Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

Hall of States
National Guard Association of the U.S.
One Massachusetts Avenue, NW
Washington, D.C. 20001

Thursday, April 11, 2013
10:38 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
RICHARD CHAMBERS
DONNA CHECKETT, MPA, MSW
ANDREA COHEN, JD
BURTON L. EDELSTEIN, DDS, MPH
PATRICIA GABOW, MD
DENISE HENNING, CNM, MSN
MARK HOYT, FSA, MAAA
NORMA MARTINEZ ROGERS, PhD, RN, FAAN
JUDITH MOORE
TRISH RILEY, MS
ROBIN SMITH
STEVEN WALDREN, MD, MS

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

Session 1: Adult dental services under Medicaid 3
Terry Dickinson, DDS, Executive Director, Virginia Dental Association 4

Mina Chang, PhD, Chief, Health Research and Program Development,
Ohio Office of Medical Assistance 9

Paul Glassman, DDS, MA, MBA, Professor of Dental Practice, Director of Community
Oral Health, Arthur A. Dugoni School of Dentistry at the University of the Pacific 14

Session 2: Draft June report chapter on primary care payment increase

Ben Finder, Senior Analyst 40

Session 3: Draft June report chapter on waivers

Chris Peterson, Director of Eligibility, Enrollment and Benefits 55

Session 4: Draft June report chapter on maternity care in Medicaid and CHIP

Amy Bernstein, Senior Advisor 74

Session 5: Draft Report chapter: literature review on access for people with disabilities

Anna Sommers, Director of Access and Quality 100

Session 6: Draft June report chapter on program integrity

Moira Forbes, Director of Payment and Program Integrity 114

Session 7: Draft June report chapter on data

April Grady, Director of Data Development and Analysis 128

Public Comment Day1 138

Adjourn Day1 141

Day 2 142

1 P R O C E E D I N G S [10:38 a.m.]

2 CHAIR ROWLAND: Could the Commissioners please reconvene? I am pleased to open this
3 session of the Medicaid and CHIP Payment and Access Commission.

4 We have been looking at a number of issues that involve the way in which individuals covered by
5 the Medicaid program gain their access to services, and one of the services that we have been most
6 concerned about and are glad to have this panel today involves oral health and the access to care for
7 especially children, as well as adults enrolled in Medicaid, although I think we are going to focus today on
8 some of the issues regarding adults.

9 So I am going to turn it over to Lois Simon to open this discussion and introduce the wonderful
10 panel that we have to share their views with us today. Lois?

11 **### ADULT DENTAL SERVICES UNDER MEDICAID**

12 * MS. SIMON: Thank you, Diane, and good morning.

13 At an early Commission meeting, we had a session on advancing children's access to dental services.
14 As Diane said, today we will be focusing on issues related to oral health services for adults enrolled in
15 Medicaid.

16 We have heard numerous times over the past few years, particularly from Burt, about the connection
17 between good oral health and good overall health and well-being. Even so, oral health coverage is an
18 optional service in Medicaid and, therefore, subject to wide State variation and instability over time. This
19 has led to an enormous amount of unmet need and significant numbers of individuals who seek care for
20 avoidable dental problems and hospital emergency rooms. Also of concern are the difficulties that
21 individuals with disabilities and the elderly may encounter when trying to access care in dental offices.

22 To kick off a discussion on the challenges and opportunities for improving access to dental services
23 to the Medicaid adult population, we have assembled a panel of experts who will provide their perspectives

1 on the topic and will highlight some promising program interventions.

2 Our first speaker is Terry Dickinson, executive director of the Virginia Dental Association. He will

3 discuss the consequences of poor oral health and the Medicaid program and its enrollees.

4 Dr. Dickinson will be followed by Dr. Mina Chang of Ohio's Office of Medical Assistance. She

5 will speak about an intervention in the Cincinnati area designed to reduce avoidable dental visits in the

6 emergency department by the Medicaid population.

7 And, lastly, Dr. Paul Glassman of the Arthur Dugoni School of Dentistry in San Francisco will

8 discuss issues related to delivering dental services to persons with disabilities, and he will share details on the

9 Virtual Dental Home, an exciting pilot program liking allied dental providers in community settings with

10 dentists via telehealth technologies.

11 So I will now turn it over to Dr. Dickinson.

12 * DR. DICKINSON: Good morning, and thank you for allowing us to share some information

13 with you today.

14 I have labeled this, "The Good, the Bad, and the Ugly" because having an optional benefit for dental

15 adults' Medicaid coverage, there are some good things about the program that we have seen, but there are

16 some bad things, and there are some ugly things. So we are going to talk about each of those as we

17 proceed.

18 You know, this is not Haiti or the Congo or Guatemala. This happens to be in far southwest

19 Kansas. This is the current adult dental Medicaid program, far too many instances across the country.

20 That people that are adults that will stand in blowing snow to be able to see a dentist to get a tooth taken

21 out is simply not acceptable anymore, in my opinion. And if we continue by our actions or inactions to

22 allow this to happen, I think it is immoral and unjustified.

23 Too often I have seen people stand in line for more than one day to access dental coverage. We

1 have seen over 50,000 patients in Virginia alone. This just doesn't happen in Kansas. It happens all
2 across this country, and we must concentrate our energies and our resources in a better way to allow us to
3 make a difference.
4 So when we look at the percentage of adults with any dental visits by income, it is pretty apparent
5 that a number of things affect whether people access the system or not. In the adult system, you can see
6 that the numbers are way low simply because of income.
7 Now, if I put up there not only the poverty factor but race, geography, education, and whether they
8 have insurance or not, or if they have medical insurance, all of which affect them accessing the system as we
9 currently know it. So if the parents, for instance, have medical insurance, they will access the dental system
10 at a higher rate.
11 Now, of course, if adults are an optional service, it is still not going to help them. It will help their
12 children, but not let them.
13 This is what it looks like. You saw it in the snow. This is at an airport down in southwest
14 Virginia in 2000. These folks stand out in the sun to get that tooth out or get a filling or get their teeth
15 cleaned or whatever. So we have done 64 of these projects and have seen almost 50,000 people.
16 You know, if you look at that line, some 70 percent of those people in that line, somebody in that
17 family has a full-time job. It is not that they're not working. It's simply that the jobs that they get do not
18 have benefits. Consequently, that is how they spend their weekend. So we have provided over $30
19 million of care. It has now expanded to 26 other States.
20 Now, is that good news or bad news or ugly news? One thing I don't want you to walk away from
21 here, that this is a health care system that works. This is not. This is an acute-care, mobile unit that
22 provides care to people that simply have no other access. But it is not -- and I emphasize that -- it is not a
23 solution. It is a temporary fix, that is all. These folks deserve more.

1 And I guess the question you have to ask, is this the health care system that you want for this
2 population? I would hope not.
3 So when looking at the states -- and this is the closest I can get from 2012. If you look at 2002,
4 obviously 13 states had full services. Today, none. Limited services, 13; today, 26. So what has
5 happened is those states that had the full services have transferred -- they started dropping benefits or
6 maximum services in some type and have put them into limited services. Emergency services stayed the
7 same. That is what we have in Virginia. No services at all, eight states. That has pretty stayed the same.
8 So when we look at the number of adults with unmet dental needs by income, we see a similar
9 problem compared again to the poverty level. And think about all the things I told you earlier about the
10 various parts, whether they have insurance, whether they have the finances, a geography, education. All of
11 these things have an effect on it. But it's very clear that the people that live at or below the federal poverty
12 level struggle, the adults struggle to get that needed care.
13 So challenges for success. To take a program -- and I'll use Virginia's program because I'm familiar
14 with it. These are the challenges that our providers face in establishing a great Medicaid program.
15 Payment is a critical key. We know that if you increase reimbursements, you increase provider
16 participation.
17 Administrative challenges, trying to find somebody on the phone that can answer your question.
18 The paperwork. I mean, when we started this changeover in 2003, I wouldn't have filled out the
19 paperwork simply because it was so cumbersome and so long. That has been all streamlined.
20 The patients in and out of the system, we had no way of accurately verifying whether they were
21 eligible or not. You'd call one day; they'd be eligible. The next week they're gone. But you couldn't find
22 that out, so you do the treatment, and they'd deny the payment.
23 Preauthorization. It was a cumbersome system, again, that you had to get preauthorized before

1 you could do the majority of the services. So that added to the paperwork and the frustration, and that's
2 provider frustrations.
3 Literacy and education. Again, it comes down to how do you communicate messages that get
4 people to have behavior change. And we struggle with that.
5 No-show rate. Most of the offices in Virginia, we get about a 35 percent no-show rate. So even
6 though you offer a benefit, we still struggle with the no-show rate. But we are working on it. We are
7 reporting those. They're getting follow-up calls by our folks that administer that program, and it is getting
8 better.
9 And we also have to educate our providers that they're part of the solution, and they have to be
10 there, and they have to be involved.
11 This is what happens in a program when it's mandated and you intentionally take the steps that you
12 have to take to change a program that's dysfunctional into one that is functional. And so when it was --
13 the changeover you can see is pretty close to 2005. It took us two years, because we also had to have
14 legislation to make a better program. So everyone gathered around the table to try to make something that
15 was going to work for everybody with the central goal of what are we here for if we're not here for these
16 kids, to take care of these kids. The same thing can be done for adults. It has to be intentionally done,
17 and it has to be mandated.
18 When I went to the first NGA dental Medicaid conference -- and it was in the early 2000s -- a group
19 of us from Virginia went to that meeting. We're sitting there, and we're looking around at some of these
20 other tables from other states. And we noticed that a lot of those states had legislators, somebody from
21 their health department, somebody from their secretary of health's office, or whatever. We had nobody.
22 We had nobody. So here's a group of dentists and other people that are interested in making changes in a
23 system, and we had nobody to talk to. That's different today, but it was through intention that it

1 happened. You can't just expect it to happen serendipitously. You have got to make it happen. We
2 made it happen.
3 So when you look at -- let me get mine where I can read it. This is our adult system today. When
4 we started in 2006, we saw around 3,000 people and spent $650,000 plus. And today 36,000, almost
5 37,000 people, $11 million in care. We call that "forceps success," because that is all it is. It is taking
6 teeth out.
7 The thing that scares me, because success in a program like this also creates fear, because I sit and
8 look at those numbers, and you know what I'm afraid of? That some legislature, when they're cutting the
9 budget, is going to look at that growing number and decide to add us to the state that has no benefit. So
10 it's not just all about success, but sometimes success brings the chance of failure. So we have to be very
11 careful with it and spend our dollars wisely, and we intend to do that. But I am concerned that as the costs
12 of the Medicaid system go up, they're looking at services to cut. We're an optional service. It's pretty
13 easy to knock that $11 million off. So you've got to educate the policymakers.
14 You know, we see a lot of patients at these projects. I'll tell you about a couple of them. And the
15 point is, you know, why insure a kidney or a toe over oral health?
16 We had a patient that came to us at one of these projects consistently with uncontrolled diabetes,
17 350 to 400 blood sugar. That is not healthy. That creates a lot of long-term systemic problems for those
18 folks. We over a period -- we entered him into this, but we had to finish it up in a private office. We just
19 got a dentist to finish the treatment because we felt like it was so important to complete that treatment.
20 That patient, now their average blood sugar runs around 90. Nothing else changed. All we did was took
21 the infection out of their mouth. So those inflammatory mediators, anything that is associated with that is
22 going to cause a systemic problem.
23 So now the guy, I mean, he writes us a letter and says we saved his life. Whether we did or not, I

1 don't know. All I know is their internist was very impressed that just taking bad teeth out and creating a
2 healthy environment for their gums, all of a sudden that uncontrolled diabetes is now controlled.
3 So there's story after story about this, the systemic connection, and that we all have to be aware of it.
4 So it's not the cost that you're paying for the tooth when they end up -- and Mina is going to talk about the
5 emergency room. But it's the systemic causes of the diseases that are costing us so much money that
6 would have cost a tenth to do the dental treatment as a mandatory service than waiting until they end up in
7 an emergency room or in a hospital.
8 So optional enhances and exacerbates a systemic disease. It creates a burden on ERs. It creates a
9 less effective workforce. It creates a less employable workforce. It's not fair in trying to make healthier
10 communities. It creates a less ready military. It's medically inappropriate, and it destroys hope.
11 Sometimes that's all these people have is hope.
12 Thank you.
13 * DR. CHANG: Thank you. Good morning. Thanks to the Commissioners to invite me to
14 speak with you.
15 CHAIR ROWLAND: Could you pull the microphone a little closer?
16 DR. CHANG: Yes. Thank you for inviting me to speak with you about this initiative that we did
17 in Ohio called IMPROVE. Today I will focus on one specific intervention. It looks like there's some
18 issue, but it's all right.
19 So it was an initiative we did to improve or reduce avoidable ER visits by the Medicaid population,
20 and Fast Track Dental Referral is one of the five of the initiatives. And I'd like to point out, this is an
21 approach that takes on community collaboration. The community would identify the issues in their
22 respective community and also develop solutions. As you know, health access issues are different, and you
23 shouldn't address it as one size fits all.

1 So there are two key features of our quality improvement effort. It's an 18-month rapid-cycle
2 quality improvement. The beauty of it is that the group can continue to fine-tune their intervention until
3 they find it's useful and that it will work before they spread it to a larger scale, so it is more cost efficient, so
4 you don't need to wait for three years to find out your quality improvement research has now worked.
5 The second distinct feature is that all the issues and solutions are patient centered, so it's not from a
6 doctor's perspective why the patient goes to the ER for their dental fix. It's from the patient's perspective.
7 And this allows us to understand, as you know, the Medicaid population and their subpopulation.
8 Oftentimes medical care is not the first thing every day they get up in their mind. It's how to put food on
9 the table or even have a means to go to see the doctor in the next two weeks. So this really allows us to
10 look into what are the issues those patients encounter.
11 So there is a strategy how to make this approach work. First of all, it needs to be a large
12 population that are homogeneous, so the reason is that it warrants a quality improvement intervention.
13 And those interventions and health status need to be actionable, meaning that we can make an impact.
14 There could be an illness at the end stage that you may really not be able to do any impact. So those are
15 the key factors when you develop those strategies.
16 There needs to be practical solutions, so don't wait for three years the EMR come up and running to
17 do this. Look for what resources that we can do as a community.
18 There are several features that you can use to identify a homogeneous population such as diagnosis,
19 those with a similar diagnosis; age group; day of the week they visit the ER; or potentially ethnic
20 background.
21 So one of our five regions, in southwest Cincinnati urban center, identified that they would like to
22 address this. It's inner-city/urban dental hot spot issues, meaning that we would like to focus on the
23 Medicare managed care population that have dental coverage, that they go to the ER for their dental fix.

1 And those ERs are located in the inner city.

2 So we asked, we interviewed the patients to find out what are the deciding factors for them to go to
3 the ER for their dental fix, and we see the foremost reason -- many of those reasons are not surprising, but
4 it's very revealing. The number one reason is toothache, and I personally have a very low tolerance of
5 aches, pains, especially dental aches, so I can associate those kind of urgency.

6 Patients experience that the symptom is not acute, it is not overnight. They have the dental issue
7 for a long time, and the ER doctors tell us that they constantly see those patients with chronic bad teeth.
8 They come in, they put a Band-Aid on it, a quick fix, wait for the next pain attack. And the patients
9 perceive that they don't have -- it's difficult or inconvenient to get an appointment. Think about those
10 other folks who live in the inner city. Perhaps they don't have a car or even a bus ticket. You want them
11 to go across town, especially under pain, and probably have to wait for two weeks or more to get an
12 appointment. The most convenient thing to fix the issue is go to the ER.

13 And then they all perceive that they need antibiotics or some sort of painkiller. Now, there is a
14 perception those are the patients that perhaps are dependent on narcotics, so they go to the ER to get a fix.
15 But many of the patients we interviewed, they really do have dental issues, and I think one or two actually
16 had to go to dental surgery.

17 And one thing interesting is that they are not aware of their dental benefit. Those are the Medicaid
18 managed care population in Ohio has always -- we always have provided the dental coverage.

19 So based on those understandings, our regional steering committee came up with this intervention.
20 It's called Fast Track Dental Appointments. During business hours, any Medicaid managed care members
21 come to the ER for their dental issues, the ED staff would call one of the dental providers that are working
22 with us to secure a fast-track appointment, typically the same day or walk-in, so you can go immediately to
23 see a dentist. And then the ED, the Emergency Department, will forward the identifying information to

1 the appropriate managed care plan.

2 As you know, this is a population that's highly transient, even though Medicaid provides record file
3 to where those patients live, and guess what? Only 25 -- if you do well, only 25 percent you can identify
4 them. So this is a prime opportunity to pass on the contact information the same day to the managed care
5 plan so they can in turn follow up with the patient to find out, hey, did you really show up, do you need any
6 support to go see this doctor, and also see if there are any care intervention opportunities.

7 For the after-hours, as I indicated, what resources that's available, so for this intervention obviously
8 we don't have ongoing staffing after hours to do this, so then the ED staff will be distributing a card for the
9 patient, so the next day the patient will be calling the managed care plan to get an appointment.

10 So how does this work together? The most resource-intensive part of this is if you are familiar
11 with the Cincinnati area, you see the three crosses? Those are three participating EDs. Mercy Fairfield is
12 right available to the outer belt 275; the two crosses right in the center of downtown are University Hospital
13 and Good Samaritan. Across town, that's probably a 15-minute drive. But we were able to identify about
14 16 dental providers, not only they have experience in this population, they are willing to work with us to
15 open up their appointment time to taking same day. So if you look at the names, pretty much they are the
16 federally qualified health centers. They are accustomed to seeing our population, or your safety net clinic
17 in the Health Department, and our health plans were able to bring in two group providers in their network
18 to participate in this. So there were 16 of them.

19 So how do we know we orchestrate it? The resource-intensive part is to identify them and then
20 persuade them to work with us. The next step is how do we know it works and it's successful.

21 So when the ED makes the phone call to one of those providers, identify that I'm calling for an
22 IMPROVE patient, and if the clinic immediately will be able to say, "Oh, I know what you need," then
23 that's successful. It takes a lot of the communication, not only the coordination between the three EDs

1 and those test sites, as well as the managed care plans. So the lessons learned for us is ongoing
2 communication within those pockets of any site, but also internally, because there could be staff on the ER
3 that is on leave or turnover, so you need constantly to refresh those protocols. And once you have it
4 down, it's not very challenging.
5 One thing we find out -- and it's very rewarding -- is initially we thought we are not going to get this
6 down, because how are you going to have the ED that's so busy and still do the referral for you? The
7 medical director at University Hospital in the ED tells us that he felt he was so relieved. He had been so
8 frustrated for so long now that patients comes to the EDs seeking for dental care, and there's not much he
9 can do for them. Now he has the resources. I don't know if he went through the motivational interview
10 technique or not, but when you have a caring doctor and a nurse to tell you, "Hey, Johnny, you need to go
11 to the dentist right now to take a look at your teeth, and I can get you in in the next hour," I think the
12 patient feels a connection and trust and that development. So that was totally unexpected.
13 And then not only we have improved provider and consumer satisfaction, it also created a cultural
14 shift. The patients go back to where they live, and the word's out on the street, "Hey, did you know that
15 you have a dental benefit? I was able to see my dentist today."
16 So one thing that Terry mentioned earlier is the no-show. That was also a critical challenge. All
17 those 16 providers told us that they triple book and double book their appointments just to get by because
18 patients don't show up. And part of this unexpected finding, because we orchestrated appointments, so
19 they do have the appointment, and one patient showed up. So those clinics are more than happy to
20 continue to work with us.
21 So the result of the conclusion of the 18-month trial, this particular region wanted to expand into
22 their commercial population, and now one of our Northwest Region in Toledo, they are really interested to
23 expand this. They took on a different initiative, but after awhile they learned what can be done in the

1 Southwest Region, they wanted to work the same thing for their inner-city population.

2 So what says it better is Dr. Resar, part of the Help Ohio Initiative, "Sustainable solutions are

3 possible when stakeholders and community leaders are involved."

