abuse  
10 numbers seemed very low to me given -- maybe in Denver  
11 everybody is high. I don't know.

12 [Laughter.]

13 DR. BERNSTEIN: Again, this doesn't include all  
14 care, and this is definitely an underestimate because it  
15 doesn't include care that wasn't paid by Medicaid. So  
16 you're going to miss a lot, and it's only based on -- and  
17 it also doesn't include behavioral health drugs. And the  
18 reason that we didn't include behavioral health drugs in  
19 the denominator for this particular analysis was that Chris  
20 will show that there's actually a fair number of people who  
21 are taking behavioral -- what are defined as psychotropic  
22 drugs that don't actually have behavioral health diagnoses.

1 So it gets complicated.

2           So this is an underestimate. There is no  
3 question about that. It is consistent with other studies  
4 that have been done. The last one that I'm aware of is the  
5 Center for Health Care Strategies, which was, I believe,  
6 2008 data, and they did include drugs, and they were at I  
7 think 18 percent or 20 percent instead of 15 percent. So  
8 it's in this same ballpark.

9           COMMISSIONER ROSENBAUM: Just to go back to the  
10 earlier discussion, if there's any way to include the  
11 population of special needs adoption children, I would,  
12 because there's so much interest in special needs adoption  
13 children on the Hill, and because I think it would be  
14 interesting to contrast that group with children in foster  
15 care because they're obviously closely related.

16           COMMISSIONER SZILAGYI: Yeah, I had a -- this is  
17 really well presented and very -- I think a big step  
18 forward, so thank you very much.

19           I did have one question -- a couple points. One  
20 was about the co-morbidity, particularly for the adult  
21 population, because it's well known that for -- and exactly  
22 what you mentioned, Diane, you know, adults with diabetes,

1 if they have a co-morbidity of depression, have far worse  
2 diabetes outcomes, and so that's not just diabetes. That  
3 was just the example that I brought up. But that would be  
4 maybe worth teasing out.

5 And that gets to one of my questions. How did  
6 you -- this is the MSIS data? This is an analysis of the  
7 fee-for-service -- okay.

8 [Comment off microphone.]

9 COMMISSIONER SZILAGYI: Okay. How did you -- can  
10 you clarify again for me how you counted -- or how you  
11 selected for disability? So these were disabilities other  
12 than mental health diagnosis?

13 DR. BERNSTEIN: No, the disability is just  
14 whether they qualified on the basis of having a disability  
15 so it's--

16 COMMISSIONER SZILAGYI: Got it. If they  
17 qualified based on --

18 DR. BERNSTEIN: Yeah, it's the eligibility  
19 category. It's not --

20 COMMISSIONER SZILAGYI: Okay. So it's just  
21 looking at disability in a different way then.

22 DR. BERNSTEIN: Yeah, it's totally how they

1 qualified on the basis of eligibility.

2           COMMISSIONER SZILAGYI: Got it. But I think just  
3 even sometimes some very high level data, like this  
4 highlights the importance. I mean, if you look at the  
5 percentage of this population that has a mental health, a  
6 behavioral health diagnosis, it's enormous for every one of  
7 these, you know, 38 percent of dually eligible, 14 percent  
8 of children. I mean, it's much higher than the general  
9 population, and, you know, it doesn't necessarily point  
10 toward a particular policy lever for us, but it really  
11 highlights the importance of focusing on behavioral health  
12 for this population. You could see the next wave of high-  
13 cost, high-disability population as these children grow up.

14           COMMISSIONER COHEN: Also thank you. I thought  
15 this was so interesting, like I've been reading about this  
16 now for a little while. I'm not an expert by any stretch,  
17 but I've never actually seen sort of percentages of  
18 different particular diagnoses in the population, and I  
19 thought that was really helpful.

20           In many ways one might say this is almost a  
21 different topic, but I just did want to flag it as an  
22 important part of behavioral health in Medicaid. There are

1 those obviously who are diagnosed that we can ascertain on  
2 the basis of a claim -- not a drug but a claim -- and  
3 they're sort of a constellation of both diagnoses and other  
4 things. But I think there is literature to suggest that  
5 there are an awful lot of people who are undiagnosed but,  
6 you know, suffering with real burdens of depression and  
7 anxiety. And I think -- and probably I shouldn't say this  
8 because what do I know, but, you know, one could imagine  
9 that, you know, with the stresses of low income, you know,  
10 being low-income people, which is almost, you know,  
11 definitional, if you don't have a disability and you are on  
12 Medicaid, that the sort of rate of that as compared to the  
13 regular population might even be higher, and it's very high  
14 in the mainstream population, in the general population.  
15 So I think we should at least sort of have a flag or place  
16 keeper for the issue of whether or not in regular primary  
17 care in Medicaid people are being sort of screened and  
18 their behavioral health needs are being attended to and  
19 sort of flag that as another area for concern, because it  
20 does -- there are studies that suggest that it impacts cost  
21 for sure, but mostly it's just -- it's morbidity and  
22 suffering, and, you know, being depressed may not

1 completely incapacitate you but may keep you from being  
2 able to sort of fully participate in life. And it's a very  
3 serious issue and a very, I think, extensive issue in the  
4 population in certainly Medicaid. So I think we should  
5 park that.

6 COMMISSIONER MARTINEZ ROGERS: Thank you. It was  
7 a great report, Amy.

8 I just want to add to what Andy was saying, and  
9 that is that -- and it's well documented that amongst the  
10 Latino population, adolescent girls have a high rate of  
11 depression and suicide tendencies. Also with the African  
12 American population being diagnosed with major psychotic  
13 diagnoses more than any other population in the United  
14 States. I don't know if there's anything that we can  
15 actually put in this about it, but it has a lot to do with  
16 income, and the lower income, and who is -- you know, it's  
17 usually around the minority population. So somehow or  
18 another, some -- I don't know if we can just write a  
19 statement, a paragraph, or something that we notice that,  
20 we take that into consideration. I don't think that I  
21 would expect for you to change anything other than just  
22 making it noticeable the way Andy was talking about. I

1 would really appreciate it.

2 Thank you.

3 CHAIR ROWLAND: Well, I think that also, because  
4 this is the Medicaid population, we need to note that this  
5 is the low-income population, because to qualify you have  
6 to be low income.

7 Did you have a small point, Trish?

8 COMMISSIONER RILEY: I just want to be Pollyanna  
9 instead of Debbie Downer, but, you know, all our  
10 conversation this morning was, Oh, my God, how complex this  
11 program is. And I think that -- and it is. And that  
12 thinking leads us to tomorrow's discussion about should we  
13 just change Medicaid, should we, you know, throw it out and  
14 start again. And I think we need to remind ourselves and  
15 always frame these discussions around it's complicated  
16 because these populations are complicated. They have  
17 extraordinary needs that cut across services in  
18 unimaginable ways, in ways that we haven't yet even figured  
19 out, and in many respects, to use a phrase we've used at  
20 the Kaiser Commission before, the Medicaid program makes  
21 Medicare and private insurance work. It effectively serves  
22 as a high-risk pool, and we can't forget that.

1           So as we struggle and pull our hair out over the  
2 complexity of what we've created here, I think we can't  
3 forget that its fundamental role of serving people with  
4 profoundly challenging needs is in part what makes the  
5 complexity.

6           CHAIR ROWLAND: Well, and it's also far more than  
7 a health insurance program. It is really a health services  
8 program across the spectrum.

9           Amy, I think what you have done is terrific, and  
10 I think we really ought to think about obviously there's --  
11 we want more. We always do. And you're going to provide  
12 us with more, we know, because you always do. But I think  
13 that the pieces that are here, we should really think about  
14 pulling together as just a spotlight to put at least some  
15 of this initial data out as part of our June report.

16           [Laughter.]

17           EXECUTIVE DIRECTOR SCHWARTZ: She didn't see that  
18 one coming.

19           CHAIR ROWLAND: Thank you, Amy.

20           It's hard to stun Amy, but we seem to have done  
21 it. We liked it, Amy, a lot.

22           And now, Chris, we like yours, too, so that's a

1 good set-up because you're going to take us to the next  
2 level of looking at psychotropic drugs and medication.

3 **### Session 8: USE OF PSYCHOTROPIC MEDICATIONS BY MEDICAID**  
4 **BENEFICIARIES: PATTERNS AND POLICY**

5 \* MR. PARK: Right. Thank you, Diane.

6 Amy has kind of laid out the big picture of  
7 behavioral health use and services in Medicaid, so this is  
8 going to take a small slice of that and look at the use of  
9 psychotropic medications by the Medicaid beneficiaries.

10 During last session, last month's session on  
11 behavioral health, many Commissioners expressed an interest  
12 in learning more about the use of psychotropic medications  
13 by the Medicaid population, particularly vulnerable  
14 populations, such as foster children. So, this session  
15 presents our initial analysis of the use and spending of  
16 psychotropic medications in Medicaid.

17 First, I'll walk through the analysis methodology  
18 and then present some of the key findings on spending and  
19 utilization. Then, I'll highlight some of the risks of  
20 psychotropic medications and federal and state activities  
21 that have been designed to improve psychotropic use and try  
22 to ensure that these medications are being used

1 appropriately. And, finally, I'll present a few policy  
2 questions for your consideration as we kind of decide on  
3 what future work we may want to consider.

4           So, our analysis used 2011 Medicaid Statistical  
5 Information System eligibility and outpatient pharmacy data  
6 and we identified enrollees with at least one psychotropic  
7 drug prescription. The list of drugs and drug classes that  
8 we included in analysis can be found in Appendix A of the  
9 paper that's included in Tab 9.

10           For counts of psychotropic prescriptions, we used  
11 both fee-for-service and managed care claims. For spending  
12 numbers, we only used fee-for-service claims because the  
13 payment amounts are typically not included on the managed  
14 care encounter data reported at MSIS. Also, I'd like to  
15 point out that the drug spending is before any Medicaid  
16 rebates are applied.

17           We also excluded several populations due to  
18 limited pharmacy data. Individuals dually eligible for  
19 Medicare and Medicaid receive most of their medications  
20 through Medicare Part D, so they were excluded. We also  
21 excluded the all-year institutional population, such as  
22 individuals residing in a nursing home, as drugs are often

1 bundled as part of the total facility payment, such as a  
2 per diem. We excluded limited benefit enrollees as they  
3 may have limited or no pharmacy coverage. And, we also  
4 excluded five states with what appeared to be limited  
5 managed care pharmacy data.

6           As Amy pointed out, this analysis is an analysis  
7 of users of psychotropic medications and it doesn't  
8 necessarily equate to people with behavioral health  
9 conditions, and for a couple of reasons. One, people with  
10 behavioral health conditions may not use a psychotropic  
11 drug. And, two, psychotropic drugs may be used for  
12 conditions not considered to reflect behavioral health or  
13 mental health. For example, anticonvulsants are typically  
14 used to treat seizures, but they can also be used for  
15 bipolar, and so we haven't necessarily controlled for uses  
16 outside of behavioral health conditions.

17           Overall spending on psychotropic drugs in  
18 Medicaid is substantial. Medicaid spent \$8 billion in fee-  
19 for-service on psychotropic drugs, which was about 30  
20 percent of the total drug spending, and it only represented  
21 18 percent of all of the prescriptions.

22

1           Enrollees who qualify for Medicaid on the basis  
2 of a disability accounted for over half of the psychotropic  
3 prescriptions and 60 percent of fee-for-service spending.  
4 And, again, this may be partially explained by many of  
5 these individuals becoming eligible on the disability  
6 pathway due to a mental illness.

7           The spending varied greatly by different  
8 eligibility groups. On a per user basis, spending for  
9 foster children and beneficiaries with disabilities was  
10 about \$2,000 per user, which was about two to four times  
11 that of other groups.

12           Looking at spending and use by therapeutic class,  
13 antidepressants were the most commonly used. About one-  
14 third of prescriptions were for antidepressants. For  
15 spending, antipsychotics were the most costly. They were  
16 over half of the fee-for-service spending. In fact, the  
17 top three drugs in spending in Medicaid fee-for-service  
18 were antipsychotics, and they were over ten percent of  
19 spending.

20           Use also varied a little bit by the eligibility  
21 groups. For non-disabled children, they used ADHD drugs  
22 the most, which corresponds to some of the analysis that

1 Amy did, which presented that non-disabled children  
2 frequently had ADHD. For the other eligibility groups,  
3 antidepressants were used the most.

4           This table presents the psychotropic use by  
5 eligibility group. Overall, about 14 percent of the  
6 Medicaid population used a psychotropic drug, and this  
7 varied greatly between the different eligibility pathways.  
8 For example, foster kids, about 24 percent of them had at  
9 least one psychotropic prescription during the year,  
10 compared to five percent of the non-disabled non-foster  
11 care children. And, between these two groups, we see  
12 foster care children had about 16 prescriptions during the  
13 year, versus eight prescriptions for the non-foster care  
14 children. So, they used about twice the number of  
15 psychotropic prescription drugs.

16           For the disabled population, about half of them  
17 used psychotropic drugs, and similar to the foster children  
18 population, they used 17 scripts per user. So, this  
19 averages out to be more than one psychotropic prescription  
20 per month.

21           This table looks at children under 21 by the  
22 basis of eligibility group, and so we see non-foster

1 children who are not disabled, foster children, and  
2 disabled children. Overall, across all of the different  
3 age bands we looked at, the disabled children had the  
4 highest use of psychotropic drugs. About one-third of the  
5 disabled children used a psychotropic drug, compared to  
6 about 24 percent of foster children and five percent of  
7 non-disabled non-foster children.

8           The foster children overall were more similar to  
9 the disabled population in terms of their psychotropic use,  
10 especially for the older age bands of, like, the 7- to 14-  
11 year-olds, 15- to 18-year-olds. And, again, we see that in  
12 terms of the number of prescriptions per user, there were  
13 about twice as many as the non-foster children.

14           This table looks at the disabled eligibility  
15 group by age, and in general, the use of psychotropic drugs  
16 increases with age. About one-third of disabled children  
17 use a psychotropic drug compared to over half of the adults  
18 using at least one psychotropic drug during the year. And,  
19 again, they used about twice the number of prescriptions  
20 compared to the non-disabled populations.

21           I just want to quickly mention the use for adults  
22 over 65. We found 19 percent used psychotropic

1 medications, but this is an underestimate of use due to  
2 some of the exclusions mentioned earlier of the dually-  
3 eligible population and nursing home population, and it  
4 leaves, like, a really small sample size, so this might not  
5 be representative of the actual use in that elderly group.

6           The high usage rate of psychotropic drugs in the  
7 Medicaid population has created concern among stakeholders  
8 and policy makers regarding the use of these drugs due to  
9 some of the risk associated with psychotropic medications.  
10 For example, these drugs can increase the risk of suicidal  
11 thinking and behavior in children and adolescents.  
12 Atypical antipsychotics can increase the risk of weight  
13 gain and metabolic disorders, which can increase the risk  
14 of heart disease, obesity, diabetes, and other health  
15 conditions. In fact, the FDA has not approved atypical  
16 antipsychotics for use in children under five years old.  
17 Antipsychotics also pose an increased risk of illness and  
18 death in older adults with dementia, which has led the FDA  
19 to require a black box warning regarding this increased  
20 risk of illness and death for elderly population.

21           Due to these risks, and particularly for the  
22 elderly population with dementia and foster children,

1 federal agencies and states have undergone several  
2 activities to improve the use of psychotropic medications  
3 and try to ensure that they are used appropriately. CMS  
4 and the Agency for Health Care Research and Quality are  
5 developing performance measures regarding the use of  
6 psychotropic medications in children. For foster children,  
7 this often involves the coordination of several agencies --  
8 welfare agencies, Medicaid department, and also the mental  
9 health agency within both the federal -- at the federal  
10 level and state level. The Child and Family Services  
11 Improvement and Innovation Act requires that the state  
12 welfare agency report annually on what they're doing to  
13 monitor the use of psychotropic medications in foster  
14 children.

15 CMS, the Administration for Children and  
16 Families, and the Substance Abuse and Mental Health  
17 Services Administration have recently started coordinating  
18 initiatives among agencies and have recently issued several  
19 informational bulletins highlighting different programs  
20 that states have undertaken to address this issue. Also,  
21 CMS, in regards to use of psychotropics in the elderly  
22 population, has created a National Partnership to Improve

1 Dementia Care, and one of their goals is to reduce the use  
2 of psychotropic medication in the long-term nursing home  
3 population.

4           At the state level, we see similar efforts  
5 regarding the use of -- improved use of psychotropic  
6 medications. Some examples include obtaining informed  
7 consent from the parent, legal guardian, or child welfare  
8 agency before these drugs are prescribed; providing peer  
9 review, consultation, or prior authorization for certain  
10 drugs, ages, or doses, for example, if you submit a  
11 prescription for a child under five for a psychotropic  
12 drug, there might be a prior auth triggered at the point of  
13 service. They also provide education to providers to  
14 inform them of the risks associated with these drugs, and  
15 the appropriate prescribing guidelines recommended by  
16 different agencies. And, also, states provide utilization  
17 and performance reports regarding the use of psychotropic  
18 drugs for certain populations, for example, providing these  
19 reports to nursing homes.

20           So, here, we have a few policy questions for you  
21 to consider as we develop our future work on this topic.  
22 What have we learned about the effectiveness of state

1 psychotropic improvement initiatives? Are targeted  
2 initiatives needed for populations beyond foster children  
3 and nursing home residents? Do Medicaid programs have  
4 appropriate protocols in place to monitor for the risks  
5 associated with these drugs? And, what is CMS's role in  
6 promoting appropriate psychotropic prescribing patterns?

7           So, with that, I'll conclude my presentation and  
8 we would appreciate any feedback you have in terms of the  
9 data presented in this presentation and what next steps you  
10 might want us to consider.

11           CHAIR ROWLAND: Thank you, Chris.

12           Andy.

13           COMMISSIONER COHEN: Great job, and sobering. I  
14 guess I would just respond to your last question by saying  
15 I am very interested in the question number four, which is  
16 one that we've sort of only lightly touched on before, but  
17 what is CMS's role in sort of actually overseeing the  
18 appropriate use of services and drugs, and this is a very  
19 concrete example, and there's obviously lots of other  
20 players in the mix, but what is CMS's role if Medicaid is  
21 the payer? In many other contexts, payers are responsible  
22 for thinking about these things and I think it's an

1 appropriate line of inquiry for us.

2 I guess the one other thing I just wanted to  
3 mention is, I mean, there's the question of whether the  
4 drugs are being prescribed appropriately. I think another  
5 huge question, and it's a hard one and I don't know what  
6 Medicaid's role can be, but what is going on with our  
7 children that is sort of making people think that  
8 prescribing psychotropic drugs is necessary, whether or not  
9 they're doing it with the sort of finesse that they should,  
10 and are there prevention or other activities that Medicaid  
11 can be promoting that could get to that sort of root cause  
12 issue.