4 Thank you for your time.

5 * DR. GLASSMAN: Good morning. I'm pleased to be here. I'm Paul Glassman, as you heard.

6 I'm a full-time professor at the University of Pacific School of Dentistry in San Francisco, and I want to

7 thank my colleagues for an excellent beginning to this panel.

8 I'm going to just wind back the clock a little bit to the year 2000, in which the Surgeon General of

9 the United States produced the first and still only report on oral health in America, and one quote from that

10 report said that although there have been gains in oral health status for the population as a whole, they have

11 not been evenly distributed across subpopulations. Profound health disparities -- profound, I want to have

12 that word bolded -- profound health disparities exist among populations, including racial and ethnic

13 minorities, individuals with disabilities, elderly individuals, and people with complicated medical and social

14 conditions and situations. So this has been well known and well distributed for over a decade.

15 Last year, in the year 2011, the Institute of Medicine produced its first reports on oral health. I was

16 actually pleased to be on the committee that wrote the report in green there on improving the access to rural

17 health care for vulnerable and underserved populations. Unfortunately, the findings were that things had

18 not changed very much in the 11 years between the Surgeon General's report and the time that these reports

19 were issued.

20 Some statistics, and some of which you've already heard, is that even with children who have

21 coverage, only 40 percent of them -- and that's high in some States -- actually receive dental visits, and

22 children under three years old, only about eight percent. A little bit older statistic. Fewer than half the

23 dentists in 25 States treated any Medicaid patients. I think that's misleading because a lot of the States

1 report dentists who accept Medicaid might be the dentist who sees one or two people a year. So to say
2 that half the dentists saw some Medicaid patients, the actual availability of providers is much lower than
3 that.
4 The optional adult Medicaid benefits resulted in, I think you heard from Dr. Dickinson the statistics
5 about how few States actually provide any coverage. That has lots of consequences. I just put a couple
6 on this slide here.
7 First of all,, we do know that in States where adults do not have coverage, those parents are much
8 less likely to take their children to dental offices. So actually, not having adult coverage impacts children's
9 ability to have good oral health, as well.
10 And also, there's a couple references on this slide if you wanted to look up the source of this, but we
11 also know now based on very thorough review of the literature and looking at the impact of chronic
12 diseases and oral health on chronic diseases that providing dental care for adults, particularly those with
13 disabilities and chronic medical conditions, could actually save money for States, that the money they would
14 spend on adult coverage would be offset by the reduced costs of medical conditions, particularly diabetes,
15 and you've already heard an anecdotal story about that. The literature supports that same conclusion.
16 Some of the themes from this Institute of Medicine report that came out last year was we need to
17 start thinking about dental care as a chronic disease. We don't cure dental caries by putting a filling in a
18 tooth. We don't cure periodontal disease by going to a dental office and having your teeth cleaned or
19 scaling and replaning or periodontal surgery. These are chronic diseases and we need to think about using
20 techniques of chronic disease management.
21 We need to start thinking differently about delivery systems, that many of the people who are not
22 taking advantage of the traditional system and who don't access dental care, even though they might have
23 coverage, even for children, you just heard some of the barriers that they have to receiving care. So we

1 need to think about how can we bring care to where the people are? How can we begin to use really 21st
2 century? How do we use telehealth as a technology to be able to create distributed teams? How do we
3 think about our workforce and how to get the right people in the right place? And, finally, how do we
4 drive change through an accountability mechanism that might be based on measures of health outcomes?
5 So, just to focus in for a moment on those people with disabilities and chronic medical conditions,
6 these are the most underserved of the underserved in terms of oral health. The lack of access is
7 widespread for many reasons. We don't do a great job in our dental education system of training dentists
8 to treat people with complicated situations. The location and availability of services are often not
9 something that people with disabilities who have limited mobility can access, and many other challenges.
10 Low-income means they would be eligible for Medicaid if States provided Medicaid coverage, but as adults,
11 they don't.
12 And one of the things I think is a theme that runs through a lot of the issues we're talking about
13 today is oral health is not integrated in general health services. The fact that we have optional benefits for
14 oral health, the fact that we have dental insurance and medical insurance, lots of other ways that oral health
15 is separated out from general health care, even though anybody who thinks about it realizes the mouth is
16 actually a part of the body, and if we're thinking about health care, oral health ought to be a part of that.
17 So people with chronic disabilities and medical conditions have more severe dental disease and they
18 have greater medical and personal and economic consequences when they have disease because of the
19 chronic medical conditions and the difficulty in getting them treated.
20 So one of the things we need to be doing, among others, is rethinking how do we actually deliver
21 services to these populations. So I was asked to talk about a project we're doing in California called the
22 Virtual Dental Home, and this is a system where we have allied, and I'm going to use the word dental
23 hygienists, because that's primarily who's doing it, although not exclusively. These dental hygienists work

1 on-site. The on-site could be a place like a Head Start center or a school or a nursing home or a residential
2 facility for people with disabilities.
3 They're collecting a full set of dental electronic health records. So that thing in her hand that looks
4 like a big hair dryer, that's a dental x-ray machine. The miniaturization has gotten to the point where you
5 can do this. The thing in her mouth is a digital sensor. It's not film. You can see the laptop computer
6 in the back there. So this is in a schoolroom. You notice this is an empty room. This is not a
7 plumbed-out dental operatory. It's an empty room with a couple tables. A couple trips to the car and all
8 this equipment is brought in.
9 She can collect a full set of dental records, including radiographs, photographs, dental charting. All
10 that goes up into a cloud-based electronic health record, produces a full electronic health record with x-rays,
11 photographs, a full set of photographs that can be blown up and you can climb right down on the surface of
12 the tooth and walk around and take a great look at it.
13 We have a dentist who is then off-site. The dentist is not at the Head Start center or at the school
14 or at the nursing home. But that dentist is able to get access to those electronic health records, review
15 them, and make a decision about what ought to be done. So the fundamental decision is, is this an
16 individual who can have the things that need done, done by this dental hygienist at the location where they
17 are?
18 So if the answer to that is yes -- and this is the dentist's decision -- if the answer to that is yes, there's
19 a whole bunch of things that allied dental personnel, in this case dental hygienists, can do in these locations.
20 They can do the traditional things that you'd expect dental hygienists to do, like placing fluoride varnish and
21 clean people's teeth and placing sealants. In our -- we have a demonstration project in California -- they're
22 also placing what are called interim therapeutic restorations, which are small tooth-colored bonded fillings
23 that can be put in with no anesthesia and no filling, stops the progression of the decay, puts the tooth in a

1 holding pattern for a long period of time. This is an example of how these procedures can just be done in
2 a very low-cost environment, again, a school with no special equipment. Everything's just brought in with
3 portable equipment.
4 If we're in a situation where the person is deemed by the dentist to have more advanced disease
5 where they have to have the services that only a dentist can provide, then we actually have an easier time
6 getting people into dental offices or into dental clinics because the dentist has already reviewed the records.
7 They're already familiar with what the person needs to have done. They don't have to start from scratch
8 when they go into the dental office. It's much less appointments that are needed. And we have
9 individual dental hygienists who are embedded in the Head Start center or in the school or in the nursing
10 home, actually can integrate their services with the services of that facility to use the social workers or the
11 family advocates in Head Start or other people in the schools to help make sure that that's a successful
12 referral.
13 So when we try to think about this kind of system of delivering care, this chart looks at the cost of
14 providing care on the left side -- that's salaries and materials and equipment and infrastructure -- versus the
15 cost of neglect -- and you've heard already today a number of things about the cost of neglect, that's the cost
16 of transportation, the cost of advanced dental disease if people don't get things caught early, the cost of
17 emergency rooms and hospitalization, the cost of associated medical problems -- this system of delivering
18 on-site prevention and early intervention-focused oral health care in places where people who are difficult to
19 reach and don't take advantage of the traditional system, delivering those services on-site is the lowest-cost
20 way to get services to those people, and it's also the way to have the maximum impact on the cost of
21 neglect.
22 You're catching things early. You're seeing people before they have advanced disease. All of the
23 costs of neglect have not yet formed. If you wait until they get to the point where they have more

1 advanced disease and you need to bring a dentist in using portable equipment or send him to a clinic, you've
2 already got more costs. And certainly, if you wait until the point where they end up in a hospital or an
3 emergency room, you're spending tremendous amounts of money, and particularly in an emergency room
4 that accomplishes almost nothing, as you have just heard.
5 We're doing this demonstration project now in 13 sites across the State of California and we think
6 that we've been successfully able to demonstrate what we call a geographically distributed, collaborative,
7 telehealth-enabled, prevention focused system of oral health care without walls. Now, that's a lot of
8 words, but it connotes, I think, a way of thinking about the delivery of dental services differently than we've
9 done it in the past.
10 So just some things to think about. What are the opportunities in Medicaid and CHIP for people
11 with disabilities and chronic medical conditions? Well, first of all, cover adults. You've heard now all
12 three of us speak about how the separation between the mouth and the rest of the body in making dental
13 services for adults optional has all kinds of tragic consequences that actually cost States more money in the
14 long run than the money that they think they're saving, looking at the short-term budget allocations, and
15 that's something that it's been pretty clear that only a Federal mandate is going to do that. States are not in
16 a position. States are actually removing benefits rather than adding them.
17 When you think about, as we're doing that, prioritizing those individuals with disabilities and chronic
18 medical conditions as well as pregnant women, we've got to start to build into our Medicaid programs ways
19 to recognize new delivery systems. The traditional delivery systems, as the Surgeon General said 13 years
20 ago, works great for some parts of the population, but it doesn't work for others. So we have to think
21 about paying for telehealth-enabled services and incentivizing prevention activities. There's a lot more
22 money in the system when someone goes to a dentist for doing reparative work than there is for doing
23 preventive work. We've got to figure out a way to incentivize preventive activities, recognize community

1 delivery systems. You can actually make people healthy in a school and in a Head Start center, and those
2 are traditionally not supported under the way our Medicaid programs are organized. And incentivizing
3 integration of oral health and general health services.
4 And, finally, establish Federally-supported pilot programs to create innovative and cost-saving
5 models of care. It's clear that there's different ways of doing things that can have a better result, better
6 results on people's lives, better results on their oral health, better results on their general health, and can
7 actually save money, and we need to begin to explore those things and make sure that we can use those
8 things that are available now to the maximum extent and have them spread across the States.
9 So, I think that's the end of my presentation and I think we're open to questions now.
10 CHAIR ROWLAND: Thank you very much.
11 Patty and then Trish.
12 COMMISSIONER GABOW: Thank you very much. I would say that we're not just excluding
13 the mouth. Actually, we don't believe there's anything from the neck up, because behavioral health is also
14 separated out. So chronic mental illness, hearing, eye care, and teeth. So as soon as we put the head back
15 on our patients, it will be good.
16 The serious comments. When I was at Denver Health, we had a number of clinics in our
17 community health centers and in the hospital, as well, and these were overwhelmed. I mean, people
18 couldn't get appointments. It was the most common complaint call that I got, after billing. People didn't
19 want to pay for any service, so that was the most common. But the other was that they couldn't get access
20 to dental care, and when you're the only place in a region that provides care to the uninsured, you get
21 overwhelmed pretty quickly.
22 But as we proceeded over the years, we started putting dental clinics in every new community health
23 center that we established, and given that this is where the Medicaid patients tend to get their care, I wonder

1 about what percent of -- do we know what percent of the community health centers in the country have
2 full-service dental care? And that may be the quickest way to expand, is just to increase funding for the
3 FQs and the look-alikes and the rural health clinics to have dentists, because the profession at large doesn't
4 want to see these patients, it would seem.
5 And related to the reluctance to take on these patients broadly, what has been the resistance of the
6 profession to increasing the training of hygienists, just like we've used more nurse practitioners, physician
7 assistants, child health associates, midwives, CRNAs? But often the profession, even though they don't
8 want to see these patients, will put up barriers to expansion of allied health professions' licensability.
9 So could you talk about both those, community health centers expansion of dental care and the
10 expansion of the licensure-ability of allied health professionals to do dental work.
11 DR. GLASSMAN: Yeah, I can comment on the first question, which is the percentage of
12 community health centers. I don't actually know the number across the country, but I do know in
13 California, it's about a third of the health centers that have actually dental facilities. So it's certainly not
14 ubiquitous. The health centers that are being remodeled or new health centers now have to include dental
15 to some degree. But it certainly has not been the case in the past.
16 I think the other thing that it's important to realize, though, is that even health centers that have
17 dental services are typically overwhelmed. They cannot possibly meet the demand. They often have long
18 waiting lists. And one of the things that we're exploring in California is this idea of health centers with
19 these long waiting lists, traditionally, the way they work is that everybody they see has to come and sit in the
20 dental chair. You know, a dental chair in a health center is a surgical operatory. There's all this expensive
21 equipment there. It's set up to do the complicated things that dentists do.
22 But our real push in California is to figure out, how do we change the current regulatory barriers,
23 which there are there, to them being able to do the kind of stuff you heard about? If they could have the

1 diagnostic and preventive stuff done in schools and in nursing homes and then reserve those hard-to-use
2 dental chairs, because they're just overwhelmed, for the more advanced services, then there would be a
3 system where the community health centers could actually do a lot more than they're able to do now,
4 because currently, some estimates are, of the underserved population in the country, the health centers
5 system in terms of oral health is maybe able to meet ten percent of the need. So it's great and it ought to
6 be expanded, but it certainly doesn't meet the need as it exists right now.
7 CHAIR ROWLAND: Are any of these telemedicine kind of settings in the community health
8 centers now in California?
9 DR. GLASSMAN: Of the demonstration project, yes, a number of them are actually in
10 cooperation with -- and we're paying for them with grant funding because our regulations now really don't
11 support that kind of work. And we're actually working in California to try and change some of the
12 regulations, but again, we're in the 21st century. We've got laws and regulations that were written in the
13 18th and 19th century that are supporting how these things are done and we really need to bring those into
14 the 21st century.
15 CHAIR ROWLAND: Okay. And the follow-up question on allied health professionals.
16 DR. GLASSMAN: Yeah, I can also just comment on the idea of using allied health professionals.
17 So you did see the slide, we talked about one of the points that the Institute of Medicine report on access to
18 care for underserved populations was we need to do a better job of using allied health professionals and
19 create a team that can do a better job of reaching underserved populations, and it certainly is one of the
20 principles that we've been following, is to try to do a better job of doing that, to take people and allow them
21 to be able to function to the maximum percent of their training.
22 And the one thing we've been trying not to do is to create another silo. I mean, we have lots of
23 silos of health care in our country, and so what we found is through the use of this telehealth technology, we

1 can actually create these distributed, collaborative but connected teams so it actually can function as a team
2 with a dentist as a part of the team, the allied health professionals able to do things to the maximum extent
3 of their abilities and training in community sites and have a team that could actually reach a lot more people.
4 VICE CHAIR SUNDWALL: I want to comment on that, if I can, just because it's relevant. I
5 chaired the work group for the IOM on dental oral health workforce a few years ago, before that access
6 study, and I've got to tell you, it was appalling. Talk about disingenuous. I mean, the idea that we would
7 not allow these allied health workers into nursing homes to do cleanings for elderly people because, what,
8 scope of practice, because they were going to encroach on our area? I mean, there was really some major
9 problems.
10 While I would love to see oral health care be not optional, to have that part of health in general, it
11 seemed to me that in the medical profession, we're far more willing to use allied health professionals to help
12 us extend our capacity than has been apparent across the dental profession, and I don't think that's
13 something that can be ignored. I think it would save lots of money and improve access to basic services,
14 not just for kids, but for elderly, as well, if we had more uniform access of allied health professionals in oral
15 health. Do you not agree that's an important thing?
16 DR. GLASSMAN: I want to say, I absolutely agree with you. It's very difficult to understand.
17 We have a system where we have a national system of accreditation for using dental hygienists, as an
18 example. So that means all dental hygienists were trained to the same level. They all went to school, so
19 they met the national accreditation standards. And yet, what they're allowed to do varies tremendously
20 from State to State.
21 In California, where I am, we're fortunate that the laws are pretty liberal and dental hygienists can do
22 a lot and work independently in a lot of places. In some States, they are very restrictive.
23 That was one of the recommendations in the IOM report, is that we use people to the maximum

1 extent of their training and abilities.

2 CHAIR ROWLAND: Okay. I have Trish, Norma, Donna.

3 COMMISSIONER RILEY: I guess you can't sit next to Burt and sit on this Commission and not
4 feel the compelling need for better coverage in Medicaid for oral health, and I share it passionately. But I
5 also look at the world as a State and there's no money. So I have two questions, I guess, around costs that
6 would help us considerably.

7 One is, around the emergency department issues, we did a study in Maine several years ago that
8 showed excessive use of emergency departments for oral health and were quickly whipped back into shape
9 by emergency department physicians who said, wait a minute. Those are often not dental needs but
10 drug-seeking behaviors. And so I'd like to know what the data is around the ED piece in Ohio, about how
11 many were legitimate oral health needs.

12 And then I'd like to know from California -- I guess from both of you -- where's the data that shows
13 that cost avoidance really happens, that prevention really works, that we can really avoid other costs in the
14 Medicaid program, and how robust is it?

15 DR. CHANG: For our study, we did do a, based on the claims data, do snapshots, what are the
16 high-cost avoidable emergency department visits. Dental as a system average doesn't show up as a top-ten
17 diagnosis. But when you really look at the regional differences, it started to come into play. But we don't
18 have data to drill down to say whether this is narcotic use or whether this is dental. And based on our
19 patient interviews on this initiative I mentioned earlier, we go in with exactly the same assumption, that
20 many of them are depending on the narcotics. But for the inner-city pilot that we did, many patients do
21 have the critical dental needs. So that's what we found out.

22 DR. DICKINSON: And I'll add to that. I just finished sitting on a National Governors
23 Association policy group in Virginia on abuse of prescription drugs, and one of the things we're trying to do

1 based upon that, because we see it on these projects that we do, we see -- I mean, the emergency room
2 doctors really get nervous when we come to town because they flood those emergency rooms. Even
3 though they may get a narcotic prescription from us, by using our prescription monitoring program, we're
4 hoping to impact the misuse of those drugs. We know it occurs. We don't know how much of that.
5 Because if someone -- if you look in their mouth and they have a terrible tooth, you think, well, it's got to
6 hurt. They need a medication. But they may actually let that tooth get to that point to get the narcotic.
7 So it's, again, behavior issues that we simply don't have the capacity or capability of dealing with.
8 But we know it occurs. We're trying to set up systems that will, hopefully, decrease the abuse of those
9 drugs.
10 DR. GLASSMAN: Maybe I can just respond to the question about what's the evidence of the
11 ability to reduce the cost of neglect. And so the evidence, I would say, is not as robust as we would like.
12 It's a little bit more indirect than I would like, but it is there. The California Health Care Foundation just
13 commissioned a study by a well respected in California consulting group that did a very extensive review of
14 all of the scientific literature and rated the literature based on its quality of literature and looked at literature
15 specifically addressing the ability of preventive dental procedures to reduce costs of neglect, all the things
16 that we've talked about.
17 And their conclusion was that, again, based on the literature and showing what happens when
18 people have preventive services and that impact on cost, their conclusion is that the State would actually
19 save money by providing dental services to populations, particularly the underserved populations that we've
20 been talking about today. So that the increase in expenses by providing additional visits to people who
21 aren't getting visits would be more than offset by the reduction in the cost of all the downstream things that
22 happen.
23 Now, this is based on a review of the scientific literature. It's not based on a large prospective

1 controlled trial study. But it still, I think, adds -- I think it's still important to understand that the literature
2 does support that this is actually a vital mechanism.
3 COMMISSIONER RILEY: Excuse me. How long would it take to see the savings? Was there
4 a --
5 DR. GLASSMAN: I don't think they actually had that kind of response.
6 CHAIR ROWLAND: We'll get a copy of the report for the Commission.
7 Norma.
8 COMMISSIONER ROGERS: This is a pilot project, you said?
9 DR. GLASSMAN: The project that we're doing in California is a pilot demonstration project,
10 right.
11 COMMISSIONER ROGERS: And so what sustainability, or have you made a plan for
12 sustainability?
13 DR. GLASSMAN: We do have a plan. The plan is that -- our plan going into it was that we were
14 going to demonstrate that the system works, that we could actually reach people through these
15 telehealth-enabled teams that were not being reached and we are going to use that data to try and influence
16 the policy makers in California to remove some of the legislative and regulatory and payment barriers.
17 And, in fact, legislation has been introduced this year. It's working its way through the committee
18 structures. There's a hearing next week. And if that legislation passes, it won't be the end of the struggle,
19 but at least will provide some recognition of this style of providing care and will allow an income stream so
20 that it'll be able to begin to spread.
21 I think that having just a basic idea of coverage, of allowing coverage, as we know, is really just the
22 beginning, because having coverage, as you know, even with children who are covered, only 40 percent or
23 less are actually getting care. So you also have to do other things. But it's a road that we think we've

1 demonstrated the system works. We're now getting basic coverage and we're going to continue to work on
2 getting people to understand the system, providing technical assistance to those who need it to try to make
3 it spread.

4 DR. DICKINSON: Yeah. We, in Virginia, are actually looking at that tomorrow. We're
5 looking at copying Paul's wonderful project there. In Virginia, physicians, medical personnel, do get
6 reimbursed through telehealth. We're looking at adding on dental as part of that legislation so that --
7 because, again, we would be using hygienists out in the field to do these procedures, very similar to what
8 he's talking about. But it's kind of surprising that so few States -- because I asked Paul today, is he aware
9 of any other States using this modality, and we may be the second one, so --

10 DR. GLASSMAN: But I think it's important to understand that the reason that Virginia may be
11 the second one is that you cannot do this without some basic level of adult coverage, that we're talking
12 about changing the regulations so that you can recognize a telehealth-enabled team, but recognizing a team
13 where there's no coverage doesn't accomplish anything. So there has to be a basic level of coverage in
14 order to be able to have this kind of system.

15 DR. DICKINSON: And I think that has to do, going back to the FQHCs. I mean, if you don't
16 have any benefits, how's that going to work?

17 DR. CHANG: There's also an issue related to sustainability, is the shortage of dentists. Even
18 though we are looking at a supporting level of professionals, I think two of the Commissioners earlier
19 pointed out that many dentists do not want to see underserved populations, especially for inner-city folks,
20 that some may encounter with their behavioral health issue. They are not the greatest hygiene when they're
21 going to their appointment. So there are actually dentists who would rather shut down their practices
22 without wanting to see those patients.

23 So Ohio, fortunately, has six medical schools. Two of them are having dental schools. We are

1 aggressively working with Medicaid, working with our dental schools, trying to, in the pipeline, to train the
2 dentists not only to have a patient-centered approach, integrated approach, so they are exposed to this
3 population early on. Not only doctors are just seeking reimbursement. They do come in with the passion
4 to serve this population. So we hope to attract those early on, the quality professionals, in the pipeline and
5 so they are actually receptive in the community health centers. So they are exposed to this population and
6 learn a way to work with them as well as addressing them as a whole person. Many of them have
7 behavioral health issues, so you do need a team approach to address those fundamental issues. So
8 workforce is also part of the substantive issues.
9 CHAIR ROWLAND: Okay. I had Donna and then Steve.
10 COMMISSIONER CHECKETT: Well, first, thank you so much for coming. I really, really
11 enjoyed the presentation and learned a lot.
12 One thing that really caught my attention, and I think, Paul, you were the one who talked about it,
13 was telehealth, the use of telehealth, and I'm wondering, are any of you familiar with State Medicaid agencies
14 or any providers, insurance companies, reimbursing for telehealth for dental services, because I think it's
15 really an intriguing area for the Commission to look at in terms of access and payment issues.
16 DR. GLASSMAN: Sort of. I can give you an example of a colleague of mine in Minnesota who,
17 about 10 years ago, started using telehealth to do screenings at Head Start centers. They were taking
18 photographs of children and having dentists review them and were billing for the consultation the dentist
19 was doing and got paid by the Medicaid agency for 10 years.
20 They got a new head of the agency who came in and said, you know, I think you've been using
21 telehealth in this system for the last 10 years.
22 And they said that's right.
23 He said, well, that's not covered. We want all the money back for the last 10 years.

1 And they were lot of money in hiring lawyers and a big, long story about that.

2 So I think basically the answer is no.

3 In California, there's a quirk in our law where it mandates that if a dermatologist or an

4 ophthalmologist were to do exactly the same thing we're doing, using a store-and-forward examination

5 where someone collects records at a distant site and then the ophthalmologist or the dermatologist reviews

6 those records, makes a decision, gives them instructions on what to do, our Medicaid system is mandated to

7 pay for that. That's exactly the same system we're using for dentistry.

8 And the pending legislation that's been introduced this year would add dentistry to that list, but

9 the coverage, while it's much more advanced in medicine -- really, I don't know other states that have

10 recognized -- again, we're in the 21st Century and this is a modality that we can use.

11 COMMISSIONER CHECKETT: Right. I thought that was going to be your answer although I

12 didn't know the story about Washington or whatever. It's too bad.

13 But I just want to throw this out for something for the Commission to think about, and I think it's

14 just in keeping with the trend in technology in our lives. Everybody here has got our phone, hopefully, on

15 vibrate but nearby in case of an urgent technological emergency. I'm the worst.

16 [Laughter.]

17 COMMISSIONER CHECKETT: But no, seriously, I think it's something we really need to look

18 at -- an area where we could make a very significant recommendation that could really address the issues of

19 access and payment for this issue and probably lots of other populations as well.

20 So thank you again for a great presentation.

21 CHAIR ROWLAND: Richard.

22 COMMISSIONER CHAMBERS: Yeah, I just want to echo Donna's comments too about thanks

23 for an excellent presentation for really a troubling issue that we hear about all the time from one of our

1 fellow commissioners who reminds us of the necessity of dental services.

2 Being from California, everything you said, Dr. Glassman, is so relevant to what we face. The
3 decision several years ago of the state to eliminate adult coverage for dental was a bad decision, but it was
4 one that the governor made and is happening.

5 Just my observations on some things about FQHCs and clinics providing services -- what I saw in
6 Orange County was FQHCs setting up the infrastructure with, as you say, the big investment for chairs and
7 then having problems of finding dentists to be able to actually man those, or woman those, seats.

8 And the other issue was the hours of operation and the clinics not offering nights and weekends as
9 oftentimes chairs went empty because folks couldn't get off work to either go themselves or bring their kids.

10 Ultimately though, as a managed care person, it's the above-the-neck that Patty talks about -- is both
11 integration of oral health and mental health. I would hope someday that we can get there because when
12 you incentivize the organization that's taking care of the below-the-neck, it certainly is incentive to integrate
13 that care.

14 Dr. Glassman, I'm just curious. On your thing about established federally supported pilot
15 programs, any specific recommendations on what they'll do? I assume states could do a lot of things.

16 What, you know, could we do as to incentivize states to do something? I'd just like a little more
17 detail.

18 DR. GLASSMAN: Well, I just would say that the project I talked about, as I said, has been totally
19 supported with grant funding. It's been mostly private foundations that have supported this.

20 But I think that if you start to look at being able to do this in many states and being able to look at
21 innovative ways of reaching the populations that are hard to reach -- that kind of a federal program that
22 would actually support innovative delivery models and collect data about them and show it can work and
23 maybe even be able to collect some of the kind of retrospective data that we were asked about a few

1 minutes ago -- does this really save money? I think that that's essential.

2 We don't really know how to do this stuff. We know that we have a huge problem. We know

3 that we have some ways of being able to reach populations, and we've demonstrated in small studies. But

4 we don't really have all the answers as to how to do this, and I think that we need to be trying lots of things

5 and collecting data, so imagining some kind of federal program that would actually incentivize studies and

6 different kinds of innovation and getting people to try different things.

7 Again, I don't mean to be redundant about this, but if you're going to try to use the kind of things

8 we've been talking about -- telehealth and other ways of reaching particularly adult populations. Those

9 have all got to be on top of a system where there's at least some basic coverage.

10 CHAIR ROWLAND: Steve.

11 COMMISSIONER WALDREN: The telehealth issues -- I would agree with you Donna, that we

12 should take up those issues. I think they're pretty thorny issues. There is regulatory. There are lots of

13 other things too.

14 We have that in the primary care too. We can talk about across states and all those other types of

15 issues.

16 And thanks for your presentations. I know when I was seeing patients, trying to get my patients in

17 to see a dentist was one of my biggest challenges. So I appreciate you guys' work.

18 My comment is more, I think, for us. As you think about all these coverage issues and what Patty

19 talked about, there are other things we're going to deal with. It would probably be nice to have a clear

20 understanding of the decision-making process around what's coverage and is it mandated or not and who's

21 that, where's the authority, should there be recommendations for us on changing that authority at some

22 point or giving that authority to CMS to do more of those.

23 I like the idea; the pilot stuff was interesting.

1 The other -- is there an analytic framework for that type of decision-making right now, and if there's
2 not, should we kind of make some type of recommendation on what that would look like?
3 And then we could make some recommendations to start filling in that data because I think -- I
4 don't remember who said it around the table, but there was alluding to the fact that there are not going to be
5 good data to fill in that analytic framework, but we could start making some recommendations to do some
6 of that work.
7 CHAIR ROWLAND: Okay, I have Robin, then Mark, then Trish.
8 COMMISSIONER SMITH: I don't know if this is something that you all can answer specific, but
9 I know that now we're finding that more and more of our other health issues, like health disease, possibly
10 some autoimmune disorders, whatever you were just talking about -- I can't remember now. But there are
11 so many other things that our dental health can impact on our body. Diabetes -- that's what it was.
12 Are we getting any support for dental coverage from the physicians who are seeing people for other
13 issues, like cardiologists or internists?
14 I mean, are they --
15 DR. DICKINSON: One of the things that we're currently working on is trying to involve
16 physician offices more, particularly in -- because of the well baby requirements, to let them be the
17 continuum to get the child into the system, into the dental system. But we're also trying to get them to be
18 more aware.
19 Carilion, which is a hospital system in Roanoke, actually started a dental curriculum for the medical
20 school, and I think that's one of the places that it has to start because traditionally physicians have graduated
21 from medical school with very little, limited knowledge of oral health care. And so by increasing the
22 educational level, I think that's going to make a difference too.
23 But when a physician sees -- I had an anesthesiologist at one of these projects that was not going to

1 let us take several teeth out on a patient that had a blood sugar around 900. It was a very difficult decision,
2 and she finally said that we could do it but the patient would have to go spend the rest of the day down in
3 their emergency facility.
4 And she came back late that afternoon, and she said I still don't believe it -- that the blood sugar
5 went from 900 to 400 and nothing else was done. She will tell that story from now on.
6 So it's one at a time until the literature really supports that and we see more in the literature; we see
7 more in the New England Journal of Medicine, or whatever, about that anything that has any inflammatory
8 modulator in it is going to be affected.
9 DR. GLASSMAN: I might just also add that I think that the -- you know, HRSA has just finished
10 a project where they're looking at a design for an interdisciplinary curriculum. One of the Institute of
11 Medicine recommendations was that people across the health care spectrum should have at least a basic
12 level of oral health understanding as a part of any kind of training program if you're involved in health care.
13 And they've just created -- finished an interdisciplinary curriculum design based on that IOM
14 recommendation.
15 I think there's a lot of support from individual physicians, nurses and other health care practitioners
16 across the country who recognize the impact that oral health has on other kinds of things that they're trying
17 to do.
18 So I think that recognition is certainly there, but I think we could go a long ways further in having
19 better understanding and doing a better job of integrating oral health and general health services.
20 DR. DICKINSON: Yeah, again, it's the silo effect. I mean dentists train in dental school, and
21 there's no cross-pollination.
22 VCU now has an actual part of the nursing school faculty there in the dental school to start that type
23 9of process, but -- what is the name? I'm trying to remember the curriculum.

1 Is it Smiles for Life? But it's a great program, and that's what we're trying to get medical schools to
2 use.
3 DR. CHANG: One of our medical schools -- Case Western -- Medicaid funded recently the
4 workforce issue -- is that they are required to develop an integrated outpatient team approach, and the
5 dental school hired a navigator. So, as you see, this is a group of patients that in addition to their medical
6 need they may also have -- that falls through the cracks -- either housing or food or transportation, and so
7 on and so forth.
8 So the navigator actually was able to step in, and we're examining this model as well. So not only
9 the medical support from the medical team as with the dental school, but we also have a navigator that will
10 help the patient to navigate the health system.
11 COMMISSIONER SMITH: Just a follow-up real quick. I guess I'm wondering if there's any
12 support from physicians that don't deal with dental to get Medicaid coverage for adults with -- so they can
13 get Medicaid coverage. Do they see it as important that they get coverage, not just that they get the
14 referral, but that the states actually start covering adults for -- and that it's important. It's part of their
15 overall health.
16 DR. GLASSMAN: I think there is a lot of support for that idea among individual physicians and
17 people across the health care spectrum. I'm not sure that it's risen to the level yet of a loud voice from the
18 organized health care professions outside of dentistry.
19 CHAIR ROWLAND: I think, clearly, the Commission has to look at two issues here -- who's
20 eligible, first of all, as an adult for coverage under Medicaid and then what kind of coverage that would be.
21 And, obviously, the decisions going forward with the Affordable Care Act will influence in which
22 states -- to go back to Patty's concerns about variations across states -- people actually have access to dental
23 services generally.

1 And the coverage issue is first, and the access issue is really second.

2 But we have Mark's comment and Trish.

3 Norma, did you have another comment?

4 And then, Burt, since you've been silent, we're going to have you make some closing comments.

5 VICE CHAIR SUNDWALL: You get the last word.

6 CHAIR ROWLAND: Mark.

7 COMMISSIONER HOYT: Yeah, maybe a question for commissioners as well as the panel.

8 It feels to me like one of the elephants in the room is a decision about adult dental and should we

9 make that mandatory or not. It seems like we're hesitant to make that recommendation. But the first

10 question would be maybe, is there some other part of the case that needs to be made that shows this is

11 medically necessary?

12 It feels to me like our only hesitancy is the cost. And if that's it, is that a bar that we apply to every

13 recommendation that we make, and is it being consistently applied to other things that are added to the

14 Medicaid program?

15 We all know new drugs are added every year, and technology. New health care treatments are

16 approved. But it doesn't seem to me like the criteria or the protocols are the same -- that those things can

17 only be added if they're cost-neutral or produce savings. I think there are things added all the time that

18 produce additional costs but benefit fewer people.

19 DR. GLASSMAN: If I might just thank you for that comment -- I think that clearly is something

20 we say to ourselves all the time.

21 You know, the cheapest cost is the cost that you don't provide at all, and we can certainly save a lot

22 of money in our country if we decide that for anyone who had heart disease we're not going to provide any

23 treatment. Heart disease -- you die. That would be a way of reducing cost, but obviously we don't do

1 that.

2 We do support things that produce better health for the population, and this is an opportunity to do

3 that in oral health care.

4 CHAIR ROWLAND: Trish.

5 COMMISSIONER RILEY: My timing couldn't be worse. I want to talk about costs.

6 [Laughter.]

7 COMMISSIONER RILEY: I just want a quick question for Ohio. Is there any evidence that

8 shows reduced ED costs (A), and (B), were there any pushback issues around EMTALA?

9 DR. CHANG: The first question about whether it is sustainable -- this is an 18-month trial. So I

10 did have an opportunity, checking with one of our health plans on the cases that we examined. And after

11 the improve concluded, we were very fortunate to find out the cases that participated in the initiative -- not

12 only were their costs sustainable, they significantly reduced their ED, among all the five initiatives included

13 as well.

14 EMTALA -- that was one of the most talked about challenges when we did this. As I indicated,

15 for our initiative to be able to work, the ED needed to be feeling comfortable. So you would know that

16 ours is like an ED diversion.

17 So the patient actually was referred after care. And our ED doctors feel that it needs to screen for

18 necessary medical issues, and if they feel it's okay then they would refer on.

19 So that was a decision the committee made.

20 COMMISSIONER RILEY: So, given that you would do the EMTALA, how do you save money?

21 DR. CHANG: I think some of the examples that we looked at -- they were able to do a very basic

22 screening to make sure that -- so it's not extensive care provided to the patient.

23 So they were able to refer the patients.

1 So they are preventing the next visit and also ultimately looking into their medical issues. And that
2 was the concern initially -- that if they are complying with this expectation.
3 So our EDs feel that they wanted to do a diversion and they wanted to actually have a look at those
4 patients.
5 CHAIR ROWLAND: Okay. I had one question before I'll let Burt go.
6 One of the other issues that, of course, we deal with is the role Medicaid plays for people with
7 disabilities. Could you speak a little bit about the challenges of providing oral health services to that
8 particular community because are there not special issues there that we need to be aware of as we proceed?
9 DR. GLASSMAN: Yeah, and I listed some of them in the presentation.
10 There certainly are -- I said, I think it's the underserved of the underserved in terms of oral health
11 and probably in many other things as well.
12 And the issues, as I said in the presentation, are about workforce that's actually trained to deal with
13 people with very complicated problems. We graduate people from dental school who have great training
14 in terms of basic disease and basic health care services for fairly healthy people, but in terms of people who
15 are very complicated we don't have a workforce that's adequately trained.
16 We have huge challenges in even the trained workforce in oral health being able to get to people
17 who don't have adequate mobility, and our system has been that dental care is delivered in dental offices.
18 So the way you have dental care is you make an appointment and you to go a dental office. Well, that can
19 be immensely challenging for people who have transportation issues, for people who have behavioral issues.
20 We have numbers of stories of someone who was in a nursing home, and there was a decision made
21 that they needed dental care. And they end up getting an ambuvan and a couple staff people, and it's
22 hugely expensive. They spend an entire -- it's an eight-hour event to get to a dental office.
23 Having someone come into a dental office and seeing the dentist for the first time, the dentist has to

1 do what they have to do at the beginning -- take a history and collect records. And they didn't have all the
2 medical information, so they needed to make a medical consult.
3 So the person, after the eight-hour appointment, went home, in the minds of the individual, getting
4 nothing done.
5 Certainly, in the mind of the dentist, they collect a lot of information. They did the diagnosis.
6 They prepared for future visits.
7 But it's a hugely expensive way, and it's a discouraging way for people to work in those facilities.
8 So they don't go through that kind of process very often.
9 So there are lots of challenges for people who have medical, physical, behavioral challenges of
10 accessing the traditional system, which is why I think we need to think about ways of reaching them that can
11 be a little different and allow people in that traditional system to expand their horizon and be able to care
12 for more people without them having to come directly to their offices every time they have something done.
13 CHAIR ROWLAND: This is an issue you would hope we would focus on as the Commission?
14 DR. GLASSMAN: Absolutely.
15 CHAIR ROWLAND: Thank you.
16 Okay, Burt, for the last word.
17 COMMISSIONER EDELSTEIN: Just a couple of observations.
18 First off, it's gratifying that the Commission has turned its attention to this issue. It's one that
19 we've long sought to do and we'll do more on. Clearly, this is the beginning of an investigation and an
20 investigation that really does need to be data-driven and analytic, and we need to maximize the use of
21 whatever information is available.
22 I can't help but recall, especially when Patty was talking about a retrospective -- we're finally around
23 long enough to think about a retrospective.