13 CHAIR ROWLAND: Marsha.

14 COMMISSIONER GOLD: Yeah. A couple of different  
15 comments. One, in the paper, you talk about the difference  
16 in managed care. I think you need to go back to who's  
17 enrolled in managed care. A lot of the SSI population  
18 isn't in that, so it may be a function of case mix and I  
19 think you may just want to mention that.

20 Second, I'm not sure you really want to bring in  
21 the 65 and older population because you have so few of  
22 them, because you don't have the Part D data, and the

1 analysis is quite strong without them. They could be  
2 mentioned, but with the reason for not being there.

3           Third, and this will sound funny, but I think, if  
4 we think about it, given that this is on adverse effects of  
5 drugs or whatever, it probably is important -- I think it's  
6 important -- to put a statement in here that drugs can be  
7 really useful. Rightly used, drugs have an important role  
8 to play. The concern is the other side of it, and I just  
9 think that might balance what you have to say.

10           And, then, finally, and this is one I would hope  
11 Sheldon talks about -- I am going to put you on the spot --  
12 because there are clinical issues. I, actually, also am  
13 interested in the oversight issues. But, I think, as we  
14 talk about them, sort of philosophically, we should talk  
15 about, and these are things that happen between patients  
16 and their clinicians. There are roles of professional  
17 societies in educating clinicians as to what is appropriate  
18 use. There are certainly appropriate oversight provisions  
19 and incentives that both health plans and Medicaid has to  
20 build in to oversee and sort of from their perspective do  
21 things right. But, as we're sort of talking about those, I  
22 think putting it in context with the broader health care

1 system and who's responsible for what might be important.

2 CHAIR ROWLAND: Patty, Norma, Yvette, and then  
3 Chuck.

4 COMMISSIONER GABOW: I have my usual four  
5 comments. Well, the first is just to clarify, when we look  
6 at the percent of people with a prescription for a  
7 psychiatric drug, if they have one prescription in a year,  
8 does that put them in the "yes" column, and if so, it may  
9 be more interesting to try to figure out if -- and I don't  
10 know if the data permits it -- the people who are on a  
11 psychotropic for a longer period of time, not a single  
12 prescription, but multiple prescriptions for the same drug.

13 The second point I would make is while we all  
14 love drugs, especially in Colorado --

15 [Laughter.]

16 COMMISSIONER GABOW: -- that this is an area  
17 where there's tremendous misuse and overuse, where off-  
18 label use as sleeping aids, et cetera, are being used.  
19 And, so, being able to figure out how we can attack the  
20 misuse, overuse of psychotropic drugs and the overuse of  
21 high-cost non-generic new drugs as opposed to the drugs  
22 that there is, as you pointed out, a lot of the cost is in

1 the newer drugs.

2           The third issue that would be interesting if the  
3 data -- I suspect it doesn't allow it -- but, I know that  
4 in our system, there was a substantial amount of  
5 prescribing that were done by the PCPs not in the mental  
6 health arena and it was out of necessity. The patients  
7 couldn't get into the mental health system, so they were  
8 coming to their PCP with a variety of issues. And, so,  
9 thinking about how it could support primary care physicians  
10 more effectively in utilization of these drugs and  
11 prescribing would be important.

12           And, the last point I would make is with the  
13 expansion into adults, the criminal justice system --  
14 people coming out of the criminal justice system onto  
15 Medicaid are going to have a huge impact on this. I always  
16 said in Colorado, the biggest mental health institution in  
17 the state was the city-county jail, and we ran the medical  
18 part of that, and our biggest expense after personnel was  
19 psychotropic drugs. So, as these individuals become  
20 eligible for Medicaid, the implication of how this is going  
21 to be dealt with is non-trivial.

22           CHAIR ROWLAND: Norma.

1           COMMISSIONER MARTINEZ ROGERS: I just want to  
2 mention that I think that sometimes what happens is that  
3 instead of dealing with the symptoms -- of what is causing  
4 the behavior problem, we sometimes just give the medication  
5 and not include the behavioral therapies that may help this  
6 individual change eventually, because you just -- you go to  
7 a psychiatrist. Most psychiatrists, even children's  
8 psychiatrists, which you have very few of them, prescribe.  
9 That is one of their major roles. Unless you are referred  
10 to have behavioral therapies, it is not going to happen.

11           My research is with federal female offenders who  
12 are under community supervision. Every single one of those  
13 female offenders that come out of prison receive their  
14 children on the day that they come out of prison, even if  
15 they had been in foster care or wherever they were. The  
16 day they come out of prison, those children are handed  
17 over. When we started working with them, the Feds wanted  
18 us to do a 16-week program. It ended coming out to be a  
19 year program. But, in that year program, we had to have  
20 family therapy included in there, because every single one  
21 of those kids had anger management problems, had problems  
22 with substance abuse, or high at risk for substance abuse.

1 So, of course, they put them on psychotropic drugs because  
2 that's the way a lot of people deal with anger management  
3 problems.

4           You know, this is an area -- and, I truly believe  
5 what Andy says. What is Medicaid paying for other than  
6 just a drug, because in the state of Texas -- great state  
7 of Texas, which, you know, whatever --

8           [Laughter.]

9           COMMISSIONER MARTINEZ ROGERS: -- they have cut  
10 the amount of money being spent on behavioral therapies.  
11 That is the number one complaint we get from caseworkers  
12 and social workers, is that we're not getting reimbursed  
13 for this. So, I guess we really do need to look at that.  
14 Thank you.

15           CHAIR ROWLAND: Yvette.

16           COMMISSIONER LONG: As I look at this, it just  
17 upsets me to see that a lot of children here are on these  
18 type of drugs. And, I go back to think when my son was 12  
19 years old, I took him to the primary care doctor and the  
20 doctor was observing him and said to me, "Is he like this  
21 all the time," because he kept moving around and, you know,  
22 doing things there, but he wasn't getting into any trouble.

1 And I said, yeah. And he said, "Well, I'm watching him. I  
2 think that he needs to go on some type of Ritalin" or  
3 something that they were talking about at that particular  
4 time. And I said to the doctor, I don't think that he need  
5 any of that. I said, if he can sit eight hours in school  
6 and do his work, okay, and then when he come home, if he  
7 want to get into whatever he want to get into, as long as  
8 he ain't bothering anybody, it's fine. So, I didn't  
9 understand that.

10 But, I think that just looking at this here, and  
11 I do agree with what Patty said -- Patricia said -- I gave  
12 you a new name, Patty -- I agree what she said. I think  
13 that there is a lot of prescribing that is unnecessary  
14 here, and I think that I'm just not understanding the part  
15 about how is it a child from zero to two years old -- and,  
16 I'm not a doctor, I don't understand it, you know, and I'm  
17 just trying to figure it out -- to be prescribed these type  
18 of drugs or what not.

19 So, I think we need to really take a real look at  
20 this here and begin to hold states accountable, especially  
21 for the managed care program. And, the reason that I say  
22 for the Medicaid program is this here, is that in

1 Pennsylvania, we have a DUR Board, which is a Drug  
2 Utilization Board, and I sits on that and I hear a lot of  
3 psychiatrists and doctors and all stating that children are  
4 being given these drugs that should not be given these  
5 drugs, and they have a good monitoring system in place.  
6 And, I'm hoping that other states have something like that,  
7 too. So, I want to keep number three on the issue as to  
8 making sure that states are monitoring these type of  
9 programs or what not. Thank you.

10 COMMISSIONER RETCHIN: Well, I just wanted to  
11 echo what Marsha had said. I mean, as I look at these  
12 data, we know there is some inappropriate prescribing going  
13 on, but that the drugs are also very applicable to this  
14 particular population, as well.

15 So, one question I had was in terms of site of  
16 prescription. In Virginia, we found a lot of the abusers -  
17 - so, now go onto the inappropriate side -- would come to  
18 the emergency rooms to get refills, especially for  
19 sedatives and antianxiety drugs. And, so, they put in --  
20 and I saw that another state did it, as well -- a system  
21 where you could click on it and see where they were  
22 prescribed in real time. So, that worked.

1                   COMMISSIONER SZILAGYI: Yeah, just quick. I  
2 don't want to repeat what other people said. I do agree  
3 that CMS does have a role in overseeing psychotropic  
4 prescribing patterns. The word "appropriate" is a really  
5 difficult game to get into, but at least overseeing it.  
6 And, one area that data could be useful is signals, is  
7 comparing across states, or where there are outliers, or  
8 where there's huge variability in psychotropic prescribing.  
9 If there's an -- I mean, that's a general rule in medicine.  
10 If there's an enormous amount of variability for a certain  
11 population or for a certain disease, it's probably not all  
12 great, even though everybody may think they're doing great.  
13 So, that might be one area, of identifying signals.

14                   I do see things both ways, so if -- psychotropics  
15 includes here Ritalin, so I know there's sort of a common  
16 sense that people have that 90 percent of kids on foster  
17 care are taking antipsychotics, and your data clearly show  
18 that's not the case. Ninety percent of kids in foster care  
19 are not taking antipsychotics, are not on antipsychotics.  
20 The most common psychotropic is Ritalin, by far, and the  
21 second most common is antidepressants. So, I think there  
22 is a problem with overuse and there's huge variability in

1 overuse, but it's very helpful to look at the data and to  
2 notice that there's -- not all children in foster care are  
3 drugged up, and so what we need to do is kind of hone in  
4 and get under the hood a little bit better, I think, in  
5 trying to identify what is the best therapy and where are  
6 there outliers and try to reduce those outliers.

7           And, Norma, I totally agree with what you said,  
8 and I mentioned this last time, too. One of the newer  
9 areas in foster care is that almost every child in foster  
10 care has been traumatized, and so they need this newer  
11 level of mental health care called trauma-focused care, and  
12 that's not easily obtainable in the data, because there are  
13 often not ICD-9 codes for this, if this is sort of a newer  
14 level of care. But, if CMS is going to go into the  
15 business of sort of overseeing this type of care, that is  
16 the evidence-based newer level of care. And, if these kids  
17 received trauma-focused care, a lot fewer of them would be  
18 on psychotropics.

19           COMMISSIONER CHECKETT: You know, just a, like, a  
20 comment, I guess, for the Commissioners and perhaps helpful  
21 to Chris, but, you know, what I am hearing is people are  
22 saying, it's an interesting issue. We agree it's something

1 to be concerned about, but not necessarily clear what our  
2 role is or what Medicaid's role is. And, I would point out  
3 that in -- that a number of states who are moving their  
4 more medically complex populations into managed care, in  
5 fact, are requiring extensive PIPs, as we call them,  
6 Performance Improvement Programs, where they will say, you  
7 know, we're concerned about this. You managed care plans,  
8 we want you to put a program together that tells us how  
9 you're going to identify these kids or these adults, what  
10 are you going to do. And, so, I guess I throw that out,  
11 because initially, I was thinking, I don't know what our  
12 role is here, but, I think, actually, there are a lot of  
13 things that we could guide, whether it's CMS or Congress or  
14 whomever to say, it is an issue and here are ways to think  
15 about making it meaningful to Medicaid, so --

16 CHAIR ROWLAND: You know, I think that some of  
17 the state activities that were identified here, we really  
18 do want to know more about do they work, what's their  
19 experience. I think that being able to report on best  
20 practices is something that we really can do.

21 I think this is really important to shine a  
22 spotlight on the fact that this is a serious area that we

1 need to do more work in and to look at more extensively. I  
2 would be a little interested in knowing how these  
3 utilization statistics compare to those in the general  
4 population. I mean, are children on Medicaid more likely  
5 to be getting psychotropic drugs, or is this more of a  
6 societal problem that Medicaid is just picking up the theme  
7 there?

8           And, I think that as we move forward on this one,  
9 we come back, again, to the issue of, don't we need to pull  
10 out children in foster care and really have a much more  
11 intensive look there, because we've now picked that up in  
12 three of our presentations. So, I think that was a good  
13 suggestion earlier on and would be something that I know  
14 there are many in Congress who are really quite concerned  
15 about how the foster care program works, how the special  
16 adoption programs work, and that we can really look at  
17 that.

18           So, thank you, Chris.

19           MR. PARK: Thank you.

20           CHAIR ROWLAND: And, now, we'll move to one of  
21 those benefit issues that we have talked about a number of  
22 times and that we always know is something that we will

1 come back to. In honor of our former Commission member  
2 Burt Edelstein, we're going to talk now about the fact that  
3 the mouth is a part of the body --

4 [Laughter.]

5 CHAIR ROWLAND: -- and Medicaid coverage of adult  
6 dental services, which is always a sketchy part of the  
7 Medicaid program. So, welcome, Sarah, and thank you.  
8 We're now at Tab 10.

9 **### Session 9: MEDICAID COVERAGE OF DENTAL SERVICES FOR**  
10 **ADULTS**

11 \* MS. MELECKI: Yes. So, good afternoon, once  
12 again. As Chairperson Rowland stated, this presentation is  
13 going to focus on dental benefits for adults enrolled in  
14 Medicaid and provide state-level information on coverage  
15 policies.

16 I'll begin today by providing a brief overview of  
17 the impact of poor oral health and the dental coverage  
18 landscape. I will then discuss current adult dental  
19 benefits in Medicaid, followed by an analysis of recent  
20 changes in benefits. I will briefly discuss dental care  
21 utilization, and I will conclude with a discussion of  
22 future Commission work on Medicaid adult dental coverage.

1           So, we know that poor oral health affects a  
2 majority of adults in the United States, with more than 85  
3 percent of adults ages 18 and over affected by dental  
4 caries, which are commonly known as cavities. And, adults  
5 with incomes below 100 percent of the federal poverty level  
6 have particularly poor oral health and are more than three  
7 times as likely to have untreated dental caries as adults  
8 with incomes above 400 percent of the federal poverty  
9 level.

10           Poor oral health may be both a cause and  
11 consequence of several diseases, including diabetes, and  
12 may affect pregnancy outcomes. And, poor oral health can  
13 have other negative effects, such as pain and tooth loss,  
14 which can lower quality of life and jeopardize employment.

15           Evidence suggests that access to and utilization  
16 of dental care increases when a person has dental coverage,  
17 and the graph on this slide shows the percentage of adults  
18 who have private, public, or no dental coverage by income  
19 as of 2012, which is the most recent year for which we have  
20 data.

21           It's important to note that dental insurance  
22 benefits, whether private or public, do vary widely. In

1 some cases, comprehensive benefits are offered, while in  
2 other cases, limited or emergency services only are  
3 covered.

4           And, as you can see, people with lower incomes  
5 are less likely to have dental coverage than those with  
6 higher incomes, and their coverage is more likely to be  
7 through a public source than those with higher incomes.

8           Because adult dental benefits in Medicaid are  
9 optional, states vary in the number of and extensiveness of  
10 benefits offered. If you look in your paper in Tab 10,  
11 there is a chart on page five and six that offers more  
12 details of what benefits are offered by State, and there is  
13 an additional chart at the end of the brief that offers  
14 more details on the limits offered by states. Please note  
15 that states that offer emergency-only benefits also differ  
16 in their definitions of emergency services as you look over  
17 that information.

18           Because of the vast differences between State  
19 benefit offerings, it's difficult to get a sense of what  
20 any given State benefit level looks like simply by giving  
21 nationwide statistics. However, we do know that states  
22 most commonly offer preventive or restorative services, and

1 there are several states that offer denture or oral surgery  
2 services without offering benefits from any other category.

3           Additionally, states differ in annual financial  
4 and service limits. For example, State variation in  
5 denture replacement ranges from once every five years to  
6 once per lifetime. Some states cover root canals only for  
7 front teeth, others for most or all teeth. And, some  
8 states cover only a certain number of fillings per year,  
9 while others cover all that are medically necessary.

10           Dental benefits may also differ for different  
11 groups of adults in Medicaid. So, some states offer  
12 additional dental benefits to pregnant women and certain  
13 people with disabilities. In states that have expanded  
14 Medicaid, adult dental benefits may vary for the base and  
15 expansion populations. And, some managed care plans choose  
16 to offer dental benefits beyond what the State Medicaid  
17 plan requires.

18           To date, there is not a standardized system in  
19 place to group states based upon their adult dental benefit  
20 levels, but several organizations, including the American  
21 Dental Association, the DentaQuest Foundation, the National  
22 Academy of State Health Policy, and the Center for Health

1 Care Strategies, are currently working on creating such a  
2 system. In the meantime, we have grouped states on this  
3 map based on the types and amounts of services offered, but  
4 the map does not account for annual limits in terms of  
5 dollars or services.

6 Turning to recent trends in dental benefit  
7 changes, adult dental benefit changes are common in State  
8 Medicaid programs, and the Kaiser Family Foundation has  
9 tracked large-scale benefit changes from 2003 to 2012.  
10 There is a graphical representation of these changes on  
11 page 11 of your brief, if you are interested.

12 In all, 32 large-scale changes have occurred  
13 among the states between 2003 and 2012. Fourteen of these  
14 changes decreased benefits and 18 of them increased  
15 benefits. Seven states experienced only increases in  
16 coverage, and three states experienced only decreases in  
17 coverage. Additionally, ten states experienced both  
18 increases and decreases in coverage.

19 Turning quickly to utilization of dental care,  
20 regardless of income level, people are much more likely to  
21 see a doctor or other office-based medical provider than  
22 they are to see a dentist. In Medicaid specifically, about

1 21 percent of people enrolled report a dental visit within  
2 the past 12 months. And, low utilization of dental  
3 services can be attributed to many factors, but for people  
4 in Medicaid, two important factors include the fact that  
5 many State Medicaid programs do not cover dental services  
6 and the fact that few dental providers accept Medicaid  
7 patients.

8           Looking at current work that MACPAC is doing on  
9 adult dental services in Medicaid, we're currently working  
10 on updating our dental measures in MACStats and looking at  
11 changes over time. And, in the recently completed duals  
12 demonstration focus groups, which you will hear about at a  
13 future meeting, the importance of dental benefits was a  
14 common theme.

15           Looking at possible future work, MACPAC staff  
16 have identified several areas that we could look at,  
17 including the use of emergency rooms for dental services as  
18 compared to State benefit levels and an environmental scan  
19 of provider network issues.

20           So, that will conclude my presentation. Thank  
21 you, and I look forward to your discussion.

22           COMMISSIONER CRUZ: Thank you. I really want to

1 commend you, because this is a very complicated issue, and  
2 I understand this is sort of a draft for our issue brief,  
3 which I think deserves a full chapter because of the  
4 complexity of the issue. It's not only sort of the  
5 epidemiology of the disease, it's the disparities involved.  
6 It's the major workforce issues.

7           But, I think as the brief is important and,  
8 actually, timely, because as I understand, next week, there  
9 is legislation that is going to be introduced by both the  
10 House and the Senate -- I think it's called the Oral Health  
11 -- the Dental Comprehensive Reform Act to include oral  
12 health services in both Medicare and Medicaid. It's really  
13 a rather comprehensive piece of legislation. So, the issue  
14 brief at this point could help in some of the discussions  
15 while we wait for the chapter.

16           My main comments are, as I read this as an issue  
17 brief, is in some of the way the data is presented and some  
18 of the contextual aspect. I think it's important to point  
19 out the issues that are caused by oral health, such as the  
20 pain and suffering and the loss of work hours. You know,  
21 there's something like 165 million hours lost of work  
22 because of oral disease. I think there are some other

1 data, like oral cancer data, the mortality from oral  
2 cancer, that is tremendously, specifically among this  
3 population, because they have no access to the preventive  
4 or early detection of oral cancers. I think there are some  
5 factors that are really very important, like, you know, 52  
6 percent of new military recruits couldn't be deployed  
7 because of dental problems.

8 All this to say that as I read it, and maybe that  
9 was not the intention, oral health was sort of linked to  
10 the effect on systemic diseases, and the important, I think  
11 that should be sort of de-emphasized a little bit, just  
12 because some of the data is equivocal. Some of the data is  
13 just emerging data. It is important data, but oral health  
14 is important by itself. It affects the quality of life of  
15 the individuals and families. It affects, you know, self-  
16 esteem and work and all of that.

17 So, I have made some written comments that I can  
18 send to you in terms of how to sort of put this in context,  
19 and a little bit editorial, if you don't mind. Thank you.

20 COMMISSIONER ROSENBAUM: Yeah. We were talking  
21 about this a little bit before, actually. At this point --  
22 I can never remember numbers exactly, but I think something

1 like three-quarters of all community health centers in the  
2 country are offering dental care. It's been -- of all the  
3 services they've ramped up over the past decade, this has  
4 been, I think, number one, ahead of mental health, which  
5 has also been a huge increase.

6           And, I think it would be very helpful to  
7 understand -- because, of course, I mean, I have several  
8 colleagues who run health centers that include dental  
9 programs and they're drawing patients from as many as three  
10 and four hours away. One has a two-year waiting list for  
11 adults for appointments. And, I think it would be helpful  
12 here to understand the interaction between the coverage  
13 issues, which are one level of problem, and the payment  
14 issues, that is, how states build their FQHC payment  
15 methodology, particularly to take into account oral health.  
16 There are a number of states, of course, that cover only  
17 emergency care, a very, very limited range of services.  
18 But, it might be interesting for us to compare and contrast  
19 FQHC -- not just the coverage rules, but the payment  
20 methodologies, particularly in safety net providers, and I  
21 think it would help a lot to understand, generally  
22 speaking, the payment methodologies in oral health care

1 more generally for private dentists.

2 I mean, this is -- I don't know enough to know  
3 whether the differentials are as pronounced as they are in  
4 the case of primary care payment methodologies, but,  
5 obviously, all the questions about both incentivizing  
6 participation, but also where you have the federal  
7 government literally having capitalized a ramp-up of dental  
8 practice, which is how to think about the 330 funding here,  
9 is there a sustaining financing element that comes behind  
10 it, particularly in a practice setting where half the  
11 patients are going to be enrolled in Medicaid. So, do we  
12 have a sustainable model? You can ramp it up, but then can  
13 you sustain it depending on coverage and payment rules, so  
14 --

15 COMMISSIONER RILEY: Just real quickly, this is a  
16 great presentation. The future work around the ED is  
17 probably pretty interesting, but let me share a painful  
18 experience. When I was with the Governor's office, we did  
19 a study of claims and found great ED use. The number one  
20 ED use was oral health-dental issues, and we were quickly  
21 reprimanded by the ED physicians who pointed out that lots  
22 of that was drug-seeking behavior and not "real," quote-

1 unquote, dental issues. So, I think, somehow, we have to  
2 split up -- that's a very important issue to look at, but  
3 we have got to do so pretty carefully.

4           COMMISSIONER CRUZ: Yes, it's true, but it's  
5 also, if you look at the data in some of the states that  
6 have cut oral services, the ED utilization just rubs off.  
7 So, we have to look at both.

8           And, if I may add another comment, the issue of  
9 viability. Since there is no mandated service, the states  
10 can and do cut as they will. So, that did affect not only  
11 the sustainability of programs that may be developed within  
12 the State, and it affects also sort of the workforce issues  
13 that we are sort of dealing with right now.

14           So, I think it would be interesting in looking at  
15 this viability. I think that charge is really very  
16 interesting, how states now do cut according to their  
17 budgets and dental is always on the budget cut -- on the  
18 cutting budget. And, how does that affect maybe the  
19 sustainability of public oral health programs in the State  
20 and the acceptability of providers of Medicaid and other  
21 public funding.

22           COMMISSIONER MILLIGAN: I also thought it was a

1 good presentation. I want to suggest maybe three parts to  
2 a potential environmental scan of provider network issues.

3           One is I do want to pick up on some of what Sara  
4 said about the site of care. In my experience, dental  
5 services is one of the areas where there's the most  
6 segregation of the Medicaid population into sites of care.  
7 A lot of it isn't community health centers. A lot of it  
8 has become for-profit chains that have been under a fair  
9 amount of scrutiny from a fraud, waste, and abuse  
10 perspective. And, there's a debate about whether they're  
11 meeting a need that isn't being met and they're good  
12 programs. But, site of care, I think, is worth looking at,  
13 because this is really, I think, an area of a lot of  
14 segregation from individuals covered by other payers or  
15 private pay, out-of-pocket.

16           The second is I think it is helpful to look at  
17 some of the scope of practice issues that are going on  
18 around dental services. There is a lot of debate and some  
19 changes nationally and some good examples in some states --  
20 in Alaska, as I recall -- about dental hygienists, dental  
21 assistants, and others, and this is an area where scope of  
22 practice debates are playing out quite actively.

1 [Off microphone comments.]

2 COMMISSIONER MILLIGAN: Yes. And, the scope of  
3 practice is really, to me, of relationship to access.

4 And, the third is I think there is some good  
5 literature out there about kind of the elasticity between  
6 raising dental fees and whether it has a relationship to  
7 increased access, and I haven't seen a lot recently, but I  
8 remember seeing a pretty good study out of Indiana where  
9 the rates were doubled, but the increase in access was only  
10 about ten percent because it was not enough money to  
11 encourage dentists who had previously not chosen to  
12 participate to change their minds. And, it was really --  
13 it was a good fee increase for the dentists who were  
14 already participating, but it didn't expand more slots in  
15 offices. But, that whole elasticity point, I think, would  
16 be helpful to just not do original research, but I think  
17 there's some stuff worth capturing.

18 COMMISSIONER GOLD: Yeah. Hi. Just a small  
19 point. It's a nice job. I don't have comments on the  
20 general thing.

21 I just -- I wasn't sure if you were going to  
22 include the figure that compared dental coverage for

1 adults, private and others, from AHRQ that's in the  
2 handout, but not in the brief. If you include it, I was  
3 hoping that you could go back to the documents and figure  
4 out how they define private health insurance coverage,  
5 because this may very well be the right figure. I just  
6 looked at it, especially at the 200 percent poverty and up,  
7 and I said, gee, that seems high, and I wonder if they just  
8 included sort of the surgical, oral surgical benefit or  
9 something like that, it would be counted. So, it's just a  
10 checkpoint, if you include that, to make sure you put a  
11 footnote with what the definition was.

12 CHAIR ROWLAND: I guess I would ask for an  
13 addition to that, because that only goes up to age 64, and  
14 I think one of the important things that Medicaid provides  
15 for the Medicare population is dental coverage for some of  
16 the adults over age 65. So, if we could look at that, that  
17 really is a part of the dual --

18 COMMISSIONER GOLD: That would be the MCBS,  
19 probably?

20 CHAIR ROWLAND: Yes. Then I had Patty, and then  
21 I had Sheldon.

22 COMMISSIONER GABOW: [Off microphone.]

1 CHAIR ROWLAND: Scope of practice.

2 COMMISSIONER GABOW: Scope.

3 COMMISSIONER RETCHIN: Just a comment on the  
4 scope, and then going back to a point Chuck made. But, I  
5 think this is a workforce issue. The dental schools, now,  
6 they are starting to proliferate. There are new dental  
7 schools opening. But, the workforce is really -- it's  
8 really a supply and price issue.

9 But, I did want to mention, and Chuck, you said  
10 that there were for-profits, but I believe all those are  
11 pediatric, aren't they?

12 COMMISSIONER MILLIGAN: [Off microphone.]

13 COMMISSIONER RETCHIN: Yeah. Okay. I don't  
14 think there are any for-profits in this space. There's no  
15 money.

16 COMMISSIONER CHECKETT: Is that true? Pro  
17 Dental?

18 COMMISSIONER RETCHIN: Oh, yeah.

19 COMMISSIONER CHECKETT: Is only pediatric?

20 COMMISSIONER RETCHIN: Oh, I don't know about  
21 that one, but I don't think there are -- I think they're  
22 all pediatric.

1           COMMISSIONER CRUZ: In the -- yeah, they're all  
2     pediatric.

3           In terms of the workforce issues, the scope of  
4     practice is a workforce issue and I think it could be sort  
5     of seen as maybe looking at some of the, what they call,  
6     Medicaid dental reforms, or they have different names,  
7     because one of the issues of the new dental schools is that  
8     it is a very sort of expensive way of treating disease in  
9     underserved populations and not necessarily creating more  
10    dentists are going to solve the issue.

11           There is not only the issue of the number of  
12    dentists, it's the maldistribution of dentists. Dentists  
13    don't want to practice in underserved areas. I mean, you  
14    have them -- in New York, you have them all practicing in  
15    Manhattan, but there's none to be found in Upstate New  
16    York. Just recently, actually, we heard of a pregnant  
17    woman that had a tooth abscess and actually lost her baby  
18    because she couldn't find a dentist. She had to drive two  
19    hours.

20           But, cases like that are sort of a bigger  
21    umbrella beyond the scope of practice. It's education.  
22    It's rates. It's reimbursement rates. In New York, the

1 Dental Association sued the State and won and the rates  
2 were hiked, I don't know how much, but they were pretty  
3 high, and it did not increase -- no, it did not increase  
4 the number of dentists that participated. It made a lot of  
5 dentists that are actually already participating in  
6 Medicaid richer, but it didn't increase the actual  
7 accessibility, so --

8 COMMISSIONER GOLD: Just a note that, like with  
9 physicians, it's not just payment and supply, it's also --  
10 especially when supply is tight, you know, concern about  
11 missed appointments, concern about language barriers,  
12 concern about where people are. There's a lot of reasons  
13 why people might not get the care they need.

14 COMMISSIONER ROSENBAUM: Well, Gustavo and I were  
15 talking about the fact that, actually, there's some slack  
16 in dental use right now --

17 COMMISSIONER GOLD: [Off microphone.]

18 COMMISSIONER ROSENBAUM: Exactly. I mean, this  
19 is the part that is so complex, I think.

20 COMMISSIONER CRUZ: It is. When you look at -- I  
21 was looking at a study recently where you see the  
22 individuals that have private dental insurance, that have

1 had dental insurance for a while, the utilization is  
2 actually coming down and it's actually because of a lack of  
3 perceived need. So, there is a -- while there is this huge  
4 buckets of the population that have no access and do need  
5 but do have no way of accessing it. So, I think -- Peter  
6 was saying before that, you know, dental caries is a  
7 disease of the poor, and it's largely also big oral health  
8 issues is also a disease of the poor. So, a lot of the  
9 people that actually have dental insurance have had it for  
10 many years, can pay for it, and don't feel they need it  
11 because they don't have any issues. So, usually, those  
12 that need it the most have the less access to care.

13           COMMISSIONER GOLD: You know, I would ask you to  
14 check the numbers on that and see if some of the results,  
15 and maybe I'm using myself as a poor example, one. We  
16 always say not to do that. But, dental insurance has real  
17 limitations. It often doesn't cover a lot. It has a price  
18 out of pocket. Where it has a network, that network may  
19 not include people's doctors. So, there's a lot of out-of-  
20 pocket cost, and even people who have more money may still  
21 have trouble affording dental care. And, I certainly -- I  
22 mean, maybe the kids coming up don't have any cavities, but

1 all the people I know had plenty of cavities, so I'm not  
2 quite sure that it's just a disease of the poor --

3           COMMISSIONER CRUZ: Sure. It's definitely multi-  
4 factorial. It's not -- they claim it's perceived need.  
5 This is the data that comes from the ADA. But, it is  
6 definitely out-of-pocket cost. It's network. It's --  
7 yeah.

8           CHAIR ROWLAND: Okay. Well, clearly, we want to  
9 look at dental issues, both these for adults, but also we  
10 have to be reminded that one of our big charges is also to  
11 look at access to dental services for children and some of  
12 the differences there in their accessibility versus that  
13 for adults.

14           This has always been a benefit on the adult side  
15 that's obviously an optional benefit under Medicaid. It's  
16 the first one cut when states have to save some money.  
17 It's sometimes counterproductive to cut it, but they do,  
18 and I think the look that you've had at kind of where it's  
19 available and digging deeper on some of the challenges  
20 there, combined with raising the workforce issues, because  
21 I think the twin side -- it's not really payment, as we've  
22 just talked, it's often just availability and who's willing

1 to see these populations.

2           And, I'm struck by remembering that whenever you  
3 look at some of the free clinics that are available for  
4 people without insurance, the biggest need that comes  
5 through the door there is not actually medical care, but  
6 it's dental care.

7           So, thank you, Sarah. This is the first time  
8 Sarah has briefed us and she's obviously done a great job.

9           So, with that, we will ask if anyone in the  
10 audience wants to make any public comments to us. We  
11 always encourage those who listen to us to also comment in  
12 writing if, after you get back to your offices, you  
13 discover that there was some point that we really missed  
14 that you'd like to clarify or some additional information  
15 you'd like to provide.

16 **### PUBLIC COMMENT**

17 \*           [No response.]

18           CHAIR ROWLAND: Well, then we will stand  
19 adjourned until tomorrow morning. Thank you very much for  
20 weathering the weather to be here.

21           [Whereupon, at 4:48 p.m., the proceedings were  
22 adjourned, to resume at 9:30 a.m. on Friday, February 27,

1 2015.]

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PUBLIC MEETING

Hall of States  
National Guard Association of the U.S.  
One Massachusetts Avenue, NW  
Washington, D.C. 20001

Friday, February 27, 2015  
9:39 a.m.

COMMISSIONERS PRESENT:

DIANE ROWLAND, ScD, Chair  
MARSHA GOLD, ScD, Vice Chair  
SHARON L. CARTE, MHS  
DONNA CHECKETT, MPA, MSW  
ANDREA COHEN, JD  
GUSTAVO CRUZ, DMD, MPH  
PATRICIA GABOW, MD  
YVETTE LONG  
CHARLES MILLIGAN, JD, MPH  
SHELDON RETCHIN, MD, MSPH  
PATRICIA RILEY, MS  
SARA ROSENBAUM, JD  
PETER SZILAGYI, MD, MPH  
  
ANNE L. SCHWARTZ, PhD, Executive Director

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1 P R O C E E D I N G S

2 [9:39 a.m.]

3 CHAIR ROWLAND: Good morning, and welcome to the  
4 Medicaid and CHIP Payment and Access Commission's Friday  
5 morning session, and we are delighted to be able to begin  
6 this session with a discussion of Medicaid shared savings  
7 programs and other approaches to look at spending growth.  
8 We've brought two highly knowledgeable experts to join us  
9 who have each talked about this option, and they're going  
10 to both reveal their thinking not only on this option but  
11 any of the other things that we choose to ask them  
12 questions of. So I want to welcome Mark McClellan and Alan  
13 Weil and ask you to do miraculous things in the ten minutes  
14 Anne has given each of you to talk, and then we will have  
15 lots of time to engage in conversation afterward. And I'm  
16 not sure who was planning to go first.

17 Well, it's great to have you both, and thank you  
18 for joining us.

19 **### Session 10: MEDICAID SHARED SAVINGS: AN APPROACH TO**  
20 **ADDRESSING SPENDING GROWTH**

21 \* MR. WEIL: Thank you, Diane, thank you,  
22 Commissioners. It's really a pleasure to be asked to join

1 you today. It's also a pleasure to know that someone  
2 actually read an article that I published in Health Affairs  
3 a few years ago called "Promoting Cooperative Federalism  
4 through State Shared Savings" and --

5 CHAIR ROWLAND: You only wanted to make sure the  
6 editor of Health Affairs knew that occasionally we read it.

7 MR. WEIL: Yes. Needless to say, I was not the  
8 editor at the time the paper was published.

9 It was my effort to lay out a concept for a  
10 future for the program, but I think any discussion of  
11 Medicaid reform has to begin with the goals of that reform.  
12 And it seems to me that given the size and cost of the  
13 program and the rate of growth that people have experienced  
14 and expect to experience in the future, cost savings are an  
15 inherent part of any agenda around Medicaid reform.

16 Since the Institute of Medicine tells us that as  
17 much as a third of the spending in the health care system  
18 provides no added value, it's enticing to believe that you  
19 could just take a third out of the Medicaid program and  
20 everyone would go merrily on their way with no negative  
21 consequences. I don't think it's quite that easy. No one  
22 has actually figured out how to take that third out

1 anywhere, but Medicaid has a few features that make this  
2 particularly challenging, starting, of course, with the  
3 already quite low payment rates relative to other payers,  
4 which then translates into financial strain on providers,  
5 many of whom have limited access to capital that they would  
6 need to use to invest in reengineering systems to reduce  
7 the cost of care.

8           Of course, a large portion of the cost of the  
9 program are associated with long-term services and supports  
10 and the needs of those who need those services. Many of  
11 those costs are not medical, so any analysis of sort of  
12 waste in the health care system doesn't really speak to the  
13 social needs.

14           Which, of course, brings the next issue, which  
15 is, given the population served by Medicaid, there's this  
16 very complex interplay between the social and health needs  
17 of the population served by the program, and so looking at  
18 health spending in isolation from social spending is, I  
19 think, going to lead us to perhaps some erroneous  
20 conclusions about where the money can be found.

21           The program serves, as you all know very well, a  
22 very heterogeneous set of folks, but it includes some

1 extremely vulnerable, medically fragile, socially fragile  
2 enrollees where, if we make mistakes, the consequences for  
3 them are particularly high.

4           And, by the way, Medicaid is the largest player  
5 in managed care. While the private sector has had this  
6 love-hate relationship with it over the years, it's  
7 actually quite mature in Medicaid. And so, again, when we  
8 talk about redoing financing, we kind of already did that  
9 in Medicaid.

10           So all of this is to say that even if we accept  
11 the existence of excess spending in health care, figuring  
12 out how to modify Medicaid in a way that contains costs  
13 without having negative consequences is, I think, more  
14 challenging than for the health care system as a whole.

15           I was asked to reflect of where I think savings  
16 could be found, and I guess this is -- I don't know if this  
17 is helpful. It's probably the same list pretty much anyone  
18 would come up with.