1 I can't help but think that the first thing we did was to establish a model to think about the
2 relationships between coverage to access to utilization and then on to quality. And for most of our issues,
3 as a payment and access commission, we've been able to start right with payment and access, but here we
4 have to start with coverage before we even get to payment and access.
5 And, if I was as eloquent and targeted as Mark, I would love to just reiterate what he had said.
6 We're talking about an essential health service that for whatever reasons has a congressional history of being
7 overlooked in Medicare, in Medicaid, in SCHIP originally -- before the CHIPRA reauthorization that made
8 dental services mandatory in CHIP -- and it's a fundamental misunderstanding about the nature of the
9 mouth.
10 I would only add one more perspective to what the panel has done, and that is to say that we don't
11 need to rely on the medical consequences of oral pathologies in order to justify caring for oral tissues, that
12 they are every bit as much a part of our bodies as other tissues. And so we can turn our attention to the
13 benefit of oral health coverage for the benefit of oral health even before we get to the attendant issue of
14 impact on general health.
15 So I thank the Commission staff and the speakers and look forward to working closely as we move
16 forward on this oral health issue.
17 CHAIR ROWLAND: And I want to thank the panel for coming to join us today, for the excellent
18 presentation and your even better answers to our many questions.
19 This is the beginning, as Burt said, of continuing to look at the oral health issue. We know that the
20 mouth is a part of the body, but now we're really going to have to talk about the head being a part of the
21 body too.
22 And so we thank you for joining us, and we'll be in touch, and we'll certainly benefit from all of the
23 work that you're doing. Thank you.

1 DR. DICKINSON: Thank you for having us.

2 DR. CHANG: Thank you.

3 COMMISSIONER EDELSTEIN: I do want to add one thing about the head. It's often said
4 that we ignore everything above the neck, but in terms of physical pathology we do cover eye services; we
5 do cover ear/ENT services. But we don't cover oral health services. So we have functional issues that go
6 beyond that, that really do need to be attended to.

7 And I think one of the things the Commission could take away from today is the consequence of
8 optional as the nature of a benefit and how that plays out for people's abilities to be healthy and to function.

9 Thanks.

10 CHAIR ROWLAND: Thank you. Thank you very much.

11 We are going to turn now to look at one of the upcoming chapters in our June report, and we
12 continue to explore the issues of the primary care payment increase that was incorporated into the
13 Affordable Care Act for the years 2013 and 2014 to raise Medicaid primary care provider fees up to the
14 Medicare levels. So Ben Finder of the staff is going to walk us through the overall framework of this
15 chapter.

16 Again, any comments that the Commission members can make in shaping this chapter we would
17 like to get on the table now so that this chapter can be finalized as soon as possible for the report.

18 **### DRAFT JUNE REPORT CHAPTER ON PRIMARY CARE PAYMENT INCREASE**

19 * MR. FINDER: Thank you, Diane.

20 As Diane mentioned, my name is Ben Finder, and I'm here to brief you on our draft chapter for the
21 June report on the Medicaid primary care payment increase.

22 Much of this is a recap of work that we've already discussed, work in our November meeting when
23 we briefed you on the final rules, and in the February meeting when we briefed you on our survey results.

1 In this session we'll review the draft chapter for the June report. And in addition to the work I've just
2 mentioned, this chapter will also focus on and include a review of previous research on the relationship
3 between payment and access to care as a context for us to analyze the primary care payment increase.
4 The chapter also includes a section on statutory and regulatory requirements and other federal
5 guidance. It includes a summary of our survey on implementation of the primary care payment increase.
6 And the chapter concludes with a brief looking-ahead section.
7 So as I mentioned, the chapter explores research on the relationship between payment increases and
8 access to care. The research is extensive and spans decades. The research concludes that Medicaid
9 physician fees are low compared to other payers, in particular Medicare. For example, a 2012 survey shows
10 that Medicaid pays 59 percent of Medicare on average for primary care services.
11 One way to measure access to care is by measuring physician participation, as the Commission noted
12 in our June 2011 report. Research finds that low fees are generally associated with low participation.
13 And it's true among Medicaid programs as well where one study found that Medicaid programs with low
14 Medicaid to Medicare payment ratios had lower physician participation in general.
15 And it's important because research shows that when fees are low, Medicaid enrollees tend to seek
16 care in more costly settings, such as outpatient hospital departments and emergency rooms.
17 But fees are not the only factor that affect physician participation. In physician surveys, physicians
18 also report that factors like delayed payments, paperwork requirements, and other administrative
19 requirements are factors that affect their participation.
20 The chapter reviews the statutory and regulatory requirements which the Commission was briefed
21 on in November and briefly in February. And the chapter also adds a brief discussion of sub-regulatory
22 guidance.
23 CMS has published six Q&A documents to help states implement the provision. Some of these

1 were published with the final rules on November 6th, and others have been released since then. The
2 documents review a lot of the questions and issues that have emerged as states have begun to implement the
3 provision. And as we heard in our survey, although the provision seems straightforward, it has proven to
4 be more complex in its implementation and operationalization. And I think the Q&A reflect this to some
5 extent.

6 In particular, the Q&A addresses questions on the timing of payments. It addresses the question
7 on whether states could begin to make payments before their SPAs were approved. CMS clarified that, no,
8 the enhanced FMAP and matching funds would not be eligible for payments made prior to SPA approval.
9 The Q&A also provides a lot of details and instructions on the self-attestation process. And you'll recall
10 that the regulation requires providers to self-attest to their eligibility as a primary care provider, and they do
11 this by supporting their attestation, showing that they are board certified in family medicine, internal
12 medicine, and pediatrics or a number of subspecialties. And, alternatively, providers can self-attest if they
13 meet a 60 percent threshold where 60 percent of their bills Medicaid claims, codes, were for the primary
14 care services.

15 As we move back to the sub-regulatory guidance, we see that this has proven to be one of the more
16 challenging aspects of the provision. CMS has provided some clarification, including specifying that states
17 can establish reasonable deadlines for self-attestation for retroactive payments. As we heard in our survey,
18 many of the States would plan to make retroactive payments at least initially. States are allowed to
19 establish a deadline for physicians to be eligible for those retroactive payments. Otherwise, physicians
20 would become eligible based on the data of their self-attestation moving forward.

21 The Q&A also clarified that physicians who participate in both fee-for-service and managed care
22 arrangements are only required to submit one self-attestation for both arrangements. This sort of lowers
23 the administrative burden for physicians, but maybe increases a little bit requiring some sort of coordination

1 between the Medicaid fee-for-service program and the managed care contractors. And the Q&A specified
2 that physicians may be required to resubmit attestation annually to keep this information up to date for
3 states.

4 The chapter also presents information from our survey on the implications of implementation.
5 You'll recall from our February meeting that this was a survey of state Medicaid officials, Medicaid managed
6 care organizations, and provider organizations from six states and the District of Columbia. In that survey,
7 states told us that the late publication of the final rule resulted in delayed implementation. All of the states
8 we spoke with anticipated having to make at least some of the payments retroactively.

9 Respondents also reported that the temporary nature of the provision may limit its effectiveness,
10 and states in particular reported there was some uncertainty about their ability to maintain these rates after
11 the enhanced match would sunset.

12 Among the operational challenges, states noted that the provision required them to make
13 modifications to their claims processing system, amend their managed care contracts, and develop and put
14 in place a process for self-attestation. States noted that each of these issues required considerable time and
15 staff resources, while at the same time they're in the middle of ongoing Medicaid transformation efforts.
16 And states reported that this may affect their bandwidth for doing internal comprehensive evaluations.

17 Most responses were optimistic that the increase would result in participating physicians accepting
18 new Medicaid patients or devoting more of their time to the number of Medicaid patients they see. On the
19 other hand, they were less optimistic about the effect that the rate increase might have on physicians who
20 were not currently participating in the Medicaid program.

21 And while everyone expressed an interest in conducting a comprehensive evaluation, there wasn't
22 consensus on who should conduct it or what that evaluation would look like.

23 The chapter concludes with a brief looking-forward section that discusses questions like: What

1 happens when the provision sunsets in 2014? Responses to our survey noted that the provision creates
2 some uncertainty, and it remains to be seen what impact this uncertainty will have on incentives for
3 physicians to participate.
4 Some states also expressed concern about which providers the provision applied to and wondered
5 how this would affect the impact of the provision on access to care. And how will CMS and states
6 systematically evaluate the policy change? The chapter goes into a little bit of detail about the data
7 requirements that states may be required to provide to CMS and some of the challenges with the data in
8 conducting an evaluation.
9 So that's the chapter in a nutshell. I would like to conclude with a few discussion questions.
10 Does the chapter provide a useful overview on the implementation of the primary care rate increase?
11 Does the chapter accurately reflect the Commission's views about the implementation and expected
12 impact?
13 And what, if any, follow-up would Commissioners like to see at subsequent meetings?
14 Thank you.
15 CHAIR ROWLAND: Thank you.
16 COMMISSIONER GABOW: Thanks, Ben.
17 To answer your first question, does the chapter provide a useful overview, I'm not actually sure. I
18 have mixed response to that, and one of the reasons for my mixed response is not the importance of the
19 issue. I think the issue is important. But I've never been much of a qualitative data girl, and I've been
20 accosted about that over the years that qualitative data is every bit as legitimate as quantitative. But I've
21 never been convinced. And under that rubric, I wasn't clear how we picked the states that we picked.
22 And I would suggest that the Commission, if we're going to do surveys, actually develop a framework and
23 criteria that, if we're going to so surveys of states, how do we decide which state for which question, because

1 I think that is very important.

2 It's also very important to know what do we mean by the state, who did we talk to, do we have
3 criteria that we only talk to X, and what do we ask them to supply to us to go beyond a telephone
4 conversation. So I have a problem when we have just a few states and then we have comments like "most
5 said." I don't know what -- I don't know how to contextualize that or weigh it.

6 So I think that's an important thing that we need to discuss, not just for this chapter but a broad
7 framework that we're going to establish for this kind of survey.

8 The other thing is I'm not sure we shouldn't make a -- if we're going to do this as a chapter -- which
9 I'm still not sure we should do. But if we do, I wonder if this chapter provides an opportunity to make
10 some broad recommendation, for example, that legislation, before it's implemented, has to consider what
11 the administrative burden and cost to implement that will be, because, clearly, this is -- fixing your MMIS
12 system, fixing attestation, all the things that are issues clearly were not well thought about. And maybe we
13 can't tell Congress that they need to think about that, but it wouldn't be a bad plan.

14 The second thing is that I think we should also think about saying that when we do institute
15 something new in Medicaid that has a certain threshold of cost -- I don't know what threshold we'd like, you
16 know, $500 million, $100 million, some number -- that there be clarity about what metrics we're going to
17 use to understand if this worked. And I think -- I don't know how many of you heard Bill Gates in his
18 recent interview talk about the Gates Foundation and how critically important they thought that anything
19 they did having measurable metric, and that metric data on outcome, if you're going to develop a vaccine or
20 use mosquito nets or whatever, that you know what you spend your money on did. And I think this may
21 be an example where saying this was good intentioned was an important concept, but that we must always
22 think about the administrative burden it places, and we must think about what are the metrics we're going to
23 measure to determine the ROI, that maybe we shouldn't make general recommendations like that. But,

1 clearly, this is probably one of the best examples of where those two things went awry.

2 VICE CHAIR SUNDWALL: You said it better. I was going to say the same thing. I think as a
3 primary care physician who has long believed that the payment is a big barrier, although we kind of skirt
4 around that issue, it is important. So I'm glad that they tried to address this. The process is simply
5 flawed. A two-year fix, the cost of fixing this or of adapting to it is, as we've documented here with this
6 survey -- whether the survey was correct or not, I think it really captured what I've heard from many
7 practicing physicians -- is it's just hardly worth the effort. And I don't think it should have been done
8 broad scale. I think it should have been a pilot project, that they could have drawn from that. But to
9 have everybody try and jump through these hoops and to comply with this is wrong. And I would like for
10 us to make a recommendation along the lines of what Patty has said, that if you're going to do this, it ought
11 to be a fix. It ought not be a two-year trial. And how on Earth they'll ever go back I don't know. But it
12 to me was a bad process to accomplish a reasonable goal.

13 COMMISSIONER HOYT: I thought Patty made some good points in general about surveying
14 some of the states, although honestly this chapter read fine to me. I'm not sure there'd be much new to
15 add by surveying more states or looking someplace else. But for whatever that's worth, it felt good to me,
16 pretty well done.

17 The one comment I wanted to make is, no surprise I would guess to anyone, I am still in contact
18 with my comrades back at Mercer, and I would just say it's impossible to overstate the complexity of this
19 programmatic change to rate setting and the amount of effort and resources that are being spent on this,
20 just as kind of a rule of thumb that we would use. I mean, programs are changed all the time. CMS will
21 issue rules and regulations. You know, things change.

22 And so when we provide a bid or a contract number to a state to do rate setting, you know, we
23 would hold to that within certain bounds. This is a total deal breaker. This is where you go back to the

1 state and say, "I'm really sorry, but there's no way we can hold to the fee we quoted for this." And they are
2 spending huge numbers of hours trying to drill down to this. You, I think, touched on most all the points
3 of the services themselves, but, you know, down deep in the weeds at the encounter level, is this a primary
4 care service we are talking about? What is the service setting? Is it covered here but it's not covered
5 there? And then, you know, our general client would be a large state with managed care contracting all
6 over the waterfront. So now you've got to go into the managed care contract somehow to satisfy yourself
7 and then satisfy CMS that we've got -- this is as close as we can get, and then, CMS, do you agree, are we
8 going to get 100 percent match on this? And, you know, just kind of piling on.
9 If at the end of the day we're just doing this for two years and then you're going to rip it up, the
10 clients are, like, "You've got to be freaking kidding me. We're spending a bloody fortune on this." For
11 what? To change the rates by a buck or two. And some of these rate cells are $5. This is a nightmare.
12 So you've got it mostly there, but just state it stronger.
13 COMMISSIONER RILEY: I guess I thought it was a very useful chapter, and I thought you did a
14 very good job unpeeling the onion to how complex this really is. And I thought that was very much value
15 added. I guess it raises a question for me, though, not that you should make it a five-year or -- it raises the
16 question of what is this going to tell us, because I think it won't tell us anything judging from the sort of
17 detail here.
18 There are two little caveats I would raise. One is we talk a lot about -- it's sort of assumed that fee
19 increases are a good thing and they always increase participation. I think we need a balance, and you did a
20 nice job pointing out the other issues. But that study that just keeps coming back to me is a 10 percent fee
21 increase increased participation by 4 percent. Where is the ROI? And so it keeps raising back to me as --
22 we also know when we talk to physicians, primary care physicians, they'll tell us these are tough patients to
23 see. Often they have mental illnesses. They're often disabled. They're very tough. The literature isn't

1 very rich on that, and I suspect because people think it's discriminatory. But I think that issue has to be
2 raised as part of what drives physician behavior.
3 The only -- the last piece, I guess, is similar to where Patty came down. I was very surprised by the
4 -- either Medicaid people have become way more polite since I was in state government, or the statement
5 that they raise uncertainty about their ability to continue struck me as profoundly weak and maybe
6 represents just the sample is too small. But it seems that from the budget officers and governors' staff that
7 I talk to, it's not an uncertainty. It's an "Are you kidding me?"
8 So it may be our sample, or maybe I'm talking to the wrong people, but I wondered if that was
9 maybe too weak a statement.
10 COMMISSIONER COHEN: So, Ben, I think the chapter did -- you did a good job with what you
11 had, but I think what we are reflecting here is that we don't have very much. And I think -- I have a
12 slightly different take on sort of what to do with that, though. I don't think it's -- it was obvious -- I think
13 we all understand what the intention was behind this provision, and having been there, you know,
14 sometimes decisions are made with less than full information when a giant bill is being put together. I'll
15 just say that as an understatement kind of a thing.
16 I think what we can add here is a little bit -- rather than -- I think the chapter has a bit of a tone of
17 this is -- there is a good intent here and some data behind it that, you know, payment increases can increase
18 access, or participation at least. But it's this, you know, implementing this provision is so complicated,
19 different, variable, happening late, such a short time period that there's sort of nothing we can do and that
20 sort of like destroys the value of the whole provision. I think we could do more, and maybe we can't do
21 more for the June report. But I think we could do some concrete things.
22 First of all, we could definitely ultimately down the road use this as a case study for, you know, what
23 are some criteria that might just be helpful for Congress and sort of like what is a minimum time period for

1 implementation of a certain kind of initiative that can make it -- you know, that sort of allows the
2 administrative burden that used to be worth a squeeze? I think we can eventually do a case study on this
3 that could actually have some real learnings rather than a little bit of like a "throw up the hands" kind of like,
4 you know, this is too tough.
5 I also think that for us to say -- because the regs came out late, because the implementation period is
6 so short, we have no way to evaluate this within a time frame that could allow for sort of informed
7 policymaking as to whether something like this gets extended or sort of what we do with that. I don't
8 think that's good enough. I think we should really think about let's, you know, we've got -- we've got the
9 sources that we've got. Let's figure out a way that somewhere in the middle of this implementation we can
10 say something about its value. And whether or not that has to be a little bit more qualitative than we'd like
11 -- well, probably a lot more qualitative than we'd like, let's figure out what are the data sources that we
12 possibly can get in time, and let's give some suggestions about how to use them, because for us to say there's
13 no way to evaluate this in time to continue it, I mean, you know, we're basically saying it was, you know,
14 almost like a failed experiment that can't be -- we're suggesting there can't be an informed decision about
15 extending it when it ends. And I think we can do better than that with a little bit more -- with a little bit
16 more thought and maybe a little bit more creativity, recognizing that we're not going to have the perfect data
17 to -- nobody's going to have the perfect data to do an evaluation while it's -- you know, in time to make a
18 great policy decision. I think we need to make the best of the circumstance that we have.
19 CHAIR ROWLAND: There is also a requirement that the administration evaluate this as well.
20 COMMISSIONER COHEN: So we might want to make some suggestions about what are some
21 decent sources that they could use or what are not decent sources. I feel a little bit like the chapter has a
22 little bit of "throw up your hands" sort of a flavor to it, and I think we should try to offer some more
23 suggestions.

1 CHAIR ROWLAND: Okay.

2 COMMISSIONER GABOW: I think the point you made about failed experiments shouldn't be
3 overlooked. As a scientist in my past life, you learn a lot from experiments that don't work. In fact,
4 oftentimes you learn more from experiments that don't work than you do from experiments that do work.
5 And so I don't think it's bad to call this out as an experiment which didn't work for the following reasons --

6 COMMISSIONER COHEN: We don't know quite yet. It hasn't started.

7 COMMISSIONER GABOW: No, but I'm just saying if -- it's going to be very hard to evaluate
8 the experiment, and that's an important part of experimental design, that if you design an experiment at
9 which at the end you cannot get the answers to the question you asked, that's a poorly designed experiment.
10 And you learn from that about how to redesign future experiments, because you often cannot go back and
11 repeat them. If they're a rat experiment, you get another cage of rats and do it again. But most
12 experiments aren't that way.

13 So I don't think it's bad to say this was an experiment that wasn't about an important issue, but the
14 experimental design was flawed to validly answer the question that was being posed. And to make it into
15 that kind of case study I don't think is throwing up your hands. I think it's saying we learned from this,
16 and here's the things we learned: that it shouldn't be administratively costly and complex to administer, we
17 should be able to measure the ROI in time to decide whether to continue the experiment.

18 I mean, I think we can make some observations about experimental design in this kind of a read,
19 which is different than a bench experiment.

20 CHAIR ROWLAND: But let's be clear. This is not an experiment or a demonstration.

21 VICE CHAIR SUNDWALL: It should have been.

22 CHAIR ROWLAND: This is a change in the law that is in place for two years, and that change
23 should be evaluated, but it was not set up to be meeting experimental design and to have -- but it is set up to

1 include an evaluation. It's set up in response to years of saying if you increase payment, will you increase
2 the supply or not? It's an issue -- that issue was one before us that we are to be examining and to be
3 looking at, and so we should be addressing that and seeing whether there are, as you said, lessons about
4 either success or failure. I mean, and this may also demonstrate very well that in some states it has made a
5 difference in terms of improving access and they will continue.
6 We also know that the two-year period was not designed to say in two years this will be fine, but
7 when Congress decides to do things, they often cannot get enough financing into it to make it permanent.
8 So that's really one of the problems of cost-related policy development.
9 But I think what Ben's chapter and what this chapter is trying to do is to really set out how is this
10 going forward, what are some of the places we should be watching to learn what worked and what didn't
11 work so that we can draw lessons for the future. And I think that's really what the point of this chapter
12 has to be.
13 Secondly, I think that when we talk about going and talking to different states, it's always kind of a
14 dilemma that we'll always face. We'll never be able on many of these issues to get 50 states to respond to
15 us, and in some states this is not a big issue because their payment policies were already at the Medicare
16 level. But it's one in which we have to figure out where there are states that could be particularly
17 informative and try to get them to participate. There's a lot of concern, I know, among the states about
18 how often they're being asked 17,000 different questions about the ACA implementation, their budget, dual
19 eligibles, and whatever. So I think we have to be very selective in what burden we put on the states to
20 provide information to us.
21 And, clearly, we can come up with a better rationale for how we pick the states we do, and it may
22 differ from one particular issue to another. But I think in many cases we're going to have to just rely on
23 more quasi-experimental design issues, but on qualitative and some might say even anecdotal information.

1 And I think, Patty, to your point, though we can characterize what we're doing, I mean, you don't describe a
2 focus group as a rigorous survey, and so we need to just be clear on what we're basing it on and that these
3 are interviews with selective states and how we chose that rationale.
4 COMMISSIONER CHECKETT: Yeah, all going points, and I think no great surprises.
5 In terms of the chapter itself, I do think Andy raised some points in terms of -- and I think what I
6 responded to was simply just the end, is that the -- and I'm looking here at the very last sentences -- the
7 Commission will continue to monitor. I think we should just strengthen the ending, and I think that might
8 actually go to some of your issues. It actually is very well done, Ben, and I think you've laid it out nicely,
9 and I was able to move through it pretty quickly and got the issues. And then you're, like, "Pffft."
10 So, you know, I think simply just strengthen the ending with a stronger idea about what we're going
11 to be doing or just don't monitor. My boss once said, "Never write down that you're going to monitor
12 anything."
13 [Laughter.]
14 COMMISSIONER CHECKETT: Do it. Right. Thanks.
15 CHAIR ROWLAND: Okay. Other comments?
16 COMMISSIONER CHAMBERS: Just one comment. It talks about the administrative burden,
17 and it talks about managed care, and it talked about the administrative burden on attestation. But it's also
18 the administrative burden -- you know, Donna probably can concur with this -- that the whole managed
19 care plans, nobody should probably feel sorry for them. You know, they're in it for business. But when
20 you have thousands of primary care physicians, you're renegotiating contracts constantly. It is an
21 administrative burden that, you know, Medicaid rates are already pretty low. So I think it's mentioned in
22 here, but maybe just a little bit more is that it's a major, major concern on the part of managed care plans,
23 particularly where you have capitated arrangements that aren't easily tied back on an actuarial basis as to

1 Medicaid versus Medicare fee schedule, is how the flexibility built in as to be able to, you know, trust that
2 the money is ending up in the hands of the right people. But it's not going to be this easy to monitor as it
3 would be in a fee-for-service or arrangement or state fee schedule or the way that they process claims as
4 managed care is different. So I'd just put that picture --
5 CHAIR ROWLAND: I think that is an area which the draft could be expanded somewhat. The
6 managed care section is a little skimpier, and some of those points could be brought out.
7 And I think the other point that might be worth adding here that goes with the administrative
8 burden is that while the federal government is providing for 100 percent financing of the fee differential,
9 that there are associated costs that have not been so compensated, and perhaps that's an area that we could
10 really add some discussion of to this chapter.
11 VICE CHAIR SUNDWALL: I was just going to say, would the Commission entertain a
12 recommendation like we don't think it is good policy to do temporary reimbursement modifications? I
13 mean, I don't know if that applies across the board, but understanding from actuaries and others how
14 terribly complicated this is, it just seems bad policy to me to do temporary fixes to reimbursement policy,
15 might apply across the board, not just to this update on Medicare.
16 COMMISSIONER GABOW: Well, I wouldn't want to go that far because, like the FMAP
17 change, when there was a recession, is critically important, and that's temporary reimbursement. So I think
18 it is complicated.
19 CHAIR ROWLAND: I think we could, however, without it going to the recommendation level,
20 raise in this chapter that the administrative complexity of implementing this when it could only potentially
21 stand in many places for a two-year period needs to be considered in enacting things on a temporary basis,
22 or, you know, on a short-term basis or, you know, in future policy development.
23 COMMISSIONER MARTINEZ ROGERS: I know that it's the law, but, you know, with nurse

1 practitioners that work in rural areas, they work independently -- primary care nurse practitioners work
2 independently of physicians. And I know that this law only pays for those that are with physicians.
3 VICE CHAIR SUNDWALL: That's right.
4 COMMISSIONER MARTINEZ ROGERS: Is there any way or would we be thinking of making
5 a recommendation that they might revisit this at one point?
6 CHAIR ROWLAND: Well, since we seem to be going down two tracks that we have, this
7 two-year problem and then we're saying but we should add on some more complexity to the two-year
8 problem. I think that in the conclusion, looking forward, might, in fact, raise the fact that there are these
9 administrative burdens, there are these other issues. And one also needs to revisit what the scope of such
10 an adjustment would be if it were going forward or if there's a recommendation at some point to make the
11 increase permanent, which, of course, could be something that we take up. Okay?
12 VICE CHAIR SUNDWALL: It costs money.
13 CHAIR ROWLAND: Yes, it costs money, and we would do the cost estimate of what the money
14 would be, and we probably wouldn't have a temporary fix if it didn't cost money either.
15 So thank you, Ben. I think you got a lot of comments on your chapter. I think the chapter itself
16 stands in very good shape, but I think some of the modifications that we have talked about here would be
17 useful to add into the chapter going forward.
18 So we will adjourn now for a lunch break and reconvene at about 1 o'clock or 1:10.
19 [Whereupon, at 12:31 p.m., the meeting was recessed, to reconvene at 1:10 p.m. this same day.]
20
21
22
23

1 AFTERNOON SESSION [1:14 p.m.]

2 CHAIR ROWLAND: Okay, I think let's reconvene and let's begin the public session of our
3 meeting.

4 And, Chris Peterson, you're up, right?

5 Okay.

6 EXECUTIVE DIRECTOR SCHWARTZ: And we have asked for the heat to be turned up or the
7 AC to be turned down.

8 [Pause.]

9 CHAIR ROWLAND: Okay, if we can please reconvene to continue our discussion now of the
10 various chapters proposed for our June report.

11 Many of you expressed an interest several meetings ago in getting more of a handle on the use of
12 waivers and the implications of waivers for the Medicaid program, and so Chris is going to take us through
13 the highlights of the chapter that you are reviewing on this issue -- mostly descriptive in nature. We're not
14 undertaking a revision of the waiver system, just here trying to describe what's in place today.

15 Chris.

16 **### DRAFT JUNE REPORT CHAPTER ON WAIVERS**

17 * MR. PETERSON: Thank you, Diane.

18 In this session, I will review the work we have ongoing on waivers in Medicaid; then I'll provide an
19 overview of the draft chapter entitled The Role of Waivers in Medicaid, which you have received as part of
20 your materials.

21 This chapter begins with an overview of all Medicaid waiver authorities, some of which have rarely
22 or never been used.

23 SPEAKER: [Inaudible.]

1 [Laughter.]

2 MR. PETERSON: Peterson.

3 CHAIR ROWLAND: The magic wand of waivers.

4 MR. PETERSON: Now we're up and running. I was waiting for the man behind the curtain to

5 turn everything on.

6 So, as I mentioned, the chapter begins with an overview of all Medicaid waiver authorities, some of

7 which have rarely or never been used. Then the chapter focuses on the three main waivers used in

8 Medicaid -- 1115s, 1915(b)s and 1915(c)s.

9 Our goals here today are, number one, to get your feedback on our general approach to our analyses

10 on waivers and, two, to get your feedback on the draft chapter in particular.

11 So, as Diane mentioned, you've expressed an interest in waivers. This is an important issue in

12 Medicaid. Every state has at least one Medicaid waiver. And the data that we ran found that 41 percent

13 of Medicaid benefit spending occurred under a waiver in FY 2012 and, in FY 2009, 66 percent of Medicaid

14 enrollees were in a waiver program.

15 So, given the widespread use of waivers, it raises many questions, a few of which are here:

16 What does this mean about the statutory requirements being waived?

17 What are the implications for states, for example, when they're having to renew their waivers for

18 approaches they've had in place for years or even decades?

19 And then, on the flipside, what are the implications for the federal government in assuring program

20 accountability but also going through the process of renewing and reviewing waivers?

21 In terms of what we are doing, we contracted work with Abt Associates to do two things. First

22 was with the Muskie School in Maine as the subcontractor to put together information on all current

23 Medicaid waivers. Then secondly is to do interviews with Medicaid experts and thought leaders on the use

1 of waivers.

2 So we have received a draft report of the first item, the compilation, on which the descriptive
3 chapter for June you have is based. On the second piece, those interviews are now completed. They
4 were with, I think, about a dozen experts, mostly current and former state Medicaid directors, but we also
5 interviewed CMS and some other folks as well.

6 So what we anticipate is that, as Diane mentioned, this is a descriptive chapter, but we plan to build
7 on this and have sessions in future meetings where we can dig into some of the more fundamental questions
8 raised, hopefully bringing in some of the interviewees that we used on the project.

9 So now the big picture overview of all the available Medicaid waivers -- we scoured federal law and
10 found nine different possible types of Medicaid waivers that we'll talk about over the next couple slides, and
11 I'll hit on these before we focus on the main three.

12 We categorized Medicaid waivers into two groups -- demonstration waivers and program waivers.

13 And demonstration waivers are supposed to be experiments with a rigorous evaluation component
14 and other features. That's actually how 1115s started, based on information that we have in the contractor
15 report, where the administration would generally say this is an initiative we have in mind and you can apply
16 for an 1115 waiver to do this kind of thing -- kind of like what is happening now under the 1115A authority
17 with the Innovation Center Grants.

18 But Arizona's entry into the Medicaid program in 1982 was the first time that an 1115 waiver was
19 used in a bigger kind of way, to expand enrollment as they did. Arizona continued to be the exception
20 rather than the rule until the failure of Clinton health reform in 1994. After that, 1115s started to evolve
21 into what they are today, where the state reaches out to CMS and says we're interested in doing something
22 that we can only do if we can get some portion of the requirements in Title 19 waived.

23 As shown in this multicolored slide, there are also waivers – 1115A is the Innovation Center Grants,

1 and that was described in a previous meeting. Sean Dunbar from the Innovation Center had come and
2 presented on what they are doing there.
3 1938 are Health Opportunity Accounts -- those were created in the DRA, the Deficit Reduction Act
4 in 2005-2006. Those HOAs enabled states to take an approach that would pattern after Health Savings
5 Accounts, where there would be a high deductible health plan and then there would be a funded account
6 that would cover most or all of that deductible and enrollees would choose how to spend money out of that
7 account.
8 Although CBO and a lot of folks expected states to take up this option, it ended up only one state --
9 South Carolina -- took up this option and had a grand total of five enrollees.
10 [Laughter.]
11 MR. PETERSON: Indiana actually has something similar you might have heard about -- their HIP
12 plan -- but that's actually being done under an 1115 waiver.
13 Money Follows the Person was created also by the DRA, and MFP provides funding to states to
14 transition beneficiaries from institutions to the community with additional federal funding for states. It
15 began in the DRA as a five-year demonstration. So from FY 2007 to FY 2011, it was appropriated $1.75
16 billion. Then the ACA extended it by another five years, appropriating $2.25 billion for FY 2012 to FY
17 2016.
18 So, similar to the Innovation Center approach, MFP is a grant initiative; states apply. And now 47
19 states are participating in Money Follows the Person.
20 And the last one on the slide, Section 402, has really only been used twice for Medicaid purposes.
21 The first time involved three states, and the second time involved eight. This is primarily a Medicare
22 waiver that brings Medicaid along to do some multipayer initiatives.
23 And the current initiative in those eight states has to do with Medicare and Medicaid and private

1 insurance paying similarly to certain primary care practices. So it's kind of along the lines of the medical
2 home concept.
3 Now, the program waiver authorities. And so we define program waivers to be waivers that aren't
4 generally testing new approaches but are used to replicate discrete program reforms but that still require a
5 waiver of certain statutory provisions.
6 1915(b), Freedom of Choice waivers -- we'll dig into that a little bit more, but that's primarily how
7 managed care -- that's often how managed care is implemented in states.
8 And 1915(c) waivers for home and community-based services.
9 1915(d)s and (e)s are in the statute and are not currently in use right now.
10 So the three primary types of Medicaid waivers are 1115, 1915(b) and (c).
11 The 1115 waivers are in 39 states. It gives the Secretary broad authority to waive federal Medicaid
12 requirements. And it's important to note that states that have 1115s -- some states have virtually all of
13 their Medicaid program running under an 1115, like Arizona and Vermont, for example. And then other
14 states will have a very limited portion operating under the 1115, so it may be used to provide family
15 planning only services to individuals not otherwise eligible for Medicaid.
16 All three of these waivers have a requirement that they do not increase federal spending above what
17 would have occurred in the absence of the waiver. They have different terms for each of these waivers,
18 and in the 1115 context it's generally called budget neutrality.
19 1915(b)s are called Freedom of Choice waivers. The Secretary actually has broad authority to
20 waive a lot in Medicaid here as well, but because 1915(b) is for very specific things around managed care,
21 they're usually called Freedom of Choice waivers. So, as the slide says, states may mandatorily enroll all
22 populations in primary care case management or in a single managed care plan, and it must demonstrate
23 cost effectiveness.

1 1915(c) waivers enable states to provide home and community-based services to certain groups and
2 to cap enrollment. So that waives several provisions of the Medicaid law in order to accomplish that.
3 Every state has a waiver to offer home and community-based services. The other states that do
4 not have 1915(c)s do it through an 1115.
5 All states under 1915(c) must demonstrate cost neutrality. And because the waivers are -- each
6 individual waiver is targeted toward a particular population, most states have five or more (c) waivers.
7 I mentioned the 41 percent. Now that we're providing some more detail, the usual Medicaid data
8 caveats apply.
9 We are looking into depth about what states really are reporting for these numbers, but this comes
10 from the 64 form. And you see that almost a quarter of Medicaid spending is under 1115s and 9 percent
11 for 1915(b)s and 9 percent for 1915(c)s. So that's looking at the spending, and that's for FY 2012.
12 The latest numbers we have for enrollment then go back to 2009. For the chapter, we ultimately
13 want to have 2010, but this is what we have available at this point. So it's not quite apples and oranges.
14 It is apples and oranges, rather, to the previous slide.
15 But what it shows is 40 percent of enrollees were in a 1915(b) program during the year, and that's
16 much higher than the comparable spending number. And there are many reasons for that.
17 Number one is that individuals enrolled in managed care tend to be less expensive populations.
18 Number 2, 1915(b)s are also used to cover primary care case management, which generally is where the
19 individuals receive services and those services are paid on a fee-for-service basis but there is a payment that
20 goes to the primary care provider that can be relatively small. So a lot of people may be enrolled in this
21 program, but the spending under that program maybe relatively small.
22 And the reverse is somewhat true with the 1915(c) because there are only 2.4 percent of enrollees
23 enrolled in a 1915(c) but they tend to be more expensive individuals But, again, there are some

1 differentiations between the years. So there could be other things going on there.

2 With this slide, I should note that individuals may be in more than one type of waiver over the

3 course of the year, or even at one time. So the next slide tries to unduplicate those numbers.

4 So, if we start with the pie up at the top and then work our way counterclockwise, we have 34

5 percent of enrollees not in a waiver. Only in 1915(c) is 1.3 percent of enrollees; only in (b), 35.2; and only

6 in 1115 is a quarter. And then for those who were in multiple waivers during the year you have a little

7 breakout to see how that works out.

8 One of the issues that often comes up when you talk about waivers is the approval process and

9 other process-related requirements. And to compare that to the typical State Plan Amendment -- or SPA

10 -- process, the SPA process works such that when a state submits their SPA, CMS has 90 days to respond,

11 deny and/or request additional information.

12 If CMS requests additional information formally, in writing, the clock stops. The state takes its

13 time to respond. It submits its response for that additional information, and then a new 90-day clock

14 starts.

15 That's the same process used for 1915(b)s and (c)s.

16 For 1115s, there is no required time frame for CMS approval. So those waivers can take months

17 or even years to get approval.

18 I should note, though, that SPAs, 1915(b)s and 1915(c)s address relatively discrete things whereas a

19 Section 1115 waiver can, as I mentioned, be comprehensive and can incorporate everything in the state's

20 Medicaid program.

21 And at the same time you've got budget neutrality requirements, and each element of that 1115

22 waiver has to have calculations about how much each component costs. And so this adds to the

23 complexity of the process.

1 SPAs, of course, are generally indefinitely approved. So once they're approved and that is in place,
2 there is no renewal required whereas the waivers have renewal periods, as you see there.
3 SPAs do not require monitoring and evaluation beyond what is required to show that they are
4 maintaining compliance whereas for the waivers there are annual state requirements for 1115s and other
5 evaluational requirements for all these waivers.
6 And, as I mentioned, all of the waivers require meeting some budget targets whereas none is
7 required for a SPA.
8 I know that you have many issues and considerations, and we put in a list in the back of the chapter,
9 and these are a few:
10 Does the universality of certain waivers suggest the need for additional state plan options?
11 What is the role of the statutory principles in Medicaid of statewideness, comparability and freedom
12 of choice when they are waived so often?
13 And what are the opportunities for streamlining waiver approvals, particularly for long-used
14 approaches?
15 So that is a summary of where we're headed on waivers, what our approach in the draft chapter, and
16 we look forward to your feedback.
17 CHAIR ROWLAND: Thank you.
18 David, first, and then Patty.
19 VICE CHAIR SUNDWALL: Oh, sorry.
20 Thank you, Chris. This was really helpful for me. I have been responsible for a state Medicaid
21 program, but I don't think I ever appreciated this variety as much as I have from this. It was really a good
22 presentation.
23 My one overarching question is I've always had the impression that waivers were to demonstrate

1 something that works better, cheaper, that ought to be adopted. Do you have the impression that with all
2 of this remarkable waiver activity we've had a concise lessons learned from all of this that we ought to
3 maybe take to the next step of recommending be adopted nationwide, or is this just an eternal state
4 experimentation?
5 MR. PETERSON: I think that's a concern that's been expressed by the National Association of
6 Medicaid Directors and state Medicaid directors at large -- is there is no path to permanence for a lot of
7 these waivers.
8 So even if an 1115 waiver demonstrates that it's effective, there is no permanent way to say, okay,
9 we've demonstrated that our managed care program -- we've limited freedom of choice. It works for us.
10 Let's just do this permanently.
11 You can't do that under a regular state plan process for all of your populations. And that's just one
12 example of where states may want additional flexibility under a state plan option, and the waivers don't
13 provide a path to go from a waiver to something more permanent.
14 CHAIR ROWLAND: Okay. So I have Patty, Mark, Judy, Trish, Donna.
15 COMMISSIONER GABOW: Thank you.
16 My only comment -- I have several comments; what can I do -- is that this is an important chapter,
17 and while it needs some tweaking I think it's going to become a classic because I think this is very, very
18 important.
19 And I have a couple comments. I think it would be good to include some detail about what is a
20 state plan and a state plan amendment because --
21 VICE CHAIR SUNDWALL: I agree.
22 COMMISSIONER GABOW: -- if you don't know that -- you know, what are the standard
23 inclusions? I think that would be good.

1 And --

2 CHAIR ROWLAND: And Patty, that would be why you would use a state plan amendment

3 instead of a waiver.