19           It does seem to me that one of the drivers of  
20 Medicaid costs is the high prevalence of chronic conditions  
21 that really should be and could be addressed through public  
22 health and social interventions, that would reduce the

1 burden of disease and, therefore, reduce the costs  
2 associated with those chronic conditions.

3           You know, these are like one-sentence -- like  
4 they'd be easy to do, and I want to acknowledge that  
5 they're not. But since I was asked where you might find  
6 it, that's a place.

7           CHAIR ROWLAND: But when you finish, we're going  
8 to ask you to --

9           MR. WEIL: I thought you might.

10           Of course, there are also high-cost patients with  
11 very complex needs who are suffering from poor coordination  
12 of services. There's a lot of attention paid to dual  
13 eligibles, which is good, but remember that duals are only  
14 a subset of the high-cost complex populations, and I feel  
15 like in the public discourse, the equation of duals and  
16 high cost is made, and it's erroneous.

17           I think there's tremendous opportunity for robust  
18 patient engagement. I don't just mean financial  
19 incentives, although maybe they're a part of the picture,  
20 but I'm talking about true clinical and social engagement  
21 with patients, community-based care, team care, self-care.  
22 And there's tremendous opportunities throughout the health

1 care system for clinical reengineering. Again, we're part  
2 of the way through this. The patient-centered medical home  
3 model is rolled out, health homes, integration across  
4 mental health, oral health, physical health. These are  
5 approaches certainly not unique to Medicaid, and, in fact,  
6 they're probably most likely to be successful if they're  
7 done in conjunction with broader reengineering in the  
8 health care system.

9           So I know it's a long frame, but it's very hard  
10 to talk about reform without talking about why you're doing  
11 it. And I think it's very -- and yet often I feel like the  
12 proposals are made without any sense of the reasons behind  
13 them.

14           So what I tried to do in my proposal was create  
15 an environment that I thought was hospitable to the kinds  
16 of savings associated with efficiency gains without  
17 creating incentives for savings that come at the expense of  
18 enrollees or providers just by cutting benefits or rates,  
19 which is something we all know how to do, but we also know  
20 the consequences.

21           The premise of the proposal is really very  
22 straightforward, which is that in a matching structure with

1 shared federal-state saving -- sorry, shared federal-state  
2 spending, the matching structure is inherently and  
3 intentionally expansionary; that is, the marginal cost of  
4 expansion is less -- of a dollar's worth of expansion is  
5 less than a dollar to the state as they make the decision  
6 because they share the cost with the federal government.  
7 So it was designed to encourage states to expand the  
8 program, and in essence, what my shared savings proposal  
9 tries to do is create, if you will, the equivalent of an  
10 enhanced match for programmatic savings that don't come at  
11 the expense of enrollees. So it's basically deleveraging  
12 the program. And, frankly, the details that I propose are  
13 less important than the concept. The fundamental concept  
14 is to try to deleverage.

15           So in the few minutes that I have remaining, I  
16 just want to set forth five design features that I included  
17 and explain why they're there and hopefully that is --  
18 again, why they're there is more important than how I  
19 address them.

20           So the first is the proposal I made, shared  
21 savings on Medicaid, CHIP, and the premium tax credits  
22 through the Affordable Care Act, and the idea was to focus

1 on items that are under the state's control, which if a  
2 state runs its own exchange, it has a lot -- even if it  
3 doesn't, it has a lot of control over premiums in the  
4 exchange.

5           There are other proposals out there that share  
6 savings on total health care spending in the state. I  
7 think that's a lovely idea, but I don't think it's under  
8 states' control. You're talking about Medicare, you're  
9 talking about employer coverage, which states have  
10 extremely limited authority over, in some instances none.  
11 So the first design feature is reward states for things  
12 that they can do something about and don't hold them  
13 accountable for things they can't.

14           Second of all, I propose savings against a  
15 baseline defined in advance. This is in contrast to two  
16 approaches that are out there. One is sort of the waiver  
17 negotiations that are done state by state, where you  
18 negotiate the baseline, which I find lacks transparency and  
19 creates serious problems for really whether or not the  
20 savings are credible.

21           It's also in contrast to a block grant approach  
22 or even a per capita cap approach. People tend to think,

1 oh, a block grant is simple. Well, actually, if you're  
2 going to do a block grant, you have to figure -- you have  
3 to go a few years back to get credible data. You have to  
4 trend it forward. So you're already off by a few years.  
5 Presumably, you're going to want to have some safety catch  
6 for hep C, new treatment, or HIV/AIDS or something like  
7 that. And it actually turns out that matching dollar for  
8 dollar is incredibly simple compared to almost every other  
9 proposal. And so the second feature is to have the savings  
10 measured against something that is defined in advance and  
11 not have this sort of constant negotiation about what the  
12 savings really are.

13           The third design feature is to try to create  
14 incentives that are strong but not too strong. You know,  
15 whether I got it right, of course, other people can judge.  
16 My view is that a block grant creates too strong incentives  
17 for savings that can come at the expense of enrollees and  
18 providers, that basically you want to, as I say, deleverage  
19 but not make it so that if you can just get another dollar  
20 out of the system, you keep that whole dollar to spend on  
21 other priorities.

22           The fourth feature that I included, which would

1 certainly be hard to take in a broader legislative  
2 environment, is that I propose an optional program, just  
3 like accountable care organizations for Medicare. My view  
4 is that in order to generate and document savings, you have  
5 to have a huge investment in a data infrastructure, quality  
6 infrastructure and cost infrastructure. And many states  
7 haven't made that, and if you make it mandatory, you're  
8 basically asking states to do the impossible, or you're  
9 forcing states to achieve results that they have no  
10 infrastructure to measure or achieve.

11           So I'm a big believer in letting the leaders  
12 lead. If you think you can do this cheaper, then you have  
13 to have the infrastructure to do it and to show that you've  
14 done it. And in that sense, making it optional I think  
15 serves that purpose.

16           And, finally, again, in a completely arbitrary  
17 way, I included a lock-in period, three years, borrowing  
18 from the ACO model. You have to acknowledge that any  
19 system of transformation takes time, that there's a life  
20 cycle of investment, probably increased costs in the short  
21 run, but hopefully a positive return in the long run. And  
22 there are too many opportunities for gaming.

1           So fundamentally my goal was to align the state  
2 and federal desire to control costs in the program, to  
3 deleverage the highly leveraged program as it exists today,  
4 but to do it in what I unabashedly would call an  
5 incremental way. I think that unraveling the matching  
6 structure, capping the structure, totally redesigning the  
7 structure has potential negative consequences that are very  
8 large. This may not go -- it obviously doesn't go as far  
9 as some people would go, but I think it creates an  
10 opportunity to give states an incentive to be creative  
11 about health system transformation within Medicaid and to  
12 align it with health system transformation more broadly.

13           That's what I propose, and I hope that explaining  
14 the rationale will help you think about where you should go  
15 with your own recommendations. Thank you.

16           CHAIR ROWLAND: Thank you, Alan.

17           Mark?

18 \*           DR. McCLELLAN: Diane, thank you, and thanks to  
19 the Commission for the opportunity to talk with you all  
20 this morning.

21           I'm going to try to hit some points that Alan  
22 didn't already cover. I agree with just about everything

1 he said in terms of the challenges and the directions for  
2 solving those challenges that a shared savings program in  
3 Medicaid could address. I just want to provide a little  
4 bit more or a little bit different perspective on context.

5           A lot of the focus, understandably, has been on  
6 coverage expansions in Medicaid, but this is occurring at a  
7 time when there are some concerns not only about rising  
8 costs but about quality of care as well. And in Medicare  
9 and commercial programs, kind of a long history of trying  
10 to keep costs down by restricting access to services or  
11 cutting payment rates. Just ask the physicians about how  
12 well that works in the Medicare program.

13           The interest behind accountable care  
14 organizations and a lot of these alternative payment models  
15 is to shift the focus away from -- just limit -- trying to  
16 limit the volume and intensity of services that are  
17 traditionally covered in health care and just change the  
18 game. You know, change to delivering care in new ways and  
19 providing support for doing that. And you heard from Alan  
20 earlier about some of the many opportunities to potentially  
21 get better quality care without increasing cost in the  
22 Medicaid program. I'd say that, you know, given the

1 vulnerability of the populations, the prevalence of chronic  
2 or multiple chronic diseases, and other factors that  
3 influence health outcomes but that are not very well  
4 addressed through the traditional health care system, I  
5 think the opportunities for these kinds of care  
6 improvements through new mechanisms of delivering care are  
7 probably greater in the Medicaid population than any other  
8 part of the American public. So it's more opportunities  
9 for managing chronic diseases effectively, more  
10 opportunities for using specialists or mental  
11 health/substance abuse services in a more coordinated way,  
12 greater patient engagement. As Alan mentioned, I'd  
13 highlight that there are a lot of interesting things going  
14 on around trying to integrate social and community-based  
15 services, family services, early childhood programs. These  
16 are not very well or extensively developed yet, but seem to  
17 be showing some promising results. And they just don't fit  
18 very well into the traditional Medicaid model of funding  
19 streams that go for traditional services or as the support  
20 for these other programs are separate.

21           So I think there's some steps happening, but not  
22 in Medicaid perhaps as much, and the Medicare ACO program

1 or other commercial programs to try to move away from  
2 paying for specific services that are covered and others  
3 that aren't and getting into a more individualized, perhaps  
4 broader but more targeted set of medical and non-medical  
5 treatments that work best for particular patients.

6           Now, there is no reason that can't happen, and it  
7 is actually happening within the traditional Medicaid  
8 context. Some of this is happening through things like the  
9 so-called DSRIP programs, a lot of federal support for  
10 trying out these new approaches to care delivery and  
11 preventing complications and improving health while not  
12 increasing costs, or maybe even saving money. This has  
13 been a big part of many of the waivers, which is most of  
14 the way the Medicaid program in 30-plus states with  
15 comprehensive 1115 waivers in place that are clearly moving  
16 -- trying to move away from traditional mechanisms of  
17 financing and delivering care.

18           But as Alan said, one problem with the waiver  
19 approach is that it's not very transparent. It's very  
20 individualized, and so it's hard to draw conclusions about  
21 what's really working in terms of saving money and  
22 improving outcomes.

1           One of the things that's a hallmark of all of  
2 these kinds of movements in care delivery towards  
3 accountable care, towards payments that are more at the  
4 person level and tied to better results as well as lower  
5 costs is that it tries to reduce that lack of transparency  
6 around what we really want in health care, which is better  
7 health outcomes, better care experience, and lower overall  
8 costs together.

9           So I know a lot of the motivation for this  
10 session has been about cost reduction, but I think that's  
11 missing sort of the biggest -- you know, one of the biggest  
12 opportunities for accountable care reforms at the state  
13 level as well as within health care organizations, which is  
14 better quality of care.

15           If you look at some of the early results from  
16 these kinds of shifts in provider payment systems in  
17 Medicare and the commercial sector and so forth, they do  
18 save some money, but the biggest impacts are typically on  
19 getting to better results in care because it becomes easier  
20 to put funding streams together, to target services, to get  
21 outside of the traditional mechanisms of funding care that  
22 tends to focus on, you know, again, volume and intensity of

1 services and not results.

2           So the reason that our proposal focused on  
3 Medicaid shared savings was because of this very big  
4 opportunity. This actually grew out of a collaborative  
5 effort that Brookings had sponsored, the Bending the Curve  
6 Initiative, with support from the Robert Wood Johnson  
7 Foundation. This was made up of a group of collaborators  
8 from kind of both sides of the political aisle, a broad  
9 range of experts. We issued a report in the spring of 2013  
10 that included participants like Tom Daschle, Donna Shalala,  
11 Mike Leavitt, Glenn Hubbard, David Cutler, Mark Pauly, so  
12 people who have been -- you know, don't always write or see  
13 political issues or policy issues in the same way, but did  
14 come together behind this one.

15           The idea was to make this focus on better results  
16 and lower costs at the same time, a more explicit core  
17 feature of Medicaid. And I think this could work, as Alan  
18 was saying, as an option for states to take instead of  
19 waivers or other more traditional approaches. But because  
20 states would have an opportunity to share in some of the  
21 savings, it could provide some additional support for  
22 states to undertake the steps that are needed to make this

1 program work, and I'll come back to that in just a minute.

2 I would also add, as Alan mentioned, that, you  
3 know, while there have been a lot of partisan issues around  
4 Medicaid reform recently, this area of trying to help  
5 health care policies, whether it's in Medicare through  
6 payment reforms or the private sector through value-based  
7 insurance initiatives and the like, it is an area where  
8 there is a fair amount of bipartisanship in terms of  
9 support in other areas outside of Medicaid. Maybe that  
10 could come here. We also thought about proposals in our  
11 group for doing kind of broader ways of sharing savings  
12 with the state. I think as Alan mentioned, though, if  
13 you're going to start somewhere in terms of engaging  
14 states, this is where the biggest part of the state budgets  
15 are, more than 20 percent of spending. This is where the  
16 biggest state concerns are about rising costs, and this is  
17 where the biggest state control is in terms of potentially  
18 influencing care delivery.

19 It is true that the federal government exerts an  
20 awful lot of control over how Medicaid operates in terms of  
21 benefit requirements and other minimum standards. But the  
22 program is actually on the front lines administered by the

1 states and giving them more resources and more  
2 opportunities for developing an infrastructure to lead to  
3 better care that the opportunity for shared savings would  
4 provide would, we think, really help with that.

5           In terms of the details of our proposal, I think  
6 for our purposes today, they're not too different from what  
7 Alan has already described. The key parts in terms of an  
8 infrastructure, key elements of a shared savings program  
9 generally, are, first of all, you have got to come up with  
10 a mechanism for determining if there are savings. That  
11 means calculating benchmarks. This can be challenging  
12 since there are different component populations in states.

13           DR. McCLELLAN: In our proposal, we talked about  
14 ways to break down the overall Medicaid population into its  
15 different subsets, so childless adults, non-elderly  
16 disabled, duals, and so forth, and ways of getting some  
17 standard approaches of calculating per beneficiary  
18 baselines for each of these.

19           I should say, too, that our proposal focuses on  
20 getting savings at the per beneficiary level, so it's not  
21 to provide too strong incentives to get costs down by just  
22 restricting enrollment in the program or participation in

1 Medicaid. But, with a benchmark for spending, where it is  
2 and where it could be, and doing that in a comparable way  
3 and publicizing it across states, we think would be healthy  
4 from a transparency standpoint more generally, and also  
5 could help guide further waiver discussions for states that  
6 did not opt for the shared savings approach.

7           But, then you also need benchmarks for  
8 performance measures, and this is an area where, frankly,  
9 Medicaid has been behind in terms of what's available  
10 publicly to understand the quality of care being delivered.  
11 CMS has been focusing on trying to make progress on better  
12 measures and supporting states in implementing better  
13 measures in Medicaid. There's a core CMS measure set, at  
14 least for the non-elderly Medicaid beneficiaries. There's  
15 work in other areas, for dual-eligible Medicare and  
16 Medicaid beneficiaries. The Medicare side of quality  
17 measurement programs have developed some better measures.

18           But, compared to, say, the Medicare ACO program,  
19 where there are now 33 measures, many of which are very  
20 much population outcome oriented -- diabetes control,  
21 prevention of readmissions, things like that -- measures in  
22 Medicaid have not been that well developed, nor, because

1 they're voluntary, have they been that extensively adopted.  
2 So, that's an area where, as this program got off the  
3 ground, some support from CMS, from the federal government,  
4 would be very helpful.

5           In the implementation of the program, the idea  
6 would be to get a baseline set of measures, both financial  
7 performance, so that's a cost benchmark by population, and  
8 a baseline set of quality measures, with the recognition  
9 that the quality measures may not be ideal, or anywhere  
10 near ideal, to start with. That's not a reason to not go  
11 forward. The way that a lot of these reforms have worked  
12 outside of Medicaid is that you kind of start where you  
13 are, maybe in a limited way, so a limited version of shared  
14 savings until, perhaps, states get better performance  
15 measures in place.

16           Maybe there could be some support for putting  
17 those performance measures in place. For example, in the  
18 Medicaid DSRIP programs now, all of those come with  
19 expectations that you're going to measure the impact of the  
20 program on performance. Unfortunately, there aren't really  
21 widely available consistent measures that are used for  
22 those DSRIP pilots, even in areas where you're dealing with

1 similar populations.

2           So, I think there are a lot of tools that CMS  
3 could use to help make more consistent measures available  
4 that would really add to the confidence that these programs  
5 are doing what's intended in terms of impacts on quality of  
6 care and access to care and the like.

7           So, with those features in place, I think both  
8 our program and Alan's highlighted that you would look at  
9 the comparison of financial performance and have a minimum  
10 standard for improvement in quality, in these quality  
11 measures, at the same time. If states beat their trend in  
12 financial performance by far enough, and when these  
13 programs are typically implemented, there's kind of a wedge  
14 or corridor that the actuaries think of as being random  
15 variation that you don't want to necessarily pay out in a  
16 different way for, so there might be a corridor around  
17 which states don't share savings. But, if you beat that  
18 corridor, say, savings of more than one percentage point or  
19 something like that, then beyond that, the State would get  
20 a share of the federal savings.

21           The program can be more or less incremental,  
22 depending on what the share of the federal savings might

1 be. If it's a small share of the federal savings, it is  
2 truly incremental from where we are today. And, for people  
3 who are reluctant about going down this road, that might be  
4 a place to start. It at least would provide some  
5 incentives and get CMS and the states used to thinking  
6 about the program, not only in terms of sort of their  
7 existing reporting requirements around minimum benefit  
8 standards, but, again, this shift towards better outcomes  
9 and more flexibility in how they use funds and combine  
10 funds to get to those outcomes and put these quality  
11 measures and access measures more front and center.

12 Or, it could be a larger share of savings to the  
13 states, which would provide more incentives for them to  
14 undertake efforts to get to improvements in quality and  
15 reductions in cost at the same time.

16 I think in both our proposals, we talk about how  
17 a 50 percent of sharing between states -- of the federal  
18 savings with the states might be a good place to aim. That  
19 would mean that, say, for the childless adult recent  
20 Medicaid expansion, states would get more support, more  
21 financial savings, than they would with a core Medicaid  
22 population, or a core Medicaid population where the State's

1 share is larger to begin with. But, that might offset some  
2 of the concerns I know Alan and others have raised about,  
3 in the current models, with very high contribution rates by  
4 the federal government might not provide states with as  
5 strong incentives as you'd like to be accountable and limit  
6 costs. But, again, this is a design choice in how much you  
7 want those savings to be shared.

8           From the states' standpoint, this does -- these  
9 kinds of efforts do require more infrastructure than just  
10 paying the bills or signing a capitated contract with  
11 Medicaid managed care plans. It requires identifying and  
12 then tracking a set of performance measures. Depending on  
13 how the program is designed, those might be consistent  
14 across states, which would allow for more comparability and  
15 more transparency and more learning about what's really  
16 working in these care reforms. But, states could get more  
17 financial support for making investments in that  
18 infrastructure because they're sharing in the savings.