4 COMMISSIONER GABOW: Right. And what is a state plan in the first place?

5 What are states required to include in their state plan?

6 When do they have to do a state plan amendment?

7 When do you choose one or the other?

8 I think that would add to this becoming a classic.

9 I also think it may be worth pointing out that the waivers have contributed to having no national

10 standard for Medicaid. The law that was enacted when Medicaid was enacted, and the things that came

11 after, were to establish a national program that was jointly administered and funded by the states, but this

12 has enabled it not to be a national program. I think that's worth pointing out, maybe not in a negative way

13 but pointing it out.

14 And part of that is, I think it's worth pointing out, that this has given states enormous flexibility.

15 And I think the whole issue about states needing flexibility is that it's worth pointing out the range of

16 flexibility that the waivers have given states.

17 You know, you sort of do that, but I think sort of more particularly calling out how this has, on one

18 hand, made it not a federal program and, on the other hand, enabled flexibility across a whole range of

19 things is important.

20 And I wondered if you have any data about whether there were really good data on the

21 demonstration projects in terms of what were the metrics that they were intended to demonstrate and what

22 were the metrics that we have from them. I think that's very useful. Would they pass the test of

23 preventive task force, high quality measure, or medium quality or low quality?

1 I think that would be helpful if we have that.

2 And I think your point about no pathway forward and whether the kind of flexibility that is in the

3 CMMI, that if it works the Secretary can implement it should be thought about.

4 I mean, I know we're not ready to make recommendations at this point, but that is something I

5 think that you point out that's very important.

6 CHAIR ROWLAND: Mark.

7 COMMISSIONER HOYT: I thought the chapter was really well written. And if anything has

8 ever tempted me to break the confidentiality agreement, it was those charts. I would love to send those

9 charts to a number of people. Those are going to be really popular when those come out.

10 I think you're asking the right questions. It seems like you walked right up to the line of shall we

11 make a recommendation or not.

12 In my mind, we should. There ought to be something about this we could recommend.

13 So I spent 20 years in the field and talking to states. I know I'm not the only one in here who's

14 done that.

15 I guess my sense from all the people I've talked to would be a number of the things that are

16 demonstrated, tested, monitored through the waivers were new, creative, innovative in the 90s; in the early

17 2000s, around managed care contracting or especially in long-term care the use of home and

18 community-based services.

19 And to some people this is like Groundhog Day by now, every day. They wake up, and they're just

20 following the same waiver over and over, for things where there's nothing left to prove. There's nothing

21 left to demonstrate.

22 And when you think of how many resources are tied up behind the administration of all these

23 waivers that you've documented and how short-staffed states are right now, I really think there's no juice left

1 here for the squeeze. The effort is just not returning the value. There's nothing new under the sun here
2 to do. And, furthermore, it's blocking certain things that they could test in the way of new things or
3 innovation if they didn't have to keep complying with these processes behind the waivers.
4 So I'd like to see -- although it's not well formulated -- some kind of recommendation that we move
5 a block of these services or delivery approaches into the permissive column instead of having to continue to
6 file waivers for things that have been around for 10, 15, 20 years that 30 states have done.
7 MR. PETERSON: I'll just note that with our -- our approach at this point is that the June chapter
8 provides the baseline and that we anticipate, even in the next meeting, bringing in some experts so that we
9 can start to get some perspectives brought to you as a body on what the States think on these issues, what
10 the Federal perspective is, what the tradeoffs would be in trying to create such a path to permanence on
11 some of these.
12 CHAIR ROWLAND: Isn't there also a provision with regard to the Innovation Center that does
13 set up that kind of a pathway?
14 MR. PETERSON: Yes.
15 CHAIR ROWLAND: And we might look at what they have proposed there or what they're using
16 as their standard for deciding how to move forward and think about that in light of Mark's comments.
17 I've got Judy next.
18 COMMISSIONER MOORE: Nice job, Chris. I think this is a good chapter. It's got a lot of
19 really good information in it.
20 I'd like to see a little bit more perspective in terms of the history, and some other folks have brought
21 this up, too, in terms of what's been done in the past that actually has been accepted or adopted into the
22 program, the family planning stuff, expansions and coverage to a variety of groups, especially kids, for that
23 matter. And you can't necessarily draw straight lines, but I think through your interviews and through the

1 things that have been written before, that that's fairly clear.

2 There were a lot of fairly sophisticated evaluation efforts way, way, way back in the 1980s and 1990s

3 and I think we could maybe reflect a little bit of that. I think the ball got dropped a bit in the last couple of

4 decades in terms of real evaluations, but there were some going back.

5 And as Patty said, you know, the States like to complain about the waivers, and I understand why

6 they do in terms of the burdensome administrative requirements that are in place for some of them. But it

7 seems to me that over -- if you look back for decades across these programs, these waiver programs, they've

8 really served the States very, very well in providing a kind of, like, civility that wasn't necessarily available in

9 the statute, and they still do to this day, and I think we need to kind of reflect that qualitative and, again,

10 tonal kind of thing in the chapter. At least, I'd like to see that there, because I really do believe that the

11 waivers have served both the Federal and the State governments well.

12 But they have also resulted in a difference in the program from State to State. And if all health care

13 is local, then maybe waivers were good. And if you want a national floor, then maybe waivers are bad.

14 So, I mean, I think you can reflect a bit more of those kinds of sentiments and ideas based on the work that

15 you've done and the interviews that we've had and I'd like to see a little bit more of that in the chapter.

16 But it's great to have all these data, the charts and the information. I don't know if we will try to

17 keep that up to date. I know other groups do these kinds of things from time to time. But it's terrific to

18 have all that in one place.

19 CHAIR ROWLAND: Trish.

20 COMMISSIONER RILEY: Yeah, I agree, and I'd just follow up from Judy's point. I think for

21 the next round, we need sort of a richness here, but what -- it's not just that there's no pathway to

22 permanence. What have we learned? What are the lessons learned? And if variation is a cost in health

23 care, is this an exacerbating problem of variation in high costs and no program left, it's State by State by

1 State, or are there real buckets of similarity, and I think it's the latter.

2 So what are these initiatives doing? I know there's a lot of them, but if you could sort of

3 characterize it in a more real kind of way so we have an understanding of what States are doing, because I

4 think there is actually more similarity than there is variation.

5 One piece I'd like to see added, the Global Commitment waiver in Vermont and the Rhode Island

6 waiver, I think were 1115, and there's new interest in those, so I think we ought to add that here and talk a

7 bit more about what they were intended to do and what we learned from them.

8 CHAIR ROWLAND: Okay. Donna.

9 COMMISSIONER CHECKETT: Well, you know, obviously, I agree with comments of the other

10 Commissioners in terms of this is just such important work, and I think it will be so well received by a

11 number of people because it is, in some ways, it's the heart of a lot of frustration between States and CMS.

12 And it's something that Governors have latched onto. But when you ask them and they say, well, we want

13 more flexibility, you know, unfortunately, they and a lot of the people who work with them haven't had the

14 ability to look at it like this and say, okay, wow, this is what we really mean. So I think it's really what will

15 be the beginning of a discussion.

16 To that vein, I guess I have to point out the obvious conclusion, which is that if only 34 percent of

17 Medicaid beneficiaries aren't in a waiver, perhaps we need to have a waiver to do nothing to people. I

18 mean --

19 [Laughter.]

20 COMMISSIONER CHECKETT: Put up with me for a moment. But it called out to me when I

21 looked at the slide. Seriously, if only 34 percent of the beneficiaries aren't in managed care, they aren't in a

22 1915(b), they're not in a -- you know, you should have a waiver to enroll somebody in a program and not

23 help them access care, not get them the supplemental services they need to live at home. I'm half in jest,

1 but maybe not totally. But I think that --

2 CHAIR ROWLAND: Well, Donna, I think the duals waivers may be cutting into that 34 percent.

3 COMMISSIONER CHECKETT: And, you know, one of the best Medicaid programs, one of the

4 best Medicaid programs in the country, Arizona, is still an 1115 waiver and has been since 1982.

5 And I think, and I guess I'd like for us to -- Diane, the best context for you to decide -- but really

6 think about, you know, what would we want to recommend? I mean, there are some things that are pretty

7 obvious. When something has been an 1115 waiver since 1982, perhaps -- call me crazy -- it's time to just

8 let it be its own program. And there might be things we could think about timelines, or some of these

9 things have been in place for so long and it would not be hard to imagine that CMS secretly and State

10 Medicaid directors loudly would say, let's just make them plan amendments and let them run. I mean,

11 they've kind of done their thing.

12 And I think that's really important work that we could do. I think we need to really talk to some

13 experts in how that would work and think about the implications. But I think that type of work, which

14 would be, you know, this is setting us up for, I think, some really serious and important policy and program

15 decisions we can make on behalf of the 34 percent of beneficiaries who have nobody doing anything to help

16 them.

17 So, I will stop.

18 CHAIR ROWLAND: Although I think there's a balance there, too.

19 COMMISSIONER CHECKETT: Absolutely.

20 CHAIR ROWLAND: I mean, in some cases where waivered services have then been added as an

21 optional benefit, in the case of home and community-based services, for example, the States have opted

22 instead to stay with the waiver because it allows them to do things that they can't do once it becomes an

23 optional benefit, such as restrict State-wideness. That's clearly underlying some of the points that Chris

1 has, but that's probably worth also picking up, that even if you went on some of these to say, we'll make it a
2 permanent feature of the program, there may be some other advantages that States have seen in being able
3 to do more limited approaches on those benefits.
4 COMMISSIONER CHECKETT: Or -- and I understand what you're saying, Diane, but one
5 question would be, you know, can you still do that, but do you have to do that through a waiver? I mean,
6 could that just be done through a State plan amendment? I don't know that any of us are expert enough to
7 answer that, but that would be the discussion I'd like us to have.
8 COMMISSIONER RILEY: But at a real fundamental level, we have to remember a good reason
9 for keeping a waiver is you can cap enrollment so you can control your budget. So it gets into the block
10 grant discussion. I think we have to be careful before we leap that all waivers are always good for all
11 people, and I'm not sure we know that.
12 COMMISSIONER CHECKETT: Right.
13 CHAIR ROWLAND: And, Andy.
14 COMMISSIONER COHEN: Great job on the chapter. I had a couple of specific questions,
15 maybe for this chapter, maybe for future consideration. I sort of leave that to you.
16 One is, I was intrigued when I read it and also when I saw it up there, the different financing
17 requirements, or, I should say, the different wording around the different financing requirements for the
18 different kinds of waivers, I think to get a little bit deeper on what those differences mean to the lay person.
19 They sound awfully similar, but I know that, in fact, they are not. And so I think that sort of the chapter,
20 to me, kind of begged for a little explanation of what cost effectiveness means as compared to budget
21 neutrality as compared to whatever. And those are, as I understand, they're really significant distinctions,
22 actually. So that was one very specific thought.
23 I can help --

1 CHAIR ROWLAND: Andy, could I just add to that?

2 COMMISSIONER COHEN: Yeah.

3 CHAIR ROWLAND: And I think it's important to note where those budgetary requirements are
4 statutory as opposed to administrative, because not all of the waiver requirements are a statutory
5 requirement. They're just the way the department has implemented them.

6 COMMISSIONER COHEN: And I know -- I just sort of can't help but make this sort of
7 observation, and I think it belongs at least as a sort of framing point in the chapter, probably. I mean, the
8 thing that is really, to me, at least, unique about some of the really big 1115 waivers is that, basically, you've
9 taken a program that's governed by laws that have been passed by Congress into basically sort of pretty
10 free-flow transactions between States and the administration that's in power at that time. So it is a real
11 shift in the power of who's deciding what the Medicaid program looks like, and I think that that is, in fact,
12 both sort of like, in many ways, the brilliance and the weakness of waivers, is that they do depend very much
13 sort of like the principles of them, unlike laws, are not necessarily lasting. It may very much be about the
14 priorities of the administration in place at that time and it's a really tremendous authority to be able to
15 implement them.

16 So, depending on your perspective, that can be wonderful and that can be negative. But I think to
17 explain just how much sort of authority goes with the waiver, the 1115 waivers and what a shift of authority
18 that is away from Congress is a really important point for us to make and to sort of flag some issues and
19 concerns about that. And maybe the answer is to say, you know, the broadest component of the 1115 is
20 that the only real requirement besides -- there are certain things that can be waived and certain things that
21 cannot, but ultimately, they have to be sort of consistent with the objectives of the program. Is that what
22 it says? Well, no one has defined what the objectives of the program are, and every administration and sort
23 of State does that each time transactionally.

1 You know, one place to go, in addition to the really sort of specific and hard work that Donna
2 pointed out but that's so important, is let's categorize the actual interventions and sort of decide if there are
3 ones that really have been proven enough that, by intervention, they should be sort of called out and made
4 part of the statute.
5 But, you know, we also might sort of think about ways of putting some parameters around what
6 those objectives -- that Congress might want to put some parameters around what those objectives are. I
7 know these can be scary sort of suggestions, but it does sort of go to, like, accountability in government and
8 where the authority is and I think we should at least point those issues out.
9 CHAIR ROWLAND: And I'd like to go back to the point that Judy made earlier. There's also
10 been a change in how rigorously these various waivers have been evaluated and what criteria, therefore,
11 would you have to say that something should go forward as a permanent statutory change. Just because
12 it's been around for ten years doesn't necessarily mean that the evidence is there to make a permanent
13 statutory change. So I think it is both an accountability issue, but also an evaluation issue of how well is
14 the administration really evaluating these many changes.
15 Trish.
16 COMMISSIONER RILEY: I agree, but it also has to be balanced with State legislatures and
17 governors, which is a pretty compelling point of accountability. So I think, you know, there's the rigorous
18 research test. There's also the reality of legislatures who are appropriating money for this, and that's also
19 one method of evaluation.
20 CHAIR ROWLAND: The other point is whether or not there can be some mention here of what
21 can't be waived. Is everything in the statute waivable, or -- you know, you've identified all these different
22 types of waivers, but I was always told that the one piece that can't really be waived is the financing. You
23 know, you can't change the FMAP via waiver. So it might be worth noting sort of what the overall context

1 of being able to do waivers is.

2 And then I think it's also important to point out that the 1115 waiver authority is broader than just a
3 Medicaid provision, whereas the other ones are Medicaid provisions, and how that interacts.

4 Other comments on the waivers? I think, to go back to Mark's point that this is really going to be
5 a chapter that is important and informational, and I think it also begins just to talk about what is the shape
6 of the future Medicaid program that you want, and it may be not just taking one waiver at a time, but saying,
7 are there ways that the waivers have shown us places where the program can be improved or restructured,
8 because the purpose of 1115s was to demonstrate better ways to deliver more cost-effective, higher quality
9 care to the populations being served.

10 So I think you've got a great first piece here, but we know it's not going to be the last of our -- I
11 think waivers are an incredible part of what we need to keep looking at and focusing on, and it's not just the
12 process of how you get them, but it's what is happening when people do get the waivers at the State level
13 and how to see whether those are really being instructive ways to change the program. So thank you.

14 Donna.

15 COMMISSIONER CHECKETT: I -- just to point out, is we close the discussion that, you know,
16 probably the hottest thing out there now in the Medicaid expansion world is the Arizona, or the Arkansas
17 proposal, which the solution that's being pursued is probably going to be an 1115 waiver. So, clearly, they
18 are very important.

19 I really like the concept of having a -- and I think, Diane, that you were articulating -- is taking a look
20 at what has been waived so long that you have to question, do we really need to have a waiver for that, as
21 opposed to things where we really do need to have a waiver, and I think it's time to have kind of a mature
22 look-back at a very mature program and say, what continues to make sense? What are the lessons we've
23 learned? What are we comfortable with? And then what are the things we really need this very unique

1 process for?

2 So I'm excited about the chapter.

3 CHAIR ROWLAND: You know, it's also interesting, as we look at whether States are going to

4 come in or not come in under the Medicaid expansion, the reason that Arizona had to operate under a

5 waiver was that it missed the statutory window --

6 VICE CHAIR SUNDWALL: That's right.

7 CHAIR ROWLAND: -- to decide to come in and run a Medicaid program. And so the only way

8 it could get into the program was through a waiver. A little history.

9 Thank you, Chris.

10 Okay. And, if Amy Bernstein can come up. Obviously, one of the other areas that we have

11 focused on and that we will continue to focus on is the role that the Medicaid program plays for pregnant

12 women and children, and so Amy is going to update us on the work in the chapter that we are putting

13 forward on maternity eligibility coverage and enrollment in Medicaid and CHIP. This follows up previous

14 discussions we've had in a roundtable, and Amy will now proceed to update us. And we're at Tab 4 in

15 your notebooks.

16 **### DRAFT JUNE REPORT CHAPTER ON MATERNITY CARE IN MEDICAID AND**

17 **CHIP**

18 * MS. BERNSTEIN: Thank you. Before I get into the chapter and the organization of the

19 chapter, I'd just like to give you a little bit of policy context, just to put Medicaid births in perspective with

20 all births.

21 Based on vital statistics where the latest data are actually 2010, having come from the National

22 Center for Health Statistics, I can tell you that's as fast as we can get the data out. I'm very sorry about

23 that. But in 2010, there were about four million births and the birth rate has been going down over time

1 slightly. The Caesarian rate was 32.8 percent. Again, NCHS usually makes it two digits, so I think it's
2 32.82 percent of all births, and that was a decline from 32.9 whatever it was percent in 2009. But that does
3 to them constitute a decrease because it is all births. So you don't have a standard error. This is what it
4 is. Birthrates are declining.
5 The percentage of all births delivered at 37 to 38 weeks, which is how they define pre-term births,
6 and that is different from, let's say, what CMS Strong Start does, where they talk about births before 39
7 weeks. NCHS and vital statistics define pre-term births at 37 to 38 weeks, which they call early-term
8 births, is 27, about 28 percent in 2010. And as we all know, those births were increasing and spiked in
9 2006, but they have been on the decline, again, slowly on the decline, but on the decline since then.
10 A little bit more overall context. Again in 2010, the latest year, about eight percent, 8.4 percent of
11 all U.S. births were midwife-attended, and this has been increasing over time.
12 Less than one percent of U.S. births occurred in a residence, and most of the data we have on births
13 obviously are from hospitals, and most births do occur in hospitals.
14 Supply is obviously an issue, and the latest data that we could find on that is that about half of U.S.
15 counties do not have a practicing obstetrician or gynecologist. And the latest data, which is difficult to
16 come by because supply of nurse midwife data by county is difficult to obtain, is that almost all of the
17 counties that don't have an obstetrician/gynecologist also do not have a nurse midwife. Basically, they are
18 undersupplied in all kinds of practitioners.
19 Getting back to Medicaid, Medicaid pays for almost half of all the births in the United States, and
20 that's pretty significant. Private insurance paid slightly less, so again, almost half. And the uninsured
21 comprised about four percent of all births in -- I should qualify this -- in community hospitals. So we have
22 excluded home births and births in birth centers from these data because this is from the Health Care Cost
23 and Utilization Project data, which is hospitalizations in community-based hospitals.

1 Again, you know, as with all things, this differs by State. So in some States, the rates of births that
2 are paid by Medicaid are substantially higher than births in other States.
3 I should say that these statistics vary depending on where you get them from. So these particular
4 statistics, again, come from the Health Care Cost and Utilization Project. If you were to go to the National
5 Governors Association or Kaiser State Health Facts, the numbers are slightly different because they get data
6 directly from the States and they define Medicaid somewhat differently. But the bottom line is that,
7 obviously, it differs by State.
8 Again, using Health Care Cost and Utilization data, the costs were over $7 billion, and that's just the
9 hospitalizations for deliveries. That doesn't include any prenatal care or anything like that. So we're
10 talking about some money here.
11 And when you compare the Caesarian rate to the privately insured rate, they're pretty much the
12 same. The Medicaid Caesarian rate, overall, is maybe two or three tenths of a percentage point lower than
13 the privately insured rate, but they're very similar.
14 So having said that, we can get into the organization of the chapter that's in your binder, and we
15 focused in this chapter particularly on eligibility and coverage. We didn't focus on financing issues, which
16 are even more complicated than the eligibility and coverage pathways, which were more complicated than I
17 thought they would be, in any case.
18 We start with sort of the eligibility pathways, what entitles you to become covered for maternity
19 care, and there are many different ways that you can enter the program, through many different pathways.
20 What benefits are covered, because, again, this varies on your eligibility pathway.
21 I'm not going to discuss provider issues here today because we're trying to flesh out a little more
22 data and I'm not prepared to talk about it today.
23 And utilization and expenditures, we are working on how. We actually have some fairly exciting

1 data that we're having computed for us by our data contractor, and we're hoping to present that to you in
2 the next meeting if you're interested. We should have things like the percentage of women by program,
3 expenditures, and managed care versus non-managed care expenditures, and utilization, and also by other
4 characteristics of Medicaid programs. So we're not quite done with that data yet, so we couldn't present
5 that to you today.
6 And then the chapter continues with incentives to reduce early elective deliveries and Caesarian
7 sections, because that's been a big impetus from CMS and States because it reduces costs and improves
8 quality, it is believed. And then a brief discussion of issues and next steps for your consideration.
9 So, just briefly to go through the chapter, there are, again, many different pathways to entering the
10 program for maternity coverage. We have our categorical Medicaid, where you receive services because
11 you are a pregnant woman, and there are several pathways through which you can receive that. The
12 chapter doesn't discuss specific coverage for institutionalized women who become pregnant or CHIP
13 children who become pregnant. We could add that if you thought it was important enough, but it's not
14 very many children and it sort of complicates things, but we could mention it if you like.
15 Immigrants can now be covered under CHIP, either for emergency services only or for more
16 coverage through a State plan amendment or through the unborn child amendment, which is basically the
17 pathway where, in 2002, CMS issued regulations that -- or guidance, I guess they called it -- that States
18 could, through their State plan amendment, or actually through a waiver, also say that you could cover illegal
19 immigrants -- I'm sorry, undocumented -- I'm sorry, I shouldn't say illegal -- undocumented women who
20 were not otherwise eligible for services because their child was, de facto, a citizen, so you were allowed to
21 provide care for the child, not for the mother, but the child was in the mother, so it was hard to treat the
22 child without treating the mother, so --
23 [Laughter.]

1 MS. BERNSTEIN: That's my naive interpretation of it.

2 CHAIR ROWLAND: [Off microphone.]

3 MS. BERNSTEIN: But it was basically services for the child.

4 CHIP, when it was first established, did not cover pregnant women. There was Clinton
5 administration guidance in 2000 that you could use 1115 waivers to include pregnant women, as well as
6 children, but you also had to -- again, some States were reluctant to do this because of the budget neutrality
7 issues that Chris discussed. And then State plan amendments were, under CHIPRA in specific, you were
8 allowed to cover pregnant women through CHIP.

9 Presumptive eligibility, another type of eligibility, is just 37 States now, I believe, have presumptive
10 eligibility, where a woman who thinks she's pregnant can go receive care, and then apply and the care that is
11 paid for before she actually becomes enrolled in Medicaid will then be covered.

12 So that's eligibility.

13 The ACA actually has a couple of things that affect eligibility for women. Pregnant women are
14 considered a separate group from other people in the ACA for a variety of reasons. Pregnant women are
15 not eligible for the new adult group, which is below 138 percent of the Federal poverty level, and when I
16 talk about coverage in a minute, this has implications because there are States that only provide
17 pregnancy-related services for these women and not the full array of Medicaid services. So if, for example,
18 a pregnant woman is in a State that provides pregnancy-related coverage only for when she is pregnant, she
19 would not receive services that are comparable to other new adults in the new adult group who would be
20 eligible for the full array of services.

21 And States are not required to track the status of pregnant women, so if a pregnant woman becomes
22 pregnant while she's already on Medicaid or CHIP, she doesn't have to report that and they don't have to
23 find that out. But a pregnant woman could request that she be moved to a pregnancy-relate group if she

1 so desired. The main reason for doing that might be because the pregnancy-related program had enhanced
2 benefits that weren't available under whatever plan she was already on, exchange or otherwise. So there's
3 the possibility that a pregnant woman would go back and forth among different plans.
4 States must maintain their eligibility and enrollment policies that were in place for pregnant women
5 at the time the ACA was enacted, so they can't say, okay, everybody's covered by the ACA now. Go into
6 the exchanges or go into regular Medicaid or do, you know -- they can't roll back. Basically, they have to
7 keep what they have, and then they have the option to transition pregnant women above 138 percent to the
8 exchanges if they so desire.
9 CHAIR ROWLAND: Because today, many States are covering women at higher income eligibility
10 levels than --
11 MS. BERNSTEIN: Yes, and they can't roll that back. Yes. That's correct. Okay.
12 So, talking about coverage, as I said, Medicaid is not required to cover the full range of benefits for
13 pregnant women. They are required to cover pregnancy-related services.
14 What pregnancy-related services are is not an easy thing to define. I have -- there's language in the
15 chapter, but, basically, it says services that are related to pregnancy, which -- or complications of pregnancy
16 -- which can be interpreted as pretty much everything. We actually did some investigative work to try to
17 figure out which States had pregnancy-related coverage only and which States didn't and we talked to several
18 legal and other firms and it's really hard to tell. There are seven States that the National Women's Law
19 Center has identified that provide pregnancy-related coverage only to their Medicaid population.
20 In some States, they have full Medicaid benefits for women who are below 189 percent of the
21 TANF AFDC level in 1989, so that's the very, very poor women, and they receive full Medicaid. And then
22 women above that level to 133 percent, where coverage is required, maternity coverage or pregnancy-related
23 benefits, receive only the pregnancy-related coverage. But, again, we're not sure what that is, and it's

1 possible that it's almost everything, but we don't know. So that's what makes it a little ambiguous with the
2 ACA regulations, because we don't quite know what's happening to that group that's above the AFDC level
3 and below 133 percent.
4 Emergency-only coverage is primarily for undocumented aliens, and that covers the labor and
5 delivery in the hospital. So that is paid by Medicaid. States have the option of covering undocumented
6 aliens with their own money for other pregnancy-related coverage.
7 Dental coverage is another program that is sometimes covered by States for pregnant women only.
8 We heard about adult coverage this morning. There are some States that actually do sort of cover pregnant
9 women for dental services because it's been shown that dental coverage and cleanings and dental care can
10 prevent low birthweight and other complications of birth, so that if the mother has an infection, it can be
11 passed to the child. Traditionally, dentists have been a little bit reluctant, it would seem, to cover pregnant
12 women, because they're afraid of treating them. But the literature is a little bit ambiguous. It's not clear
13 that there's a total relationship with all dental care with all birth outcomes, but the general consensus is that
14 it's probably a good thing to have dental coverage for pregnant women.
15 Again, this is one of those optional benefits that goes in and out with budgets, so some States, for
16 example, Louisiana, removed coverage for pregnant women effective January 31 of this year. Illinois
17 removed it, but then they put it back. And it can be in as quick a time period as a few months.
18 Wisconsin actually accidentally repealed -- they repealed the adult dental coverage and then they said, oh,
19 but we didn't mean that for pregnant women. So it's just one of those, I guess, money-related things.
20 ACA, again, has some things that affect maternity care. They have added maternity and newborn
21 care as essential health benefits. Pregnancy-related coverage is also a mandated essential health benefit.
22 So the exchanges will cover maternity care. It's not defined what that will mean, though.
23 And again, the pregnant women are excluded from the new adult group, so there's the issues of what

1 happens with women who have pregnancy-related coverage.

2 There's also the issue of churn that has been discussed in previous meetings, because, you know, the
3 pregnant women can go back and forth between different plans. You know, they can go from exchange to
4 pregnancy coverage. They can go back when they're not pregnant anymore. They have to get something
5 else. The income levels are all over the place. So you can get coverage in some States up to 250 or 300
6 percent of FPL and then the question is what you get when you stop being pregnant and then what's
7 available to you when that goes away. So there's the potential for back and forth.

8 Again, I'm not talking about utilization, but then the utilization would be somewhere in here, in this
9 section, so between this slide and this slide there would have been utilization data, but I don't have it to
10 show you.

11 There are two tables in the back of the report from the Health Care Cost and Utilization Project that
12 show the percentage of births to Medicaid and the percentage that are Caesarian, and if the utilization data
13 that we have from the Medicaid administrative data, claims data, is as good as we think it is, then we might
14 substitute that for the tables that are in the back, but I wanted to give you some utilization data just to give
15 you an idea of the context and how many there were and what the variation was among States.

16 We actually talked about early-induced deliveries and elective Caesarian sections, I think, at past
17 meetings. I think in November of 2011, you had a presentation where this was discussed. Obviously, it
18 is a big issue that rates have been increasing over the past decade or so and that it's been shown that these
19 particular procedures are more expensive and possibly harmful to mother and baby. Delivering babies
20 early is associated with respiratory problems, and there are many campaigns now to try to let babies wait
21 until they're ready to come out to come out and not to go in and get them because it's convenient. And,
22 obviously, there are reasons for induced deliveries and Caesarians, but ACOG and March of Dimes and
23 others all have major initiatives to try to reduce the rates of these elective procedures.

1 So MACPAC actually had a roundtable, an expert roundtable, on this topic in June of 2012 and a
2 literature review was created by our contractor, Mathematica Policy Research, and some of the results of
3 that white paper, literature review, are in the draft chapter, as well. They scoured the literature and
4 websites and States and came up with examples of different kinds of reform initiatives to try to reduce these
5 early elective procedures and elective Caesarians. They classified them in three different groups, with
6 payment reform initiatives being one of them.
7 South Carolina and Texas basically no longer pay for elective Caesarians and early-induced deliveries
8 unless there is proven medical necessity. Minnesota has a blended rate, so they just blend the rate for
9 Caesarians and vaginal deliveries and average them so there's not a particular incentive to do more expensive
10 procedures because you're not going to be paid as much. And other States are considering other payment
11 reform initiatives.
12 Performance measurement and public reporting initiatives are also on the rise. Reporting rates of
13 Caesarians and early-elective deliveries by hospital, by provider, reporting them back to the providers and
14 saying, did you know you had a 40 percent Caesarian rate, and they will say, hmm, really? And working
15 with them to try to figure out the reasons for those rates and how they might get them down.
16 And then there are provider and patient education initiatives. This is reducing early-induced
17 deliveries and Caesarian sections in the CMS Strong Start initiative. A lot of that is sort of Public Service
18 Announcements and working with providers and provider education and basically commercials with women
19 saying, you know, you should let that baby stay until it's ready to come out. Don't let anybody tell you that
20 it should come out early. But, you know, other things about the reasons why that's a good thing to do.
21 So -- and a lot of them are listed in Tables 3 and 4 of the draft report, as well.
22 So this is a foundational chapter. This is sort of our first major foray into this area. There's
23 several different roads we could take, if you were interested in further work, that are listed in the next steps

1 at the back of the chapter. We could do additional utilization analyses, although you haven't seen the first
2 ones yet, but once you see them, if you are interested in them, we could continue doing things like that.
3 We can track and monitor the effectiveness of these different initiatives to reduce early-elective deliveries or
4 early-induced deliveries.
5 We can look at provider issues and access to services as much as we can. There's not a ton of good
6 data on that and, again, we're trying to beef that up and look for more data, but there doesn't seem to be a
7 lot of recent data on access and I'm not actually sure why that is. There was a lot of research in the 1990s
8 when the expansions came out, and I think it seems like everybody thinks there sort of is decent access now
9 because there are so many babies in Medicaid. Somebody is delivering them. But the question is sort of
10 what are the problems with getting appointments and travel time and things like that, and there's less good
11 research on that than I personally would like to see recently.
12 And then, just, I would love to hear your reaction to the chapter and how to improve it and what
13 you're interested in and where we should go from here. Thank you.
14 CHAIR ROWLAND: Thank you.
15 Judy, Denise, and then Patty.
16 COMMISSIONER MOORE: Thanks, Amy. This is a good start, good information in here.
17 I would like for you to walk me through a bit more the ACA eligibility implications, because I think
18 that I'm reading -- I mean, and you're such a good health services researcher, it's very straightforward, but I
19 think I'm reading that we run the risk of losing pregnant women off the Medicaid rolls -- well, anyway,
20 maybe you can walk me through that, because I think, from my standpoint, the one thing of your list of
21 things that we could do some more of that I'd be interested in pursuing is the interaction between the
22 current program and moving to ACA and its impact on pregnant women.
23 MS. BERNSTEIN: I'll try. This is -- I've been working with Chris on this, because it's -- and I

1 might actually summon him over here, because it's complicated.

2 CHAIR ROWLAND: He's coming.

3 MS. BERNSTEIN: Well, he's actually closer to me than some of the other people.

4 CHAIR ROWLAND: He's coming.

5 MS. BERNSTEIN: And I'm just going to do what I understand and then he's going to bring in the

6 nuances.

7 My understanding is that, basically, States are going to do what they're doing now with regard to

8 pregnant women. They're not allowed to roll back. They're not allowed to cut anything back.

9 The issue is that, right now, the benefits that they give to pregnant women for some groups are

10 different than the benefits that they give to other groups. So for women under 138 percent of Federal

11 poverty, things will be pretty much the same unless they choose to expand coverage. But the only issue is

12 one sort of inequality in that the other adults who will now -- the new adults who will be in under 138

13 percent of poverty might have different or more benefits than the pregnant women. Now, that's true now,

14 as well. I mean, some groups get more than they do because they get pregnancy-related coverage and

15 everybody else gets whatever coverage they get for whatever group they're in. So it's not really different.

16 It's more of a sort of just equity or however you want to call it issue.

17 For women above 138 percent of poverty, the issue, I think, is more one of churning. So again,

18 States can keep whatever they have now -- in effect, they're required to until 2014, right? But there will

19 also be other coverage available to those women. So they could move them into the exchanges, is that

20 right, or they could keep them where they are. And then the issue would be mostly for newly pregnant

21 women or women who become pregnant who are already in that group who could go back and forth. So

22 it's sort of like CHIP.

23 COMMISSIONER MOORE: And you do run the risk in some of those cases of people having to

1 face more copays or --

2 MS. BERNSTEIN: Yes.

3 COMMISSIONER MOORE: -- or higher prices than they would had we maintained -- had the

4 States maintained their eligibility levels, which might be higher than they will be in the future, and so forth.

5 I'm just trying to get a fix on --

6 CHAIR ROWLAND: Isn't there no cost sharing for pregnant women?

7 MS. BERNSTEIN: No cost sharing for pregnant women. Well, for pregnancies.

8 COMMISSIONER MOORE: But unless they go into an exchange program -- unless the States --

9 I mean, here's -- I'm wondering if States have an incentive or any interest in, if they're now covering

10 pregnancy up to 200 percent of poverty, say, in just kind of wiping out that category and going back, you

11 know, to a lower percentage of poverty, just for ease of administration between Medicaid and the exchange

12 and so forth. Maybe I'm making things up I shouldn't be, but I'm basically concerned whether we're going

13 to lose pregnancy coverage for some low-income women who may be above 138 percent of poverty but

14 who are still pretty darn poor.

15 MR. PETERSON: I think for the above 138 percent of poverty pregnant women, there's still an

16 MOE that is in effect, which is based on OBRA 1989 or 1990. So there are several States that are

17 currently above 138 percent of poverty that, come 2014, still can't roll back. So that's a different MOE.

18 Now, the extent to which there are States who are above 138 who aren't subject to that MOE and

19 may do that, I don't know that off the top of my head.

20 MS. BERNSTEIN: There are 19 States that are subject to the MOE.

21 MR. PETERSON: The OBRA one?

22 MS. BERNSTEIN: Yeah.

23 MR. PETERSON: Okay. And then the other thing, the point I just want to reiterate that Amy

1 has said, is that having to do with the limited benefit for pregnant women. So the administration's
2 approach in the regulations was to say, look, as we're streamlining all these eligibility pathways in this
3 regulation in recognition of what happened under the ACA, we're also going to streamline it for pregnant
4 women. And even though there are several pathways that exist in the Federal Medicaid statute, some of
5 them permit you to offer limited benefits. We're going to just make one pathway the default for pregnant
6 women and just assume you're going to cover all Medicaid benefits. And I think that was partly in
7 recognition that even though limited benefits were options under these pathways, as Amy mentioned, States
8 basically said, we're going to just offer full Medicaid and be done with it. And I think what the regulations
9 recognize is, this is really where States are at. Let's just offer full Medicaid benefits.
10 The issue is that there are still some States who say that they still offer for those pregnant women
11 limited benefits and we just can't get a good sense of how different is it really, and that's the challenge.
12 And then I don't want to overstate that. I don't want you to come away thinking that there are these huge
13 differences between States, because we're not getting that kind of indication on that.
14 MS. BERNSTEIN: It's more a terminology issue, and the regulation says, we understand that this
15 happens, so if you, State, are not going to provide full benefits, then you have to come back in your State
16 plan amendment and justify why you're not. But there's nothing to keep the States from doing that. So
17 it's all kind of hypothetical, but I was just sort of bringing out issues that could happen. We don't know if
18 it's going to be or not.
19 CHAIR ROWLAND: Denise.
20 COMMISSIONER HENNING: Firstly, it's wonderful to see maternity care in print. I was really
21 excited. And I really, I think you've got a really good start here.
22 I do think that from a clinical standpoint, there's a couple of issues that would be nice if we pointed
23 out. One is that the maternal mortality rate in the United States -- we're not even in the top 50 best of all

1 the developed countries and we're getting worse, so --

2 [Off microphone discussion.]

3 COMMISSIONER HENNING: Yeah. So part of the reason why we're getting worse is because
4 the C-section rate in this country from the early 1970s, which was somewhere around six percent, is now, on
5 average, 33. If you do major surgery on women to deliver their babies, then you've got the risks of the
6 surgery, but you also have the risk that on the next pregnancy, they'll have a uterine rupture, that they'll have
7 a placenta previa, that they'll have hemorrhage, that they'll have a still birth. That risk increases. And
8 their risk for pre-term birth also increases.

9 So anything that can be done to prevent that first C-section is going to help lower the health care
10 costs and improve our mortality rates for moms and their babies. So I'd kind of like to see that in there.

11 There's also the availability of a lot of birth center data from the American Association of Birth
12 Centers. They keep really good records, so that would be a good source for you.

13 And, you know, just in general, I'd like to see a little more emphasis, and I know you're not ready to
14 talk about workforce issues, but there are a lot of places where nurse midwives cannot practice without the
15 permission of a physician, almost every State. There's a few that have now gotten the permission to
16 practice independently. And it's sort of like I'm a primary care provider for pregnant women. If I need a
17 surgeon to help me out, then I need to have a system where I can refer that patient that needs surgery or
18 that needs an opinion on her medical care that's beyond my scope of practice. I need to be working in a
19 system of that nature. But I shouldn't have to have permission from that person to be able to do my job.
20 A primary care doctor does not need permission from a cardiac surgeon to see a patient with hypertension.
21 So that's the analogy that I have.