19           We'd recommend another step that the federal  
20 government could take to support states by providing them  
21 some more systemic guidance and exchange of best practices.  
22 So, if you look at the ACO programs taking place around the

1 country today, some of the things that CMS has announced  
2 recently in terms of Medicare payment reforms, you know,  
3 they're supporting mechanisms for sharing best practices,  
4 learning networks, things like that, resources that can  
5 help providers and organizations move towards these more  
6 innovative ways of delivering care. That could be a  
7 feature of this program, too.

8           So, this can be -- I think Alan is right in  
9 describing this as not a fundamental change in the Medicaid  
10 program, but a potentially important one nonetheless. It  
11 can be more or less incremental. If the shared savings is  
12 very small, you're not going very far away from where we  
13 are today, just adding, maybe, some transparency and some  
14 emphasis on consistent ways of calculating spending  
15 benchmarks and quality of care. You could go very much  
16 further in the other direction and provide stronger  
17 incentives for states to undertake efforts to really reform  
18 their health care systems, maybe align with some of the  
19 other efforts that are taking place on the commercial side  
20 in Medicare to support bigger reforms in care.

21           But, I think the main thing to emphasize is that  
22 this shifts the focus. This is a great way of explicitly

1 shifting the focus from just being about costs and access  
2 to coverage in Medicaid, important as those two  
3 considerations are, to costs and what we are getting for it  
4 in terms of results for the populations that we're  
5 intending to cover and support through these increasingly  
6 large and important programs in the United States. Thank  
7 you.

8 CHAIR ROWLAND: Well, thank you both.

9 Could you talk a little bit about how the  
10 demonstrations going on around dual-eligibles fit into a  
11 shared savings concept? I mean, is some of the structure  
12 of those demos getting toward what you would be talking  
13 about, or are they not there yet, or -- because they do  
14 have performance standards. They do have integration of  
15 care, between two big federal programs, actually, as a  
16 goal. And, they do have shared savings, or savings  
17 targets, at least.

18 MR. WEIL: Yeah. I would say, structurally,  
19 there's a lot to learn from each other. I don't think I am  
20 currently sufficiently close to the detail of how those are  
21 designed to take the question much further. But, there's a  
22 whole second set of issues, as you know, in those, which,

1 as you say, it's two big programs and there's rule  
2 alignment and payment method alignment and figuring out how  
3 to -- and alignment around the enrollee experience and  
4 rights to services and lock-ins and all of those kinds of  
5 things.

6 But, I think, conceptually -- and I think this is  
7 really following on Mark's last point --

8 CHAIR ROWLAND: I think I was referring to it  
9 more as a model --

10 MR. WEIL: Yeah --

11 CHAIR ROWLAND: -- of how you could potentially  
12 do a shared savings demonstration as opposed to --

13 MR. WEIL: No, and that's really where I was  
14 going to close, is which I think Mark's final point, that  
15 this is really -- if we can view this as an opportunity to  
16 shift the focus toward results, the whole notion that  
17 structuring those demos is based on an expectation that  
18 there will be quality measurement and reporting and  
19 standards as opposed to just financial reporting, I think  
20 that's a huge step forward, and in that sense, I'd  
21 certainly see it consistent.

22 DR. McCLELLAN: I agree with Alan. The programs

1 themselves, I think many of them are still pretty new, and  
2 Melanie Bella has been working hard to get them off the  
3 ground, but there is a lot of alignment that needs to take  
4 place. You know, I think what -- while it fits with the  
5 kinds of proposals we've been describing, the nice thing  
6 about a framework like this is that I think it would make  
7 it an easier fit to develop these kinds of reforms. Right  
8 now, they're very much individual hard work to put each of  
9 these together. There's not a clear set of measures to  
10 draw on, not a clear understanding from the states of what  
11 they would actually save if these programs work. You know,  
12 it's not as well established a track for actually  
13 supporting reform, but I think it's, you know, just like  
14 the DSRIPs and the other individual programs, yeah, these  
15 are all moving in the right direction, but they're not get  
16 a systematic push or support for moving in that direction  
17 yet.

18 CHAIR ROWLAND: Okay. I have Marsha, and then  
19 Sara.

20 COMMISSIONER GOLD: I wanted to sort of -- I've  
21 been looking at managed care for a long time, and I wanted  
22 to say something about how I see Medicaid in relation to

1 others that may be different from you, but also put it in  
2 the context -- this Commission has written a lot about the  
3 nature of the Medicaid population, and in some ways, what  
4 the Medicaid population has is a lot of people that -- or  
5 services that don't fall in the Medicare and they don't  
6 fall in the commercial sector. And, that's where a lot of  
7 the costs are and that's where the care management  
8 challenges are that are kind of unique that don't  
9 necessarily exist -- don't exist in the commercial market,  
10 or at least are invisible, because no one pays attention to  
11 them. And in Medicare, you get them with the duals and  
12 with certain other groups.

13           But, it seems to me, if you look at Medicaid,  
14 Medicaid has actually been ahead of the game in terms of  
15 trying to manage care for kids and moms and that stuff.  
16 They're not always perfect. The measures may not be as  
17 great and there are some other challenges. But, they've  
18 used managed care quite effectively in the non-managed care  
19 states. They were some of the leaders with medical homes  
20 and other things.

21           And, so, I'm a little bit concerned with  
22 characterizing Medicaid as behind and needing to learn from

1 commercial and the Medicare program. I think where the  
2 Medicaid program has the biggest challenges is where they  
3 can't learn from those other programs because no one's  
4 doing it. So, how do you deal with the disabled? How do  
5 you deal with the HIV? How do you deal with the kids with  
6 the special needs and those sorts of things? And that's  
7 where a lot of the costs are.

8           So, I wonder if you could talk about how you  
9 think your proposals fit within that context -- and feel  
10 free to disagree with me if you don't think that's an  
11 accurate way of laying things out.

12           DR. McCLELLAN: I think you're right, that there  
13 are a lot of innovative approaches taking place in Medicaid  
14 managed care now. I guess I would just say that these  
15 kinds of reforms seem like they would reinforce and support  
16 that movement, hopefully more systematically and  
17 extensively than is the case now. There are, as you know,  
18 a number of states that are increasingly relying on managed  
19 care. There are some states -- Oregon, Minnesota, others -  
20 - that have taken more of a regional approach. I think  
21 depending on the State's circumstances, the best way to go  
22 may be different, but I think it definitely helps to have

1 this kind of more explicit focus on performance measures.  
2 If we can get to more comparability of those measures  
3 across programs, it would help a lot.

4           There is some good work, very good work,  
5 reflected in some of the studies on the HIV population,  
6 other special needs populations, and starting to be some  
7 work on integrating social services more effectively,  
8 community-based services, though some of that is happening  
9 outside of the traditional Medicaid managed care plans,  
10 too.

11           So, I don't disagree with you. I just think that  
12 if we had more of an emphasis on getting to better results  
13 for this population, it would actually help us learn more  
14 quickly from the programs that are doing something well and  
15 help expand them more widely, in a faster way, too.

16           MR. WEIL: Yeah. As a general matter, I share,  
17 Marsha, your sense that, in many respects, Medicaid is  
18 ahead of the game, and it's why, when I was talking about  
19 the barriers to savings in Medicaid, the dominance of  
20 managed care actually has created some looseness around  
21 financing that I think you don't tend to find in other  
22 areas.

1 I do think, however, that there are places where  
2 commercial plans have been able to make investments,  
3 perhaps in things like predictive analytics, where Medicaid  
4 may be behind. It's an empirical question of -- and I'm  
5 sure there are some behind and ahead and generalizing is  
6 risky.

7 I completely agree that there are few models for  
8 the most complex populations, and yet, again, around the  
9 country, there are states that have adopted them.

10 So, I go exactly where Mark did, which is that  
11 what's lacking is any sort of national endeavor to develop  
12 and embrace a set of metrics that are appropriate to the  
13 complexity of the population. I was on the AHRQ  
14 subcommittees that set the children's and the adult  
15 Medicaid quality measures. The statute required that we  
16 use measures that were already in use. And, of course, as  
17 is always the case with measure sets, you want them to be  
18 relatively small, and they're optional, and we don't have a  
19 lot. The deeper you get into the complexity of the  
20 population, the less we have. And, then, remember that the  
21 statute that created those measures also created a process  
22 for developing new measures.

1           So, I think there's an understanding that this is  
2 an evolving art. What's missing, and I'm glad Mark said it  
3 in response to the duals issue, is that, again, we're sort  
4 of doing this all one by one. I mean, Sara, you're the  
5 leader in examining states' relationships with managed care  
6 companies and Medicaid, and, you know, the old contracts  
7 were about network adequacy and now there's robust quality  
8 reporting, and it's been a long evolution through a  
9 combination of advocacy and more sophisticated  
10 understanding of the metrics, just more computing power,  
11 but also changed expectations of what managed care is  
12 supposed to do, because it used to be we just thought all  
13 it was an access panel, where access was what mattered.

14           So, I view these -- I mean, in response to the  
15 framing of your question, my reaction is very much the same  
16 as Mark's, which is these proposals are consistent with the  
17 evolution that's occurring. Whether Medicaid's ahead or  
18 behind, in exactly the right place, I don't know. I'm sure  
19 -- I know it's variable. But, it's consistent. And, to  
20 think about at a national level that we want to judge what  
21 we're getting for this investment in addition to just what  
22 we're spending on it seems to me a framework that could be

1 very positive for those who are trying to do this work.

2           COMMISSIONER ROSENBAUM: So, I'm thinking -- I  
3 think a fair amount like Marsha on this, and I'm also  
4 trying to imagine turning these ideas into legislation.  
5 Would it not make sense, actually, and would it not be sort  
6 of an efficient way to get to the point you both want to  
7 get to, to simply go back and revisit the 1997 Balanced  
8 Budget Act managed care provisions? Those provisions were  
9 really meant to take us from a very slow evolution of  
10 Medicaid into what we see today. And, yet, there are a lot  
11 of constraints on the use of managed care.

12           And, so, it has always struck me that if what we  
13 want to do is speed up an evolution, that might be the way  
14 to go, especially since built into the arrangements are  
15 shared savings. I mean, as you know, it's obviously an  
16 element of managed care. CMS sanctions specifically shared  
17 savings arrangements. And, what you both are really  
18 talking about is allowing the delivery system to evolve  
19 further. So, that's one observation.

20           And, another is we're a year away now from the  
21 State Innovation Waivers, and so I'm wondering whether it's  
22 not worth our thinking about what you're talking about in

1 two pieces. One is an immediate effort around the BBA  
2 managed care provisions, and then the second is to actually  
3 get a little bit more ambitious with the State Innovation  
4 Waivers under certain circumstances, because those waivers,  
5 I think, much more than people realize, are pretty  
6 constrained. I mean, you can deal with your Medicaid and  
7 you can deal with social services and you can deal with  
8 this, but you can't touch these other things here.

9           And, so, I think in a federalism era, the  
10 question is whether, under certain circumstances, we would  
11 want to allow states to engage in innovations that they  
12 otherwise could not. Or, for example, in a State that had  
13 a commitment to ensuring everybody in the State, do we, in  
14 fact, allow the State to have a certain kind of  
15 relationship with self-insuring ERISA plans that we do not  
16 permit in other states? Do we allow the State to take the  
17 lead on certain aspects of Medicare that we normally  
18 wouldn't allow?

19           I don't see how we get to innovations for the  
20 very toughest cases unless the State can actually think  
21 delivery system overall and not have certain payers  
22 essentially retreating into their own corners, you know,

1 when the going gets tough here.

2           And, so, I'm thinking -- as I'm listening to your  
3 excellent presentations, I'm thinking about, couldn't we --  
4 you know, could we think about breaking it into sort of two  
5 stages, some immediate work on Medicaid and then some more  
6 ambitious work on system-level change.

7           DR. McCLELLAN: I think that makes a lot of  
8 sense. I need to take a closer look at the BBA managed  
9 care, Medicaid managed care provisions. It does strike me  
10 that while that has helped a lot with giving states the  
11 opportunity to implement Medicaid managed care reforms --  
12 and some of them have been quite successful on the lines  
13 that Marsha was talking about earlier -- the key things  
14 that we've seen in a lot of delivery reform efforts are you  
15 need the flexibility and opportunity to do it and  
16 accountability for -- this involves a shift in  
17 accountability towards results, but the financial incentive  
18 smatter too.

19           While some of these Medicaid managed -- or many  
20 of these Medicaid managed care reforms have been  
21 implemented in the context of big 1115 waivers that in  
22 effect set something like a baseline and gives states some

1 shared savings below it, it doesn't really strike me as a  
2 systematic, clear, transparent, predictable, long-term  
3 approach, where if a state is going to think about some  
4 serious investments and do I need to do something more in  
5 my Medicaid agency other than have a few staff who are  
6 overseeing managed care programs, do I really want to  
7 invest in better tracking capabilities and start moving  
8 towards that more systematic approach to supporting reforms  
9 in care in a state, it would be helpful to have that long-  
10 term predictability about payoffs coming back to the states  
11 in terms of better controls of costs going along with the  
12 demonstrated improvements in results. So that seems like a  
13 fairly big difference between some of the more effective  
14 accountable care programs elsewhere and what's in the law  
15 now.

16           It would also add in terms of extending out in a  
17 broader way. I agree that there may or may not be some  
18 real opportunities to support this work through the state  
19 innovation provision. It also strikes me as something  
20 where, just like the waiver process, a lot could  
21 potentially be done in the name of some statutory  
22 provisions that are kind of vague and kind of broad, and

1 that it would behoove everyone to have a clearer, more  
2 certain pathway and ideally with some bipartisan support  
3 for how reforms could occur.

4           If you think the waiver -- Alan, if the waiver  
5 process for Medicaid is complex now, just wait till those  
6 waivers start coming in and in terms of transparency,  
7 predictability, and so forth. And I really haven't seen  
8 much work done at all to lay a foundation for how that's  
9 going to go forward.

10           So, again, I think this kind of framework would  
11 be helpful in starting to get there.

12           MR. WEIL: Let me react. This was a very  
13 interesting set of comments.

14           I do think there are probably ways to build from  
15 BBA. I don't actually think the big problem right now is  
16 that there are huge impediments to using managed care. I  
17 think the real issue is what's inside the black box of  
18 managed care, and that's where I think the thinking has  
19 evolved a great deal. It used to be sort of, well, you  
20 know, as long as we're getting the financial protection of  
21 the capitation rate and we can measure sort of access  
22 adequacy, then we kind of figure they have all the

1 incentives right. And now, increasingly, payers are  
2 saying, "Actually, it turns out they aren't doing all the  
3 things we think we want them to do, and so we're going to  
4 go inside the black box and push enhanced payments for  
5 primary care and participation in different structures and  
6 the like.

7           And I don't know that I see the federal statute  
8 as impediments to that. To me, the problem with that  
9 approach is that any savings that the state generates are  
10 then subject to the standard match rate.

11           Well, yes, I think changing the match rate would  
12 feel to me like more than just amending the provisions.

13           COMMISSIONER ROSENBAUM: Just mostly trying to  
14 figure out where lawmakers should train their vision.

15           MR. WEIL: Got it.

16           COMMISSIONER ROSENBAUM: When we have these very  
17 broad ideas, which are tremendously important, and then  
18 you're sitting there as Congress trying to think, "Well,  
19 what do I do with this?" -- and it strikes me that what  
20 you're really talking about is delivery system innovation  
21 with an opportunity to do things that aren't done today for  
22 populations that don't happen.

1           You don't really have to change the benefits.  
2    You don't have to change the eligibility rules. What you  
3    really have to change is that part of the statute that  
4    deals with state authority over the delivery.

5           MR. WEIL: Yes. So if that's the way you meant  
6    to build on it, then I completely agree.

7           I still think you need a financial component,  
8    which is I think what Mark said.

9           With respect to the state innovation waivers, the  
10   risk I have in relying on that, in addition to the issues  
11   that Mark raised, is that if I understand the provision  
12   correctly, there is an opportunity for a direct payment  
13   model, meaning the state gets the money that the federal  
14   government would have otherwise given in the form of  
15   subsidies. That is a very high-risk proposition.

16           So I feel like what the innovation waivers create  
17   is two options. One is sort of a very traditional one, and  
18   the other is give the state the money, and they're on the  
19   hook dollar for dollar. I don't want to call it a block  
20   grant because this is very different, but the marginal  
21   incentives for states are identical to a block grant  
22   because the amount the federal government gives them is

1 capped, and then every dollar they save, they keep.

2           So it feels to me like it creates two extreme  
3 options. One is status quo, and the other is block grant,  
4 and I think what we're trying to do is create an option  
5 that isn't either of those extremes.

6           Your final point about -- and the comment you  
7 just made about this is really about delivery system, I  
8 agree, but this is where I sort of go back to Marsha's  
9 point, which is there are two -- to simplify, there really  
10 are two tracks here. One is the multi-payer reorganization  
11 of the traditional mainstream health care system, what ACOs  
12 are trying to do, what patients in medical homes are trying  
13 to do, all of that.

14           The other is the Medicaid-targeted delivery  
15 systems that provide services and treat patients who are  
16 almost unrepresented in commercial plans out there, and the  
17 strategies for doing those two are very different. So what  
18 I worry about sort of calling it, part of a global delivery  
19 system reform agenda is that there are subcategories of  
20 that, that I think have very different texture.

21           COMMISSIONER COHEN: Diane, I'm going to drive  
22 you crazy because I have a two-part question again.

1 Actually, one of them is really just a -- hey, compared to  
2 Patty, I am efficient. But one of them really is a  
3 clarifying question, and I'm not quite sure I understand.

4 Do your proposals assume increased regulatory or  
5 statutory flexibilities for states, or do they assume that  
6 the incentives will encourage states to use the  
7 flexibilities that they have in a more effective way? So  
8 that's my clarifying question.

9 MR. WEIL: I will admit that I finessed that a  
10 bit.

11 COMMISSIONER COHEN: Oh, so I caught that.

12 MR. WEIL: Right. So it's a good question.

13 COMMISSIONER COHEN: So maybe yes, maybe no.

14 MR. WEIL: I mean, the answer is I think it has  
15 to be paired with that, but I think the boundaries of that  
16 are perilous.

17 Again my goal was to sort of say let's think  
18 about it this way, and if we could agree -- I don't want to  
19 go on, since I said I finessed it. Now I'm going to box  
20 myself in the corner.

21 Again, I am gravitating towards a comment Mark  
22 made, which is this is a balance. So as our ability and

1 confidence in our metrics, particularly our quality  
2 performance metrics, grows, then I think our willingness to  
3 accept flexibility should also grow.

4           But my personal view is that we're at a pretty  
5 basic level right now in that area, particularly as it  
6 pertains to the Medicaid population, and so my personal  
7 willingness to let all of the constraints go is quite low,  
8 but I think that you have to -- it's a consensus process to  
9 figure out how much of the one you need to make the other  
10 happen.

11           DR. McCLELLAN: Yes. The constraints are in  
12 place because the expectation is that by having those  
13 constraints, you are going to assure better access to  
14 needed care and get better results.

15           To the extent that we can actually more directly  
16 assess whether innovative approaches to delivering care are  
17 delivering those results that we want, which, frankly, in  
18 many cases, may not be getting delivered right now, despite  
19 the requirements in place, maybe there's some room for  
20 agreement on getting to more flexibility. But in our  
21 discussions, there's a very similar point to what Alan  
22 made, which was that the more confident you are, that

1 you're really tracking what matters for these populations,  
2 the more flexibility you'd probably be comfortable in  
3 allowing in terms of how to get there in care delivery and  
4 benefits and so forth.

5 COMMISSIONER COHEN: Got it. Okay. Thank you.  
6 Thank you. That was very helpful.

7 I have the same instinct as Marsha and Sara,  
8 which, of course, I'm tickled that I have the same instinct  
9 as Marsha and Sara. It doesn't always happen that way.

10 But this concern that we have been talking about,  
11 whether or not there are sufficient quality measures,  
12 performance measures for the populations that Medicaid  
13 takes care of and spends so much money on, DD, behavioral  
14 health, long-term care, and other things, and so I kind of  
15 want to ask this question based on your respective  
16 experiences sort of in government, thinking about the  
17 health care system changes and things like that rather than  
18 sort of experts on this financing proposal.

19 I understand that if you are going to incentivize  
20 performance in all sectors, you have to take some leaps,  
21 and you have to create a structure and some incentives  
22 before you are 100 percent confident in the measures.

1           But I guess my question is, how can we really try  
2 to focus on improving -- testing and improving those  
3 measures? Because it has been a long time that we've sat  
4 around this table. Actually, it's sort of like -- that's  
5 actually a relatively shorter time, but a long time that  
6 people have been observing the lack of good measures in  
7 these areas. And the fact that Medicaid spends so much  
8 money on it, the fact that there is so much pressure on  
9 financing and all the things. It did not seem to have  
10 really moved the ball forward very quickly.

11           And I would also say this relates to the  
12 challenge of the data systems. I live in New York now, and  
13 New York has an incredibly complicated DSRIP system, which  
14 is really taxing even a pretty deep Medicaid program there,  
15 and that's really only looking at acute care. I mean, it's  
16 really not looking much beyond that at all.

17           So I'm just sort of wondering from your  
18 perspectives, what are some steps that either we as a  
19 Commission could take in terms of our recommendation or  
20 exploration? How can we move this area forward in terms of  
21 really pushing both performance measures and good data  
22 analysis and collection?

1 I know it's a hard question. You can be brief.

2 MR. WEIL: Yeah. Well, I mean, I want to  
3 reiterate what I said in my opening, which is,  
4 fundamentally, now that I don't work at NASHP anymore, I  
5 can say if you do this in a voluntary way, it's not going  
6 to happen. And I mean measurement. It's expensive.  
7 There's a lot of resistance, and if it happens, it will be  
8 -- you won't have consistency across sites, which is what  
9 you need. The whole point of measurement is actually, of  
10 course, to be able to benchmark and improve -- or at least  
11 one of the goals.

12 A huge portion of my desire to promote something  
13 like this was to say, "Okay, states. You think you can do  
14 it better for less. You've been saying it forever. So if  
15 you believe it, the onus is on you to show it. So if you  
16 want some savings, you have to invest in the data  
17 infrastructure to demonstrate that you had savings at the  
18 same time that you were able to retain or improve quality."

19 So it's to flip the formula, and again, it's sort  
20 of where we've used access, we've used access to a  
21 guaranteed set of benefits as a proxy for quality, and we  
22 know that that's a terrible proxy, and yet it's the only

1 one we've had.

2 Sarah, when you mentioned BBA, I was thinking one  
3 of my favorite party jokes -- or I should say one of the  
4 reasons I'm so popular at parties is I tell people about  
5 the 75-25 rule, and no one believes that that ever was in  
6 place. I go to great parties. I should get out more.

7 [Laughter.]

8 MR. WEIL: SO the point is we have this proxy for  
9 quality that we know is inadequate, and what I was hoping  
10 in proposing this -- and again, it's consistent with others  
11 -- is to basically say to those who feel so confident that  
12 they can do better, then the onus is on you.

13 Mark knows more, I'm sure, than I do about  
14 various efforts that have occurred in Medicare to basically  
15 pay for reporting before you pay for outcomes. I have  
16 enough familiarity to know they exist. So that's really  
17 fundamentally it for me, is that you have to tie it to a  
18 business case, and if you're running a state Medicaid  
19 agency with 8 million things that you have to do and a lot  
20 of financial pressure, investing in voluntary quality  
21 metrics is not going to rise to the top. And so it doesn't  
22 happen.

1           So I think trying to create a framework where  
2 there is a business case for doing it as opposed to just a  
3 belief that we should is critical.

4           DR. McCLELLAN: First, I am probably not going to  
5 go to Alan's party.

6           Let's say you're a state like New York that wants  
7 to do something in terms of improving quality and lowering  
8 costs at the same time, and what you have to do now is go  
9 and apply to a bunch of disparate brands, go through a very  
10 long waiver process on top of that, try to make it all fit  
11 together when there is not really any set of measures or  
12 standard expectations that you can lean on for how you're  
13 designing these kinds of reforms. So that's a lot of work.

14           And then on top of that, you've got to actually  
15 negotiate out on a one-off basis what kind of savings  
16 you're going to get, can you get something that's beyond  
17 just the state's share. And some of that is in the new New  
18 York waiver, but it's been a long process, and it's not a  
19 very predictable roadmap, and generalizing from the New  
20 York experience -- and either it's DSRIPs or its waivers --  
21 is going to be really, really difficult because all these  
22 features are so unique. The measures that are being used

1 are kind of unique and not necessarily representative of  
2 what will be used in other states.

3           This is a federal program, and what seems to work  
4 best is when there can be something in it for the federal  
5 government and something in it for the states. So if  
6 you're going to ask the states to do more in terms of  
7 accountability on some standard, truly meaningful measures  
8 or more standard, truly meaningful measures of quality, I  
9 think they are going to understandably want something in  
10 return, which would be a faster way to get these reforms in  
11 place and an expectation in more -- not just short-term  
12 DSRIP, but long-term predictability that they can make  
13 these investments and reforms in care and there will be a  
14 long-term payoff.

15           The problem with a DSRIP, just like a problem  
16 with some of these other pilots, it is three years, five  
17 years, some short period of time, and then what? How do  
18 you make those care reforms sustainable?

19           Medicare is having some of the same issues with  
20 some of its CMMI pilots where people have demonstrated,  
21 "Hey, you gave us some money up front. We were able to  
22 reform care and lower cost, but what do we do now?" There

1 is no payment system for that or no standard model for that  
2 reform and care to fit into to make it sustainable. So  
3 this is really about making the kinds of things that states  
4 are trying to do more sustainable, more effective, and in  
5 return, I think what the states are going to have to show  
6 is more accountability for the results as opposed to a lot  
7 of -- maybe a shift away from so much emphasis on the  
8 traditional kinds of standards around benefits and so  
9 forth.

10 CHAIR ROWLAND: For the benefit of a few of our  
11 Commission members, could you just clarify what DSRIP is?

12 DR. McCLELLAN: Delivery System Reform. These  
13 are Innovation Pilots that are intended to support the tons  
14 of good ideas out there for doing better than we're doing  
15 in getting better health outcomes at lower costs for  
16 particular kinds of Medicaid beneficiaries, and many states  
17 are implementing a number of these. They are being done as  
18 sort of pilot programs under this sort of CMMI authority  
19 that came with the Affordable Care Act. And --

20 COMMISSIONER COHEN: And incentive payments that  
21 come along with performance.

22 DR. McCLELLAN: And incentive payments along with

1 them.

2           COMMISSIONER COHEN: Incentive payments to  
3 provider systems.

4           DR. McCLELLAN: Right. Right.

5           But again, these are one-time pilots, and I think  
6 a very important question, as with any pilot programs, is  
7 what do you do next? The law on the Medicare side gives  
8 CMS the authority to expand the pilot that they think works  
9 nationally. That hasn't happened with any yet. I guess  
10 we're still early on since the 2010 law, but again, unless  
11 you've got a more systematic framework of being able to pay  
12 for and support and reward states that are improving  
13 quality and lowering cost, I think it's going to be hard  
14 for a lot of these efforts to really be sustainable.

15           CHAIR ROWLAND: And for the record, I am going to  
16 have Anne just explain what the Commission is actually  
17 doing in DSRIP.

18           EXECUTIVE DIRECTOR SCHWARTZ: Yes. We are  
19 finishing up a project on DSRIPs right now with the help of  
20 NASHP, and I think maybe at the next meeting and certainly  
21 at the next meeting in May, we will be bringing to you what  
22 we have learned in that project with some description at

1 different levels because it is so complex about how these  
2 things work and how they work in different states, so stay  
3 tuned for that.

4           COMMISSIONER GABOW: Thank you both for coming.  
5 I think we all know that Medicaid has done some remarkable  
6 things, but to me there are three issues that I think are  
7 worth thinking about, and I was wondering how what you're  
8 proposing might help or further complicate these issues.

9           The first one is the tremendous lack of  
10 uniformity of what you get if you're poor and vulnerable in  
11 one state versus another, unlike Medicare, which is no  
12 matter where you live, this is how it works.

13           The second is the tremendous administrative  
14 complexity that exists within the program for the states to  
15 have to administer.

16           And the third is something that, Alan, you  
17 alluded to, that this population has much of their problem  
18 in the social determinants of health, not in the health  
19 care system.

20           So how do we know that shared savings would go  
21 back into actually dealing with the social determinants of  
22 health, which ultimately will influence the cost of this

1 population and their well-being, and not go back to make  
2 providers have bigger bank accounts or put new roads in or  
3 whatever? And is there a way that in one of your criteria  
4 the shared savings could be stepped up in some way if it  
5 were, in fact, directed to those things that determine many  
6 of the problems in this population?

7 MR. WEIL: Let me respond. I mean, I don't think  
8 the first issue you raise is addressed through these. In  
9 some respects, the more you give states a path -- and I  
10 suggest that it's optional -- it could actually increase  
11 disparity across states in their approach. Obviously, lack  
12 of uniformity in eligibility is something that this is not  
13 designed to address, and talk to the Supreme Court about  
14 that.

15 With respect to the second, administrative  
16 complexity, I mean, this is something that Mark and I both  
17 referred to. To the extent that we can create a statutory  
18 pathway that is not based on one-off waiver negotiations --  
19 I'm not suggesting waivers are the root of all  
20 administrative complexity in Medicaid, but they do create a  
21 particular type of complexity about resources, about time,  
22 about transparency, and placing this structure in a more

1 uniform formal way I think is a big win. But it doesn't  
2 really address some of what I'm sure are some of the other  
3 things you would think of as complexity.

4           With respect to the social determinants, I mean,  
5 this goes beyond this paper. I think that shared savings  
6 and the whole sort of ACO performance movement is a  
7 facilitator for the health care system to come to its  
8 senses and realize that a lot of the money that's being  
9 spent in it could yield better outcomes if it were spent  
10 elsewhere, and if you get to keep some of the savings, you  
11 now have an incentive to do so.

12           I do not believe that that facilitator is all  
13 that we need to get to where we should be in terms of  
14 rebalancing our resources toward the social elements that  
15 affect people's health, and I very strongly would argue for  
16 direct interventions that move resources and invest.

17           I'm enough of a state person and enough of a  
18 government administrator to be nervous about something that  
19 creates different shared ratios, depending on whether the  
20 service is medical or social, because I see gaming and I  
21 see administrative complexity and I see lots of ways that  
22 that goes wrong. And so to me, the approach is to

1 facilitate, and then if you want to directly target  
2 resources through another initiative, I would do so. But I  
3 personally get nervous about using the shared savings model  
4 to then also create, if you will, differential match rates  
5 for different kinds of services, although that's obviously  
6 a time-honored tradition in Medicaid.

7 DR. McCLELLAN: Just a couple points. On the  
8 lack of uniformity across states, I agree we probably will  
9 see more differences in approach, at least initially under  
10 this kind of model, but hopefully what would happen is  
11 reduction in differences in results. Right now, I think  
12 one reason there are so many varied approaches is that  
13 there's just not that much clarity on what kind of impact  
14 they're really having on the outcomes that we care about.

15 And I think, again, one of the big things for me,  
16 when I was at CMS and starting, the forerunner of the  
17 Medicare ACO program was just to shift the focus to what  
18 really matters, you know, something like patient experience  
19 with care and outcomes and getting to lower costs. So even  
20 if you don't make a fundamental shift, you know, putting  
21 all of the money into this new kind of payment system right  
22 away, even if it is truly incremental, at least emphasizing

1 that I think could help add to the momentum behind what's  
2 right now, as Alan was saying, a pretty complex DSRIP  
3 program, pretty complex waiver processes, which are all  
4 intending to be about getting to better results, but, you  
5 know, not providing as much clarity and, therefore, as much  
6 speed and support for states and doing what really works,  
7 given whatever resources they're willing to spend to have  
8 the most impact on these populations.

9           In terms of the social determinants, I think more  
10 match rate -- you know, higher match rates, things like  
11 that would be nice. I think the biggest challenge is it's  
12 just really hard to get these different kind of funding  
13 streams aligned and then shift the resources from one to  
14 the other in a way that works.

15           I can tell you from, again, back in my days at  
16 CMS, any proposals that talk about non-medical spending  
17 leading to an impact on medical spending coming from states  
18 are looked at with a very high degree of skepticism, you  
19 know, having seen a lot of, like, school transportation  
20 programs and, you know -- but that's because this is  
21 occurring in the context of what states view as kind of an  
22 open-ended, often very favorable matching rate program.

1           I think the only way -- the only way -- you're  
2 going to really get significant support from Medicaid  
3 funding streams for coordinating those kinds of services is  
4 through a program like this where you can, you know, tell  
5 actuaries with a straight face that just because we're  
6 adding in this funding stream doesn't mean funding is going  
7 to go up, and it really is going to lead to some worthwhile  
8 changes for those to work.

9           As you know from your experience in Colorado,  
10 it's not just a matter of saying, okay; we want to spend  
11 more on social services. You need a coordinated approach  
12 to how you're spending that money. You need to target it  
13 to the right people. You need to track the overall  
14 combined spending and have some accountability for keeping  
15 that spending down. That's what this kind of approach is  
16 about, and I think the fact that we're not seeing as much  
17 movement in terms of combining these funding streams  
18 effectively while keeping costs down, you know, still a lot  
19 of skepticism in Medicaid waivers to try to do this is  
20 because we don't have enough emphasis on results and  
21 encouraging states to make some hard changes in the way  
22 they run their agencies and the way they work together to

1 actually achieve better results for beneficiaries.

2           COMMISSIONER MILLIGAN: I'm tempted to ask if the  
3 state procurement process, Alan, would even fit inside of  
4 your three-year timeline.

5           I want to test a little bit of the boundaries  
6 about whether this should be a Medicaid-focused or an all-  
7 payer or total-payer, total-funding focus. Medicaid grew a  
8 lot because states saw an advantage and others saw an  
9 advantage in bringing into a leveraged financing  
10 arrangement things like child welfare and special ed. and  
11 lots of things. Some of the doors have closed over time.

12           Deleveraging I think would have maybe some of the  
13 salutary effects that you're talking about in terms of  
14 public health and how much Medicaid has taken over the  
15 financing for behavioral health and other things.

16           But I want to test sort of the permeability of  
17 this and the cost shifting and sort of the social pieces,  
18 because presumably in a shared savings model, there could  
19 be effects to other payers and other covered populations if  
20 the state achieved savings through provider rate reductions  
21 or other kinds of benefit limitations or reducing support  
22 for uncompensated care or other kinds of things. And the

1 spillover -- and I'm sort of picking up, I think, on some  
2 of what Sara was getting at. Some of the spillover could  
3 be into not only Medicare but on the commercial side, and  
4 then the spillover could be into accelerating the adoption  
5 of high-deductible plans and accelerating an employer's  
6 approach to sort of keep its premiums managed through  
7 shifting to employees and some of the sort of defined  
8 contribution instead of defined benefit model.

9           So that's all by way of asking how in your view  
10 would the unintended consequences outside of wherever you  
11 would draw the boundary of analysis, how would you address  
12 the cost shift or the shift across that boundary line into  
13 the non-Medicaid populations and non-Medicaid areas of the  
14 delivery system?

15           MR. WEIL: There have been a number of shared  
16 savings proposals made that are on total state spending,  
17 and they're designed to basically draw the circle broader  
18 so that you can't get outside of it. As I said,  
19 conceptually I love it, but I don't think we can either  
20 measure it, nor do I think states have the appropriate  
21 controls.

22           To be totally honest, I'm just not too worried

1 about Medicaid shifting costs outside of its boundaries any  
2 more than it already has. I don't see a lot more leverage  
3 to do that, and I think the political constraints on that  
4 are more relevant than some federal-state financial  
5 constraints. But I obviously could be wrong.

6 I do want to say, you know, when I wrote this  
7 paper, I was much more focused on the dynamics than on the  
8 specifics. The context of this paper for me was a fear  
9 that with states making decisions every day on things that  
10 the federal government is paying 100 percent for, whether  
11 that's the Medicaid expansion or the exchange subsidies,  
12 that over time state flexibility would be eroded as the  
13 federal government, taking a close look at the cost of  
14 these programs, started to say, wait a minute, we don't  
15 like how much they cost, we're going to tell states what to  
16 do.

17 And so I was trying to find a way that would  
18 create a dynamic of alignment around shared savings, truly  
19 the shared side. As Mark said, it's a lot easier to do  
20 these things when both the state and the federal government  
21 see that they have something in it.

22 So that's really the context I was working in. I

1 was much more worried about the state-federal relationship  
2 than the notion that the state is somehow going to shift  
3 costs outside. It's a totally reasonable question, but  
4 it's actually not the one that motivated my --

5           COMMISSIONER MILLIGAN: And, I'm sorry, if I  
6 could just -- my emphasis might have been misplaced,  
7 because partly I was getting at that issue, but partly I  
8 was getting at the issue of isn't it in the public interest  
9 to try to have whatever the shared savings in a sense to  
10 sort of raise all boats, whether it's adoption of health  
11 information exchanges or all-payer reform. So I wasn't  
12 solely focusing on the cost-shifting piece, but I was  
13 trying, I think, to elevate to the broader public interest  
14 being advanced by whatever the shared savings model would  
15 be.

16           MR. WEIL: So I could not agree with you more.  
17 The problem is I'm trying to figure out the accountability  
18 pathway. So it certainly would be better if we could save  
19 everyone something, but my concern is those individual  
20 actors, whether it's states or delivery systems or  
21 enrollees or whoever, they're faced with their own piece of  
22 it. And I just can't find a way to add up all the pieces

1 and say we're all in it together; therefore, we'll all take  
2 the approach that is best for all of us. What we're all  
3 going to do is take the approach that's best within a  
4 context, and I'm trying to align those contexts. And some  
5 of it I can do, and some of it I think it just gets too  
6 complicated. But maybe that's the next iteration.

7 DR. McCLELLAN: Maybe there's some really  
8 suggestive evidence from Medicare about these kinds of  
9 concerns. The same kinds of issues arise there, you know,  
10 if Medicaid does something -- Medicare does something to  
11 control costs like cut physician or hospital payment rates,  
12 that's going to end up putting more pressure on providers,  
13 because their costs of doing business are effectively  
14 shifted elsewhere.

15 You know, Medicare is farther down this road of  
16 at least talking about and starting to implement more  
17 systematically and nationally these changes in payments,  
18 both in the Medicare managed care plans and the performance  
19 measures used there and in the ACO programs and the other  
20 pilots and initiatives that the administration is  
21 undertaking administratively. And if and when the  
22 physician SGR legislation is ever fixed, that's going to be

1 a big further shift to these kinds of more accountable  
2 payment models. And the main motivation behind that is to  
3 give -- to provide an alternative for cost control other  
4 than just squeezing down the rates and shifting the costs  
5 and getting stuck in this vicious cycle of having to do  
6 more fee-for-service payments.

7           So it may not be easy, as Alan is saying, to come  
8 up with a comprehensive way of getting Medicare, the  
9 commercial insurers, and the Medicaid programs together,  
10 but directionally, what we've talked about here is, I  
11 think, similar to where Medicare is already heading and  
12 where many of the commercial plans are heading as an effort  
13 to avoid restrictions and reducing provider payment rates  
14 and things like that in order to keep costs down.

15           CHAIR ROWLAND: Well, I thank you for giving us  
16 such a broad and wide-ranging discussion that I think  
17 leaves a lot of room for continued thought and action by  
18 the Commission. And I'm going to ask you -- I mean, I  
19 think one of the things we are very interested in is  
20 knowing what kind of metrics would be important to measure,  
21 and one of our charges is to look at what data and  
22 information states should have and be developing. And so

1 if you have further thoughts around what we might do to  
2 stimulate in the short term through our recommendations  
3 better investment in both the data and the performance  
4 measures, we would appreciate receiving that so that we  
5 could act further on your wise counsel. But thank you both  
6 for coming today.

7 DR. McCLELLAN: Thank you, and we'll follow up  
8 with Anne on that.

9 CHAIR ROWLAND: Great. Thank you.

10 And now, since we're talking about states and  
11 state capacity, one of the issues that we have had on the  
12 Commission's agenda is do states have administrative  
13 challenges and the administrative capacity to move forward  
14 on many of these kinds of reforms, and we sponsored a  
15 roundtable on that, and I'd like Moira to come up and  
16 review that with us.

17 And think about performance measures and a  
18 state's ability to implement those as you talk.

19 **### Session 11: THEMES FROM ADMINISTRATIVE CAPACITY**  
20 **ROUNDTABLE**

21 \* MS. FORBES: All right. Good morning. Yes, that  
22 last session was a very good setup to this.

1           So I'd like to give an update on our  
2 administrative capacity work. In our June 2014 report to  
3 the Congress, the Commission included a chapter on  
4 administrative capacity, and that chapter, just a quick  
5 recap since some folks are new.

6           We covered the range of responsibilities that  
7 states have, some of the challenges they face in meeting  
8 the regulatory requirements, improving quality of outcomes,  
9 and integrating Medicaid and CHIP into sort of larger  
10 delivery system reforms.

11           We also talked about the innovative approaches  
12 developed by states and CMS and private organizations to  
13 help states strengthen Medicaid administrative capacity.

14           We noted that while there is certainly a general  
15 consensus that Medicaid, as a large public program, should  
16 be seeking value and seeking high performance, there were  
17 few clear standards to assess these objectives and little  
18 evidence on best practices.

19           So we noted the next steps for MACPAC would be to  
20 examine how administrative performance should be measured  
21 and identify which strategies are most effective in helping  
22 states to develop that capacity.

1           To help inform those activities, we convened a  
2 roundtable of experts to gain insight on the needs of state  
3 Medicaid agencies and identify some additional  
4 opportunities and strategies to develop capacity.

5           We invited a diverse group of experts to come to  
6 MACPAC's offices here in D.C. for a day earlier this month.  
7 The group included current and former state Medicaid  
8 directors and CMS leaders, representatives of other large  
9 public purchasers, such as the Federal Employees Health  
10 Benefits Program, consultants and researchers, performance  
11 measurement experts, and representatives from organizations  
12 such as the Medicaid Leadership Institute.

13           And Trish was one of the participants, and I  
14 don't know if you wanted to -- I know, unfortunately, there  
15 was weather, and a few of the folks had to actually be on  
16 by phone, couldn't make it to D.C. that day, and Trish was  
17 trapped under the snow in Maine. But I don't know from the  
18 part -- that you were able to hear, is there anything you'd  
19 like to share?

20           COMMISSIONER RILEY: The part that I was able to  
21 hear, I did participate, and Judy Moore was also there and  
22 had some very focused comments, I thought. But I thought

1 it was a challenging conversation and kind of went in  
2 circles a little bit, and I think the issue of measurement  
3 is a really tough one, and we can tell from at least the  
4 part of the conversation I heard that people really  
5 struggled with -- is that the place to focus our attention.

6 MS. FORBES: We met for a full day. These are  
7 the questions that the group was asked to focus on, and we  
8 did have professional moderators. MACPAC staff were just  
9 observers to the conversation.

10 In the morning, we focused a lot on the state  
11 strategies for recruitment and staff development. We've  
12 heard a lot about how hard it is to staff a program,  
13 especially when you're trying to pursue innovation. We  
14 talked about the different approaches states and other  
15 organizations have taken to develop or supplement state  
16 capacity, and in the afternoon, we actually spent a lot  
17 more time talking about performance measurement  
18 specifically, and we also discussed the federal role sort  
19 of broadly as well as MACPAC specifically, that  
20 participants talked about current federal efforts to help  
21 states and their suggestions for what might be done in the  
22 future.

1           In the morning, the group discussed staffing.  
2     There was a lot of discussion about the different types of  
3     staff needed to run an effective Medicaid program, not so  
4     much the specific skill sets needed, but more the sort of  
5     mix of leadership and management and frontline staff, and  
6     the differences in how you recruit and you train and you  
7     retain and you develop staff in each of those groups.

8           The participants, again, they represented a sort  
9     of diversity of perspectives, but they talked about a lot  
10    of different ways that states can get access to the breadth  
11    and depth of staff that they need to run a program. They  
12    talked about different measures to recruit, to train. They  
13    talked about hiring contractors to fill specific skill  
14    needs or to provide surge capacity. They talked about  
15    partnering with state universities. There was sort of a  
16    large menu of alternatives for states that are trying to  
17    get the expertise and the levels of staff that they need to  
18    be effective.

19           The group did talk about frontline workers a bit,  
20    which is not something that the Commission focused on a lot  
21    in our chapter last year, but certainly, with all of the  
22    changes that have happened in eligibility processes and

1 policies over the last couple of years, the role of the  
2 frontline worker is very important. They talked about  
3 strategies to involve frontline workers more in identifying  
4 opportunities for performance improvement and then  
5 implementing those, both as a mechanism not just to improve  
6 the program, but to help with the morale and with retention  
7 and with identifying future leaders. So that was an  
8 interesting sort of part of the conversation.

9           What we heard from the discussion is that there's  
10 a lot of models in the states to address all of these  
11 issues, and there's a lot of lessons that we can learn  
12 about what works in what context and in what circumstances.  
13 What we did not hear was sort of a consensus on an approach  
14 that would be applicable nationally. There's a lot of  
15 variation in the states.

16           We certainly heard that additional federal  
17 support for things like training, maybe expanding the reach  
18 of the Medicaid Integrity Institute, things like that would  
19 be welcome, but the group didn't come to some sort of  
20 consensus on this is the model that every state should be  
21 encouraged to adopt. There's a range of things that states  
22 have found to be effective, and publicizing those but not

1 necessarily requiring or incentivizing any single strategy,  
2 I would say was the takeaway from that, from the morning.

3           The group spent a good portion of the afternoon  
4 discussing performance measurement and how we can measure  
5 Medicaid performance for accountability improvement. This  
6 really echoes the conversation that we just had.

7           The participants identified a number of different  
8 dimensions in which performance measurements are important,  
9 and they sort of bucketed it into the day-to-day Medicaid  
10 operations, how quickly and accurately a state processes  
11 eligibility applications or how quickly and accurately a  
12 state processes claims.

13           They talked about the measures that you want to  
14 have as a purchaser of health care services, the quality  
15 and outcome measures, the percentage of kids that are fully  
16 immunized or the percentage of people who are admitted as  
17 an inpatient and then readmitted within 30 days of  
18 discharge.

19           And then they also talked about sort of metrics  
20 around Medicaid's strategic goals or Medicaid's role in  
21 seeking value, and some of the metrics that were identified  
22 were things such as the proportion of payments that are

1 made on the basis of value rather than volume or the  
2 proportion of payments for long-term services and supports  
3 that go to services provided in the home and community as  
4 opposed to services that are provided in an institution.

5           However, outside of -- and again, this echoes  
6 what we just heard -- outside of HEDIS and the core adult  
7 and child measures that CMS has been working on for the  
8 past few years, a lot of what folks were talking about were  
9 very state-specific measures that either the state itself  
10 has chosen to measure and report or requires its  
11 contractors to measure and report or that CMS has tied to a  
12 specific waiver or to a specific grant or initiative. We  
13 didn't hear about a lot of consensus around national  
14 measures.

15           The group did talk about the challenge of  
16 comparability among states and comparing states. Some  
17 raised the concern that if states do use consistent  
18 measures, they are going to be compared to each other and  
19 they are going to be stacked up. What folks in the  
20 roundtable sort of suggested was that part of developing  
21 measurement, sort of consistent measurements from Medicaid,  
22 is also developing a way to allow for appropriate

1 adjustment for the differences among states, who they  
2 cover, what they cover, that sort of thing, that that  
3 context is really an important part of having a measurement  
4 system. And there were several people in the room that  
5 definitely emphasized that point.

6 I would say we heard agreement among the  
7 participants that consistency in performance measurement is  
8 preferable to inconsistency, but we did not hear agreement  
9 around how we should get to those measures. There were  
10 some folks who very strongly believe that this should come  
11 up from the states, that they are in the best position to  
12 know what to measure and how to get that done. There were  
13 some folks who said this is the appropriate role for CMS:  
14 they have the national perspective, they've got the  
15 resources to invest in coming up with a measure set. And  
16 there were some folks who said the private sector, the  
17 research community, if they had good data, they can go out  
18 and really look at it and think about what should we  
19 measuring, what should we be focusing on. We did not hear  
20 consensus from the participants around how to get to the  
21 bidders.

22 So a lot of the --

1           CHAIR ROWLAND:  Maybe that's an area that MACPAC  
2 can try and give some guidance.

3           MS. FORBES:  That would be good, and I will come  
4 back to that in a second.

5           At the end of the day, we asked about federal  
6 policy opportunities, and I should point out that Judy  
7 Moore was one of the experts we had in the room, and  
8 several times, she kept trying to get the group to come  
9 back to what can MACPAC do or what can the federal  
10 government do.

11          CHAIR ROWLAND:  For the new members, Judy Moore  
12 is a retired member of MACPAC.

13          MS. FORBES:  Yes.

14          CHAIR ROWLAND:  She had this issue as one of her  
15 main issues while she served as a Commissioner.

16          MS. FORBES:  And she had been at CMS and was one  
17 of our experts for bringing that perspective.

18          What the discussion came back to when the group  
19 talked about the federal policy opportunities, one of the  
20 things that the participants sort of kept raising was this  
21 issue that Medicaid -- they acknowledged that Medicaid is  
22 jointly administered and funded by the states and the

1 federal government but pointed out that the states have  
2 tremendous flexibility in how they design and operate their  
3 programs.

4           And it's very difficult to define high  
5 performance in terms of access or quality or efficiency,  
6 given the enormous variation in coverage and payment and  
7 state organization and delivery systems. But in the  
8 absence of consistent measures of performance, of course,  
9 it's difficult for states or the federal government to know  
10 how any state's performance stacks up against other states  
11 or to determine which state structures and policies are  
12 effective.

13           So this is a challenge for some of the other  
14 potential federal policy opportunities that the group  
15 identified, which included providing a federal  
16 clearinghouse of effective practices, hoping to create the  
17 justification or I guess the business case for investment  
18 in administrative capacity, providing bonuses as an  
19 incentive for states to improve performance or achieve high  
20 level of performance, having a way to measure that  
21 performance as an underpinning to all of those policy  
22 solutions that the group identified.

1           Again, this echoes an earlier conversation and  
2 what we heard last month from the folks who reported on the  
3 Medicaid Listening Institute.

4           I know that we often fall back on anecdotes about  
5 which states are high performing. It was a struggle when  
6 we were working on the chapter last year. A lot of the  
7 information we have is based on stories about the outliers  
8 that were at one end of the performance spectrum on the  
9 other, but we don't really know where most states fall.

10           So while MACPAC has certainly highlighted a lot  
11 of these challenges in data and measurement, we have put a  
12 spotlight on this, there's still not much for anyone to  
13 work with. So in terms of follow-up from the roundtable  
14 and what I would sort of ask the Commission, is there  
15 something we can do to further this discussion? Is there  
16 any work, particularly in the area of the performance  
17 measurement, which might help move the conversation from  
18 "this is a problem" to "is there something that someone can  
19 do"?

20           CHAIR ROWLAND: Thank you.

21           Trish, then Sharon, then Andy.

22           COMMISSIONER RILEY: It's sort of where I was

1 left with the Alan and Mark discussion, thinking about the  
2 sort of fundamental rethinking. I wanted to ask the  
3 practical question of even if we could do the shared  
4 savings, where's the capacity in the state to stop, think,  
5 thoughtfully approach this? We don't reinforce that. We  
6 don't pay for that. We don't allow that to happen. So any  
7 kind of major reform becomes a full employment program for  
8 consultants, which is not a bad thing, and you certainly  
9 need them, but it strikes me that there is a very rich area  
10 for MACPAC here, both in bringing all the parties together  
11 around measurement, of which I think is less a priority,  
12 then real investment in training and support for the  
13 management of Medicaid agencies, with the recognition that  
14 Medicaid directors turn over every two years. You've got  
15 to build real capacity within those agencies.

16           We build capacity to go after fraud and abuse,  
17 and we don't build the same capacity to help states  
18 administer themselves, and it seems to me recommendations  
19 around a congressional activity and change in the statute  
20 that would have a parallel activity to the fraud and abuse  
21 work at the 90-10 with the college of fraud and abuse -- I  
22 forget what it's called -- and the sort of equivalent on

1 the administrative side is where we should put our eggs in  
2 that basket and less so in measurement, although I do think  
3 it's an appropriate role for us to bring all those parties  
4 together and begin to look at that.

5 CHAIR ROWLAND: Sharon.

6 COMMISSIONER CARTE: Moira, I thought the  
7 comments on the slide you have for what the MACPAC heard  
8 about staffing are kind of interesting, and they seem to  
9 belie what we hear informally from states and Medicaid  
10 officials, where you say they have many options to get  
11 access to the breadth and depth of expertise needed, but  
12 it's just been my experience and observation that just  
13 oversight of managed care, for example, takes a lot of  
14 expertise, very specialized expertise.

15 I heard the Deputy Commissioner for the State of  
16 Virginia, for example, say in conferences, national  
17 conferences, that really states need to have people, staff  
18 that have MBAs. They need to be able to read the  
19 prospectus of the company, the corporations that they're  
20 dealing with, know what those companies are doing across  
21 states. And frankly, I just do not see that kind of  
22 expertise in the states. I am just throwing it out there,

1 but I'd be surprised if more than a dozen states have that  
2 kind of expertise.

3 I've seen in my own state, Medicaid commissioners  
4 struggle with vacancy rates. Yes, they might. I mean  
5 large vacancy rates of more than 20 percent. I am  
6 disappointed in this response.

7 The other thing I wanted to ask you was if there  
8 was any discussion about Medicaid programs needing to have  
9 or wanting to have an office of an actuary or an ongoing  
10 actuarial contract.

11 In my state, the public employees program has  
12 one. The CHIP program has one, but Medicaid, the largest  
13 payer, has none. I mean, go figure.

14 MS. FORBES: So actuarial expertise was one of  
15 the specific areas that the states talked about, and I may  
16 have oversimplified. It wasn't that the folks in the room  
17 didn't say that they had struggles. It was that they did  
18 identify a wide range of ways to solve the problem, but  
19 they certainly all experienced the challenging in finding  
20 folks. Actuarial expertise was one of them.

21 I think a lot of states have hired that, but we  
22 did hear from a few states where they have had to make the

1 case to be able to get exemptions like the salary rules, to  
2 be able to hire that kind of expertise, and I think those  
3 states are -- the ones that we heard from in this meeting -  
4 - are states that have made a significant investment in  
5 managed care as a delivery system reform and used that to  
6 justify the investment and get the permission to do that.  
7 Whereas, I don't know that every state that implements a  
8 managed care program makes the whole sort of corresponding  
9 shift in how it staffs its own program that would sort of  
10 relate to that.

11 CHAIR ROWLAND: I think this goes to the issue  
12 that we have tried to work with before of what's the skill  
13 set that a state needs to either have in-house or ongoing  
14 contracts with to be able to manage Medicaid in a modern  
15 world, and certainly, we hear that there's real data and  
16 health information technology needs. There are real  
17 actuarial services needs. There's contracting health. So  
18 I think that is an area where we need to keep pushing as a  
19 Commission on, as Trish likes to say, what does it take to  
20 run a modern Medicaid program?

21 I have Andy next and then Donna.

22 Sharon, were you finished?

1           COMMISSIONER CARTE: I just wanted to add it's  
2 not only managed care. I currently have a utilization  
3 review nurse who is retiring. Just the time that it takes  
4 to recruit someone new -- and I'll be surprised if I can  
5 get someone who has her certification in doing health  
6 claims review.

7           The time and, as Trish said, to be able to  
8 thoughtfully manage and plan for your program is very  
9 dependent on your capacity.

10           COMMISSIONER COHEN: Moira, I wanted to ask a  
11 little more about who was there and whether or not -- were  
12 most of the people who were there consultants and  
13 researchers and performance measurement experts within  
14 health care or not within health care?

15           MS. FORBES: Primarily within health care.  
16 Several of the consultants -- and we had a few current  
17 state Medicaid directors, and some of the consultants and  
18 researchers who were there were former state Medicaid  
19 directors.

20           We purposely wanted to have a diversity of  
21 opinion. We had some folks who are involved in thinking  
22 about performance for public programs generally, of which

1 Medicaid is one but not the only, and we brought in folks  
2 who think about public value, like from the IBM Center on  
3 Excellence in Government, those kinds of folks, who again  
4 are not as Medicaid focused, but more thinking around how  
5 do government programs operate effectively.

6 EXECUTIVE DIRECTOR SCHWARTZ: I think this was a  
7 struggle here because we specifically tried to find those  
8 sorts of people I was only there for part of the day but  
9 among the people in the room who were sort of the outliers,  
10 the conversation kept sort of swirling back to their  
11 expertise and their ability to contribute, and I think in  
12 some ways, the folks who are Medicaid-centric, the current  
13 and former folks, kept zeroing in on something that was  
14 sort of hard to weigh in on, kept comparing themselves to  
15 the highway department. That's what we heard a lot about.

16 So I don't think we probably were as effective as  
17 we could be, although we certainly were trying just that,  
18 to bring in those other cross-sector experiences.

19 CHAIR ROWLAND: While your summary is helpful, as  
20 Marsha just raised, I think it would be more helpful to the  
21 Commission next time to also have the agenda and the  
22 participants of the roundtable included in our materials.

1 COMMISSIONER COHEN: Agree.

2 VICE CHAIR GOLD: Did the person who did this  
3 prepare a summary for you of the session that you used that  
4 would have more detail that we could look at as to what  
5 people said or not?

6 MS. FORBES: Our contractor is preparing a final  
7 deliverable. We just held this. This was like two weeks  
8 ago.

9 VICE CHAIR GOLD: Oh, okay.

10 MS. FORBES: We don't have the final deliverable  
11 yet, but we wanted to not wait another month.

12 VICE CHAIR GOLD: Sure.

13 COMMISSIONER COHEN: I am struck. This may be  
14 something that all of you have heard before, but I have to  
15 say when I heard it for the first time, I thought, "Ha,"  
16 and I have applied it in many different contexts. So there  
17 is this sort of the traditional sort of made-up tale, I'm  
18 quite sure, about if you had asked people 100 years ago,  
19 what do they really need to sort of make their work go  
20 better or more productively, they would say they needed a  
21 faster horse, and it was because they could not envision  
22 that coming along -- this was more than 100 years ago --

1 we're going to be in cars, so they were very focused on, "I  
2 need a faster horse. I need a faster horse. How can I  
3 make my horse faster?"

4           And I think sometimes it's very hard to get  
5 answers about how to improve the system from people who  
6 have very immediate sort of like needs and incentives and  
7 other things who are working within the system when they  
8 work under the constraints that they work under, and most  
9 systems are sort of, as the saying goes, designed to get  
10 the outcomes -- or get the outcomes that it was designed to  
11 get.

12           So I'm really glad that you tried to get people  
13 outside of Medicaid to sort of think about comparisons and  
14 other programs that may have faced similar challenges. I  
15 mean, basically, this is a management -- I mean, it's  
16 management issues, and it's management expertise that's  
17 probably needed, but both within the organizations and  
18 external to think about it.

19           But I am sort of struck by the last panel too.  
20 So I asked the question. God, our work on performance  
21 measurement in certain areas is just so weak and so behind,  
22 and so how do we move that along? Basically, Alan's answer

1 was you design a system that rewards it or punishes it and  
2 says if you can't measure it, you can't get any benefit,  
3 and then people will focus on it. I guess that's part of  
4 what I'm thinking. Maybe we can move things along a little  
5 bit by being crystal clear about what the outcomes should  
6 be or what the processes even should be of a Medicaid  
7 system, like really identifying the areas that are the most  
8 important and encouraging CMS or recommending or whatever,  
9 whatever we want to do, say you have to -- whatever the  
10 tools are, require, incentivize, reward, or punish if these  
11 things aren't met.

12 I feel like we are a bit circular here. We sort  
13 of have this big sense that there is a lack of capacity,  
14 but we haven't prioritized what are the most important  
15 areas, what are the biggest areas of deficit, and only once  
16 we, I think, are clearer on that can we say, okay,  
17 developing a system that makes states really focus on this.  
18 I mean, if you were going to lose one point of FMAP, I  
19 assure you the state would do something to get you a good  
20 nurse, and I'm not suggesting that that is the approach or  
21 the right sort of level of penalty, but we got to make this  
22 a bit more concrete with incentives, I think.

1           COMMISSIONER CHECKETT: Well, I'm so glad to hear  
2 that this is the start of more substantive and focused work  
3 in this area, given, I think, its great significance. And,  
4 in fact, it's linked to, you know, not just the discussion  
5 earlier today about what can we do to control the cost of  
6 the Medicaid program, but in many ways to all the work we  
7 do, because the Medicaid agencies are the ones who are  
8 making the final decisions -- along with Congress and CMS,  
9 the final decisions on how these programs work, what they  
10 focus on.

11           You know, I was so struck by Moira's presentation  
12 and a little saddened by some of it, although I think  
13 perhaps Andy's analogy is so accurate that you don't know  
14 what you don't know, and you don't know what the future  
15 could bring.

16           Last summer, I went to my 50th state -- a cause  
17 for celebration -- and I would say I've been probably close  
18 to 40 of those doing some type of Medicaid business with  
19 some hat I've worn through the years, and the range is  
20 startling. There are extremely sophisticated states. They  
21 are functioning like, you know, incredibly well-educated,  
22 sophisticated purchasers of health care. And there are

1 some that are just kind of woefully just understaffed and  
2 undereducated and under-everything.

3           So there's this huge range, and I really think  
4 that this is very important work for the Commission. And I  
5 have no solution, although I have thoughts, but I think the  
6 Commission has got to focus on something we can do to  
7 incentivize Congress and to incentivize the states -- and  
8 it may be the linking of managing the program, moving the  
9 program forward by doing that to ensure that the states  
10 have the capacity that they need. And we've talked on and  
11 off for the past couple years. I mean, is it a standard  
12 of, you know, you should have these types of functions or  
13 you should have these capabilities? But I just really -- I  
14 just think that we have got to address this. I guess I  
15 would close there, because the implications of not -- and I  
16 guess I would just close by saying I think it's sad in some  
17 ways that they couldn't get over the -- you know, we're not  
18 like the highway department and they treat us like one,  
19 although that is an issue because I've been there. But  
20 this is a really big issue.

21           And so I would just urge the Commission that we  
22 have to really dig in this year on this if we want to make

1 meaningful change in this program. Thank you.

2           COMMISSIONER GABOW: I would second that. I  
3 think it's really important for us to develop some template  
4 about what it takes to run a highly efficient, high-value  
5 program of this magnitude in Medicaid. And then I think  
6 the other part is how you then attach carrots and sticks to  
7 that is very important.

8           The other point I wanted to make relates to  
9 Andrea's comment about learning from other industries, and  
10 excuse me if I go back to my passion of lean, but, you  
11 know, at Denver Health, when we started putting Toyota  
12 production systems into health care, initially what we  
13 heard -- and we were at the front of that -- "We're not an  
14 automobile company. We are so much more complex. That's  
15 an assembly line thing. How could you possibly apply that  
16 to the operating room?"

17           Well, I will tell you, the operating room is an  
18 assembly line, and managing large enterprises, there are a  
19 lot of things that could be done by learning from a process  
20 like lean that reengineers the work flow, let's the front-  
21 line people have the power to solve problems, give them the  
22 tools to do it. And, I mean, we realized almost \$200

1 million of hard financial benefit, had the lowest mortality  
2 rate of all 117 academic health centers, and 85 percent of  
3 our employees said they understood how this helped us do  
4 our mission. It hits the target on all those things.

5           So we have to get over this issue that what we do  
6 is so unique that it can't -- that we cannot use the tools  
7 that others have used to effectively improve how we do our  
8 business. And, I mean, we really have to get out of that  
9 mind-set in all of health care and all of government, or  
10 we'll never get to hitting the target on quality, cost, and  
11 employee engagement.

12           So that's my sermon for today.

13           CHAIR ROWLAND: You know, Patty, I'm reminded of  
14 the fact that for years we were told you couldn't do things  
15 electronically in medicine, but you could go to a bank  
16 anywhere in the world and put in your bank card and out  
17 would come some money in the right denomination from your  
18 account. So I think that is a really important point, that  
19 you can't always just look inward. You have to look  
20 outward and apply other principles. But Marsha had her  
21 hand up.

22           VICE CHAIR GOLD: I'm a little bit -- I wanted to

1 see if I could clarify a little bit the discussion on  
2 performance measurement, because I think there were several  
3 concepts mixed in, and I'm not sure what they were saying.  
4 I mean, one of the issues is the operational effectiveness,  
5 and I think people here were talking about what it takes to  
6 run an effective program. And here it seems the measures  
7 for the federal government is sort of minimum expectations.  
8 I mean, if you're going to get this money, you need X, Y,  
9 or Z, or something like that, as well as whatever help can  
10 be done to help the states do that.

11 I think if one does that, one has to realize that  
12 different states will get that expertise in different ways.  
13 Some of them can use the insurance departments effectively  
14 to get actuarial skills or some managed care; others bring  
15 that in-house; some use a consultant. There are different  
16 ways to get it, and I think states need flexibility for  
17 what works for them to do it. But some minimum  
18 expectations are important.

19 But I was a little bit concerned, Trish, with  
20 saying performance measurements weren't important. I think  
21 maybe what you were talking about is operational  
22 effectiveness, because the performance measurements we were

1 talking about before in the earlier session I think were  
2 less management ones as how do you create tools that can be  
3 available to states and people for measuring care for the  
4 kinds of people we need. And I see it more as a technical  
5 assistance measurement thing that ultimately could be used  
6 for accountability, probably initially within states to  
7 help them get better programs. You know, there's a whole  
8 lot of risk adjustment to compare states in terms of  
9 performance, and I see less immediate value there. But it  
10 seems that for other reasons of administrative capacity,  
11 those things, a lot of states don't have the capacity to  
12 develop it alone, and there are a number of areas where it  
13 was -- it's important that some central people, whoever  
14 they are, help do things.

15           And so I was a little bit concerned with why you  
16 thought performance measurement wasn't -- I mean, was it  
17 just that you were talking about different performance  
18 measures or--

19           COMMISSIONER RILEY: No, I think it's a less  
20 important priority than giving the equal attention to the  
21 administrative needs of agencies that we do with fraud and  
22 abuse, that we spend money up front helping people do their

1 jobs, getting training, getting help, getting assistance.  
2 I think that's a much, much, much more immediate need. And  
3 I am a measurement skeptic because I think we spend so much  
4 -- not that it isn't important. It is. But we spend so  
5 much time and energy trying to come up with measures and  
6 who decides and what are they.

7           That said, I think there may well be a role for  
8 MACPAC to bring the parties together to think about some  
9 few set of measures that would really test and measure what  
10 a quality, effective, efficient Medicaid agency is. But I  
11 do think there's much more need up front maybe as we think  
12 about what those measures should be.

13           VICE CHAIR GOLD: To what extent are some of  
14 those problems created by state-specific authorities and  
15 labor markets and pay raises? I mean, they're real  
16 problems, but to what --

17           COMMISSIONER RILEY: But that's exactly --

18           VICE CHAIR GOLD: -- extent are there ways to  
19 deal with that?

20           COMMISSIONER RILEY: Well, 90-10 reimbursement,  
21 we give 90-10 reimbursement to go after fraud and abuse.  
22 We give 90-10 reimbursement, but very little on the

1 management and administration side and the planning side.  
2 We have very little capacity for states to go off and get  
3 training for their staffs. We have very little capacity to  
4 do data analytics. We spend almost no attention on sort of  
5 the nuts and bolts of how do you manage these enormous  
6 systems.

7 CHAIR ROWLAND: Let me ask you, Moira, when Chuck  
8 and the other Medicaid directors came and talked with us,  
9 one of the things they did raise was the fact that the FMAP  
10 was unequal and that the administrative match is just 50  
11 percent. They also talked about whether statutory language  
12 that would allow them to go around hiring practices and  
13 reimburse at a higher rate for certain kinds of skill sets  
14 could be included. Were those topics discussed at this  
15 forum?

16 MS. FORBES: The participants mainly focused on,  
17 to sort of Marsha's point, the state-specific flexibilities  
18 that they have been able to get in place and the challenges  
19 around -- it was more around state pay rules and, you know,  
20 state capitals being located in undesirable places. I  
21 think a lot of the things that they brought up were not  
22 areas where -- they didn't speak so much to those kinds of

1 areas where a difference in the federal incentives might  
2 matter.

3 COMMISSIONER RILEY: Well, but all the more  
4 reason -- all the more reason, exactly right, because  
5 Augusta, Maine, is not an attractive place. Lansing,  
6 Michigan, may not get the same people that Boston does.  
7 But all the more -- Jefferson, Missouri. But all the more  
8 reason to have the capacity to have a College of Medicaid  
9 Knowledge. You know, we've got a place where people can go  
10 to learn how to go after fraud, but we have no place where  
11 people can go to prevent it.

12 CHAIR ROWLAND: I think that that's an important  
13 point, and I think looking at the match issues are part of  
14 what we as a Commission recommending to Congress -- those  
15 are steps Congress can take to try and improve the  
16 resources. states may have many work-arounds they can use,  
17 but I think our responsibility is to say what impediments  
18 are there at the federal level that keep states from being  
19 able to develop the capacity they need.

20 COMMISSIONER COHEN: Can I just make a pitch,  
21 though? Again, channeling maybe Alan Weil and Mark  
22 McClellan. We can say that -- we can point out that the

1 match rate is unfair, and we can say that the match rate  
2 should be different and states would, you know, have more  
3 money available to hire. But in this day and age, would we  
4 not be making a better, a stronger kind of case to Congress  
5 if we said here are -- do this in a package that says  
6 here's five measures that go along with it and show us that  
7 you're going to do better on those. In other words, link  
8 extra money to some outcome that we help to identify, and  
9 by -- or measure that we help -- and by identifying what  
10 the priorities are, it feels a little bit less like just,  
11 you know, a cost shift from one government entity to  
12 another. And I'm not saying there's anything wrong with  
13 that, but to something that you can show there will be a  
14 value add at the end of it as opposed to just a cost shift.  
15 And I feel like that's something that potentially we could  
16 do, at least identify the areas of priority or the areas of  
17 substandard performance that could be linked to a bump in  
18 payment, instead of just talking about the bump in payment.

19 EXECUTIVE DIRECTOR SCHWARTZ: And I believe that  
20 the match rate -- and I'm probably going to get myself in  
21 trouble here, but Moira can bail me out. On the  
22 eligibility and enrollment information systems, it was not

1 just report your expenditures on that line item, but it  
2 must have these types of criteria. Correct?

3 MS. FORBES: Yes, there were characteristics --  
4 they did more to tie the additional match for updates to  
5 eligibility systems to specific standards that those  
6 systems had to reach, in terms of interoperability and  
7 being modular and things like that, where previously money  
8 had not been tied to sort of quality goals like that.

9 CHAIR ROWLAND: Or like the CHIP performance  
10 bonuses.

11 COMMISSIONER CHECKETT: You know, in the vein of  
12 just brainstorming and as part of this discussion -- and I  
13 think we've talked in the past, but saying these are the  
14 skill sets, now you can get them through consultants, you  
15 can get them through staffing, we don't so much care where  
16 you get them, but these are the things that any entity that  
17 is responsible for managing the care of, you know, millions  
18 of people and the costs of their health care, these are the  
19 skills and functions you should have. And I think, you  
20 know, in a report to Congress or some type of brief or  
21 something, I think that could be of value.

22 Frankly, I was meeting with legislators in one

1 unnamed state, and they actually asked for that, because  
2 they were saying, "Is there anything like that?" Because  
3 they're trying to figure out why they're having trouble  
4 managing their Medicaid program.

5           And, you know, it is surprising in some of the  
6 states just the lack of sophistication -- not surprising,  
7 but the lack of sophistication. Why? Because this health  
8 care industry has grown so quickly. You know, in the  
9 company I work for, it's a race for talent. We can't hire  
10 fast enough the brightest, best people that we would like  
11 to have because everybody else is trying to get them. So,  
12 you know, a state Medicaid agency trying to compete with  
13 that is just very challenging.

14           So I think a service could be done. I love  
15 Andy's idea about even linking it, but I'm in the more  
16 basic of I think we just need to educate lawmakers, state  
17 and federal level, and others, this is the basics of  
18 running a program this big, because I can assure you, many  
19 states are not there.

20           CHAIR ROWLAND: I'm sorry Chuck had to leave,  
21 because I also remember him saying that every Medicaid  
22 agency was a training ground for the consultants who came

1 back and charged seven times as much to work for them.

2 MS. FORBES: And one of the roundtable  
3 participants suggested that that was a recruiting tool.  
4 Tell them it's their golden ticket.

5 CHAIR ROWLAND: Okay. Well, this has been a  
6 great conversation, and I think this is clearly an area  
7 where the performance standards, the training, the  
8 capacity, a lot of good ideas here, but this has to be an  
9 area where we continue to focus. So thank you.

10 And now if there's anyone from our audience who  
11 would like to offer any comments, please feel free to come  
12 forward.

13 **### PUBLIC COMMENT**

14 \* MR. JONES: Hello. Good morning.

15 CHAIR ROWLAND: Good morning.

16 MR. JONES: Hi. My name is Tim Jones. I'm the  
17 Director of Government Relations at Altegra Health. Our  
18 company helps Medicare Advantage, low-income beneficiaries  
19 enroll into Medicare savings programs. We act as an  
20 authorized representative. And so I'm sorry I wasn't here  
21 to comment at the end of the day yesterday. I had to leave  
22 early. But I just wanted to go back to your session

1 yesterday and thank the staff and the Commissioners for all  
2 of your interest yesterday in highlighting some of the  
3 difficulties associated with enrolling low-income  
4 beneficiaries into Medicare savings programs.

5           As you may remember, a couple months ago we sent  
6 a document for your review that highlights some of these  
7 issues. So we're happy to work with you in whatever way  
8 possible moving forward on this issue, because at the end  
9 of the day I think we're all committed to helping those who  
10 are eligible but not yet enrolled enroll in these programs  
11 as efficiently as possible.

12           Thank you very much, and have a good day.

13           CHAIR ROWLAND: Well, thank you, and please  
14 continue to share any information with the staff and with  
15 the Commission.

16           Now, with that, we will adjourn this meeting, but  
17 I want to remind everyone, especially the Commission  
18 members, that the next meeting is March 24th and 25th.  
19 That is a Tuesday and a Wednesday, not a Thursday and a  
20 Friday, so please come on Tuesday and Wednesday. And it is  
21 going to be held at the Washington Convention Center, so  
22 please don't come to NGAUS. Please go to the Washington

1 Convention Center.

2 EXECUTIVE DIRECTOR SCHWARTZ: We will remind you  
3 multiple times by e-mail, but just the more times we can  
4 reinforce that, maybe your motor reflexes will put you in  
5 the right place.

6 [Whereupon, at 11:40 a.m., the meeting was  
7 adjourned.]

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