22 So I think that to the extent that nurse practitioners, nurse midwives, can get hospital privileges,
23 since that's where most births happen, and be able to practice in an independent but collaborative

1 environment so that there are people that they can utilize when needed to see patients that have needs that
2 you cannot meet yourself, that's the kind of health system that we need to move towards, and that will cut
3 costs and that will also improve patient outcomes.
4 CHAIR ROWLAND: Okay. Patty, Donna, Norma, Trish, Mark.
5 COMMISSIONER GABOW: I have four comments, but first of all, thank you. This is another
6 important area for us to get into.
7 I think the most startling fact in this chapter is that almost 50 percent of the births in this country
8 are governed by Medicaid, and what's startling about that is not who the insurer is, but it means that 50
9 percent of all the children born in this country are born to poor women. And given what we know about
10 the consequences of poverty on child development, education, a whole range of other things, I think that's
11 pretty startling. And I'm not sure, is it worth calling out that what this represents is we're having so many
12 births coming into a life of poverty right at the beginning that -- I bet that's nowhere near any other
13 developed country in the world. And it would be interesting, if we could get that, to make some comment
14 about that.
15 I think it would also be interesting, if you have it, what is the predominant provider of the pregnancy
16 care. Is it FQHCs? Are the deliveries mostly at DSH hospitals? I suspect that is the case. I mean, for
17 a long time, Parkland had the highest number of deliveries of any hospital in the United States. I don't
18 know if that's still true. But I think pointing this out, where the care is provided, is important, because it's
19 implications about policy, I think.
20 I also think it would be interesting to know what percentage of the Medicaid deliveries are
21 emergency Medicaid. I can tell you that at Denver Health, it was almost all. And that may vary by State,
22 but it would be -- that's interesting, because in many places, if it's emergency Medicaid, it reflects that they
23 got poor prenatal care. That wasn't our case --

1 CHAIR ROWLAND: Patty, are you defining emergency medical care to be the --

2 COMMISSIONER GABOW: Emergency Medicaid.

3 VICE CHAIR SUNDWALL: Undocumented.

4 COMMISSIONER GABOW: Well, there are a number of reasons --

5 CHAIR ROWLAND: But not totally undocumented.

6 [Off microphone discussion.]

7 CHAIR ROWLAND: For delivery.

8 COMMISSIONER GABOW: For deliveries. I'm saying, what percentage of the Medicaid

9 deliveries were emergency Medicaid. I think that would be --

10 CHAIR ROWLAND: But I thought you then said, at Denver Health, emergency Medicaid was

11 most of the deliveries.

12 COMMISSIONER GABOW: Yes.

13 VICE CHAIR SUNDWALL: Undocumenteds or --

14 COMMISSIONER GABOW: We didn't look at their documented status, but I'm just making a

15 comment that that has implications in some areas about whether prenatal care was provided.

16 COMMISSIONER ROGERS: [Off microphone.] Can you clarify that just a little bit? Are you

17 saying that it was -- I'm sorry to interrupt. I just got a little confused. Are you saying that the Medicaid

18 individual had emergency care to deliver? Are you saying that the person delivered and then needed

19 Medicaid, or what are you --

20 COMMISSIONER GABOW: I'm saying, when you're looking at the category to see the categories

21 that you can get covered under, one is emergency Medicaid. And I'm saying that the majority of the

22 deliveries at Denver Health were emergency Medicaid, which I suspect may be the case in many safety nets.

23 But I would like to know what percent of the Medicaid deliveries overall are emergency Medicaid.

1 MS. BERNSTEIN: If I can just say, in the utilization data that we hope to present next month, we
2 do have the restricted benefits flag, which I think is what you're talking about, for --
3 COMMISSIONER GABOW: No, I'm not talking about --well, it is a restricted benefit, I suppose,
4 if you say it's only emergency Medicaid, but I'm talking about the payment coverage.
5 MS. BERNSTEIN: Okay.
6 CHAIR ROWLAND: Obviously, we want a little more information on the emergency Medicaid
7 category.
8 COMMISSIONER GABOW: The other thing that I think would be useful is if we could link this
9 up with some other data, you know, the full Medicaid coverage, pregnancy only, emergency Medicaid, with
10 some outcome data. Can we link it up to NICU admissions, NICU days, maternal mortality, which is low
11 so it may not be statistically important in these groups, but I think to the extent we can link up some of the
12 maternity data to some of the child outcome data would be very useful, if that's possible.
13 CHAIR ROWLAND: Okay. Donna.
14 COMMISSIONER CHECKETT: Okay. Back to Chris. I'm interested in this ACA coverage
15 issue because I'd like to see a little bit of more work done in here. I think this is really interesting
16 information, but I think that we might have left a few angles on the table, and one of them is that as States
17 are developing their exchange policies, some of those States are setting open enrollment parameters. So
18 the exchange will be up and running, but you can only enroll, just like, you know, when we get our insurance
19 from our employer, if you don't, like, sign up between October and December, you don't get to sign up for
20 another year.
21 Well, if States are putting those requirements in place in their exchanges, there's a reason for them
22 doing that, but I think we need to explore that juxtaposition to if a State would decide to take Medicaid --
23 and it's interesting. If you're just eligible for pregnancy, which is just like a little finite time in which you're

1 pregnant, that really makes me think that the people on the exchanges might, like, go, wait a minute. You
2 know, this is the age old issue you have with managed Medicaid, managed care, too, is that you get
3 somebody and they're just pregnant. You just have a whole lot of costs and then they're gone again.
4 And so I think that we need to dig into that and make sure we understand what implications it might
5 be for policies that States are making with their exchanges. If we should really have this in the chapter, I
6 think we need to be able to articulate more what some of the unintended policy consequences might be, so.
7 But thank you. It's an interesting chapter.
8 CHAIR ROWLAND: And also, what the rationale that Congress had for putting the provision the
9 way it is.
10 COMMISSIONER CHECKETT: Right. Yeah. I think that what's missing in this discussion is
11 a true exchange expert, and I would not put myself in that category. But there are a lot of very interesting
12 issues here on this juxtaposition and we need to do some research on it.
13 CHAIR ROWLAND: Norma.
14 COMMISSIONER ROGERS: I actually only have one thing now because Donna spoke to the
15 ACA and I was going to -- I thought it needed to be expanded upon.
16 Secondly, the only other, it's a little minor thing, but it would be good to, when you're talking about
17 undocumented, not to say undocumented aliens, because it is offensive to some of us, but to say -- and I
18 know it's a term that's widely used, but undocumented individuals might be a little bit better. Thank you.
19 CHAIR ROWLAND: Okay. Trish.
20 COMMISSIONER RILEY: I just want to follow up on some of where Patty was taking us about
21 poverty, and it may be because our next chapter is disability, but when you think of the numbers of young
22 children on Medicaid who have very serious mental health and other problems, physical disabilities, it would
23 be, to me, even more than the Caesarian issues, it would be really interesting to look at the stats on poor

1 birth outcomes, low birthweight, and really compare those to a private sector and see if this -- because if we
2 could intervene earlier on prenatal care and some of these maternity outcomes, it seems to me we'd have an
3 impact on the life of a child. And I would love to see more robustness to sort of that discussion.
4 CHAIR ROWLAND: Okay. Mark.
5 COMMISSIONER HOYT: Yeah. I had a couple of comments. One thing that's sort of a hot
6 button issue now, certainly in Arizona, also Texas, on your emergency services only, I don't know if you can
7 compare and contrast the use of the ER for deliveries in some of the border States. Could you get San
8 Diego County in California, Arizona or Southern Arizona, Texas, the El Paso area, something like that, and
9 maybe it's much higher, maybe it's the same as Ohio or Michigan, I don't know. But that would be useful,
10 if you could tease that out.
11 MS. BERNSTEIN: We could do State data. We can't do sub-State data at this time.
12 COMMISSIONER HOYT: A couple other comments. I don't know how --
13 CHAIR ROWLAND: But you could look at the border State rate --
14 MS. BERNSTEIN: Yes.
15 CHAIR ROWLAND: -- versus the --
16 MS. BERNSTEIN: Yeah.
17 COMMISSIONER HOYT: I don't know how or whether this data is available, on VBACs. Are
18 VBACs as prevalent in Medicaid as they are in commercial business, higher, lower?
19 MS. BERNSTEIN: Umm --
20 COMMISSIONER HOYT: It's sort of tied to the other two things that you highlighted here.
21 MS. BERNSTEIN: Yeah. I think that's really difficult to get. You have to comb through the
22 diagnoses codes, and they don't always put it, and it's not one of the categorizations of live births. So it
23 would be really hard. It's possible. It would be really hard.

1 COMMISSIONER HOYT: One last thing that I know was pretty common, because my former
2 employer did a lot of this, there's a lot of States that -- I think you've got this in here, the bundled payment
3 or case rate approach to maternity. I know it was originally designed to reduce incentives for C-section.
4 The same would be true of the early deliveries. Has it been effective? I mean, there's a number of States
5 where they pay for all the Medicaid births, and tying to somebody else's earlier comment, I know a number
6 of the clients we had just ended up deciding there's really nothing that's not pregnancy-related. So they
7 would just group all the births together and you'd get one payment of X-thousand dollars for delivering a
8 baby. It didn't matter whether it was multiple births, C-section, what have you. Then there'd be some
9 debate over what's in the data and what are the emerging trends and kind of contesting or challenge on the
10 increasing C-section rates, some of these other things. I'd be curious to know, in States that followed that
11 approach, has that been effective compared to States that don't pay that way. If you need somebody to call
12 to get a list of all the States that pay that way, I could give you somebody.
13 VICE CHAIR SUNDWALL: Thank you. Good report. I think the most dramatic figure -- I've
14 never heard this "almost half" before. I've heard 40 percent or something, but you said the trends are
15 actually going down now instead of up. But is there any way to tease out of this almost half young couples
16 who are not really poor, but only because they're in college and don't have access to their parents' insurance
17 anymore because they're married?
18 I've just wondered. In the State of Utah, this is important because we have so many college kids
19 who get on Medicaid because they're pregnant, young, and they don't have any income, but they sure aren't
20 poor by virtue of family incomes, I mean, parents and what have you. Technically, they qualify. But this
21 is always a concern in our legislature. I'm wondering if there aren't people taking advantage of Medicaid,
22 that but for their just being recently married and in college, they wouldn't otherwise qualify. Is that a big
23 issue or is that a minor issue?

1 Because, otherwise, they don't get married, right --

2 MS. BERNSTEIN: Well, we get --

3 VICE CHAIR SUNDWALL: -- and only in Utah do they still get married.

4 [Laughter.]

5 MS. BERNSTEIN: Unfortunately, we can't get that from the hospital data and we can't get it from

6 the claims data because we don't have any characteristics of the people or their family structure. We could

7 -- not for this report, because it would be a big study -- but we could work with someone who had survey

8 data that had a sufficient Medicaid sample and try to look at family characteristics, but that would -- like I

9 said, not for this report.

10 VICE CHAIR SUNDWALL: Well, I understand the data nationwide is a lot of single births and a

11 lot of not married kids.

12 One other question. Maybe I missed it, but is there data on expenditures or just the trends of

13 pregnancy?

14 MS. BERNSTEIN: We are hoping to present the expenditure data in May.

15 VICE CHAIR SUNDWALL: Okay. Thank you.

16 CHAIR ROWLAND: Denise.

17 COMMISSIONER HENNING: Just kind of to follow up on David's comment, my son and his

18 wife has a personal account. When she got pregnant, my son is working full-time but he doesn't get paid

19 enough and he had insurance for himself by virtue of his employer, but she was not covered. Either they

20 couldn't afford the coverage or the pregnancy itself wasn't covered, one or the other. And so Medicaid

21 helped them pay the birth. And, in fact, they actually had coverage for her, but Medicaid paid the

22 difference between the employer insurance and -- in other words, to take care of the copays and things like

23 that. So there are those kind of situations, too, that are out there, where Medicaid is not paying the whole

1 bill, but they are paying part of it to help the lower-income families that are -- you know, that 185 or 200
2 percent of poverty, which is still not rich, but they definitely still fall in that category where they may need
3 some help.
4 CHAIR ROWLAND: But the question in the discharge data would be the primary payer.
5 MS. BERNSTEIN: Well, on hospital data, the source of payment is not very good because it's
6 expected primary payer. So who knows what that really is. I mean, it's in the ballpark, but it's not perfect,
7 because people may not know they have Medicaid or it might not really be the primary payer, et cetera, et
8 cetera. And the administrative data, you have a claim. I mean, that's --
9 CHAIR ROWLAND: Trish, did you have a comment?
10 COMMISSIONER RILEY: It just strikes me, to David's point, pre-ACA, if you were a college
11 student with only access to the individual market, you couldn't get maternity coverage in most States. So I
12 think it's a moot issue post-ACA, in large measure.
13 VICE CHAIR SUNDWALL: I see.
14 MS. BERNSTEIN: Interestingly, though, if I could just add, under the ACA, the one group that is
15 not mandated maternity coverage is the dependents up to 26 of other people. So they're eligible, and it
16 would be an essential health benefit for them if they were covered under the exchange, but their dependents
17 are not mandated to have maternity coverage.
18 [Off microphone discussion.]
19 MS. BERNSTEIN: No, no, this would be for exchange coverage. So the parents would have
20 exchange coverage and they say, I want to cover my 25-year-old, and then their 25-year-old gets pregnant.
21 Maternity coverage is not a mandated benefit for them.
22 COMMISSIONER SMITH: So then how do they get maternity coverage?
23 COMMISSIONER CHECKETT: Go on Medicaid.

1 CHAIR ROWLAND: They buy it as an individual because they can go into the individual market.
2 Andy.
3 COMMISSIONER COHEN: A question and -- well, two questions. One, are there any -- from
4 the States that have developed payment strategies to either disincentivize non-medically-indicated
5 Caesareans or pre-term deliveries or use the other sort of, like, payment mechanisms, any evaluation or
6 results from those innovations or those payment strategies, and if not, are there some scheduled? That
7 would seem to be an extremely important thing to do if we're looking at the role of payment in actually
8 improving outcomes here.
9 MS. BERNSTEIN: As of the roundtable, who did our white paper for us, there were no published
10 results. There have been a couple of recent papers that are not State initiatives, but they're hospital
11 initiatives, where they've shown some results. There was just one published, I think, last week that I don't
12 actually have it yet because it was too soon. But it was, I think, 27 hospitals or 36 hospitals or some large
13 number of hospitals and they did show a fairly dramatic decrease. But the roundtable results were not
14 aware of any of the results yet, and if you look in Table 4 and 5, it has the status of the evaluation, and I
15 think there's one of them that there were results, and the rest of them, it was too soon to tell.
16 COMMISSIONER COHEN: And we don't know -- and evaluations may be scheduled, may be
17 not?
18 MS. BERNSTEIN: Yeah. I mean, you don't --
19 COMMISSIONER COHEN: I mean, I guess that's sort of a question for us, is, like, when might
20 it be a place -- that this seems like a concrete and, you know, a concrete place where the evaluation is really
21 critical to whether or not there's, like, a policy recommendation to be made. It's just the kind of thing that
22 we could actually --
23 COMMISSIONER MOORE: I think the March of Dimes has got research literature that we

1 could get our hands on for this.

2 COMMISSIONER COHEN: Oh payment.

3 COMMISSIONER MOORE: On outcomes.

4 COMMISSIONER COHEN: On payment and its impact on outcomes, yeah.

5 COMMISSIONER MOORE: Oh, yeah, yeah, yeah.

6 COMMISSIONER COHEN: And then I guess my -- and then my other question is, is there
7 literature looking at State maternity benefit, or I guess prenatal and maternity pregnancy coverage and
8 eligibility and birth outcomes, and are there any observations that can be made about a relationship --

9 MS. BERNSTEIN: State by State.

10 COMMISSIONER COHEN: State by State.

11 MS. BERNSTEIN: Hmm. So the coverage is fairly similar in most States except for the
12 enhanced benefit. So pretty much all States cover prenatal care. Almost all States have some sort of
13 enhanced benefit. The literature on enhanced benefits is mixed, and from what I've been able to glean
14 from it, it basically says, everybody sort of agrees prenatal care for high-risk women is good, I mean, is
15 important and improves outcomes. Prenatal care for -- or early prenatal care for Medicaid women is less --
16 it's less clear how it's related to outcomes because there are so many other things going on with the women.
17 So only giving them prenatal care is not necessarily enough to overcome many of the other things that are
18 going on.

19 So then what you need is some sort of study of what's the combination of things that best produces
20 outcomes, and from the literature that I've read so far, it seems to be you need sort of a good method of
21 targeting who high-risk is and then good methods of dealing with whatever the high-risk problem is.

22 So that's sort of a fuzzy way of answering your question. But it's, like, yes, there is literature, but
23 it's not like there's one thing that everybody can adopt that will improve outcomes. Does that help?

1 COMMISSIONER COHEN: Yes. I guess maybe what I'm sort of ultimately getting at is, clearly
2 -- I mean, I think, hopefully, we would know if coverage and payment was the single silver bullet that
3 resulted in good, healthy births. But is it a factor? Do we know anything about whether a change in
4 those things can improve outcomes? I'm just wondering what's out there, and again, is it something for us
5 to sort of look at, like what are the -- what does coverage and eligibility look like in a single sort of service
6 with such significant implications for, like, population health, and are there any conclusions that we can
7 draw. But it sounds like there isn't really any --
8 MS. BERNSTEIN: Well, I think the reason that everybody's focusing now on these early elective
9 deliveries -- I mean, excuse me, elective deliveries and early-induced deliveries -- is because that's where the
10 literature is among the strongest, that reducing these is probably one of the best things you can do to both
11 improve outcomes and reduce cost. And so that's why a lot of these initiatives are heading in that
12 direction, whereas other sort of high-risk groups are -- it's not as clear what you do to fix the problem.
13 CHAIR ROWLAND: Norma, did you have a --
14 COMMISSIONER ROGERS: It's such a complex problem. I mean, I don't think you can just --
15 I mean, I don't know how you would put it together because it's so complex. There are so many factors
16 that come into whether or not you're a high-risk pregnancy or what -- you may have the best care possible,
17 but if you're high-risk, you're high-risk. I don't know about how much you pay or cost effectiveness is
18 going to really matter, to tell you the truth, based on what Trish --
19 MS. BERNSTEIN: Right. But with these enhanced services, many States are trying to identify
20 who the high-risk women are and trying to try different things to help them.
21 CHAIR ROWLAND: Okay. Patty, and then we're going to wrap this up.
22 COMMISSIONER GABOW: A couple of comments about these high-risk women and early
23 C-sections. Again, some data from Denver Health. For, I think, a very long period of time, more than a

1 decade, Denver Health had the lowest C-section rate in Colorado, and I think either the lowest or one of
2 the lowest in the University Health System Consortium data. And also, then, very good, very high levels of
3 outcome in the infants. So I think that that is one place to intervene, even with a population that is
4 high-risk, I mean, very poor, predominately minority population.
5 You could have some of the best outcomes among academic health centers, and I think that's good
6 prenatal care. Free pregnancy testing was one thing we found to be extremely helpful to getting women
7 into early prenatal care. We tried everything over the years, and having free pregnancy tests and then
8 immediately getting your appointment right given to you when you get your pregnancy test seemed to be a
9 thing that made a big difference in early prenatal care.
10 And then our mandating no -- we like to mandate -- no elective or early C-sections, I think, worked.
11 I think I also may have misspoken about the emergency Medicaid. It is a percentage of our
12 Medicaid, but it's not the largest percentage in Denver Health. But, I think, understanding that percentage
13 across the safety net and in general would be useful.
14 [Off microphone discussion.]
15 COMMISSIONER GABOW: We have a lot of nurse midwives. It's a very collaborative
16 practice.
17 CHAIR ROWLAND: Okay. I thank Amy, and Chris, thank you for joining Amy. I think the
18 eligibility pathways and understanding a little more about how they will operate under the ACA is important,
19 but also as you do that, I would look at the implications if a State decides to go forward with the expansion
20 versus if a State decides not to go forward with the expansion so that we can see what the implications there
21 are for coverage of pregnant women.
22 And then, clearly, we're looking forward to the initial analysis of some of the utilization and cost
23 data and anything else that you want to bring back to us from this very wide-ranging discussion. I think

1 we've got a great deal of information here already and I think we just want more. So thank you.

2 And now, Anna Sommers. We continue, of course, as a Commission to try and look at where the

3 Medicaid program stands with regard to providing access to appropriate and high-quality care for its

4 beneficiaries, and Anna is going to talk to us today about access issues with regard to the population of

5 people with disabilities.

6 **### DRAFT JUNE REPORT CHAPTER: LITERATURE REVIEW ON ACCESS FOR**

7 **PEOPLE WITH DISABILITIES**

8 * MS. SOMMERS: Thank you, Diane.

9 The purpose of this session is to allow the Commission opportunity to provide feedback on this

10 draft chapter for the June report. The chapter summarizes a literature review that we conducted on access

11 to care for adult Medicaid enrollees with disabilities under the age of 65.

12 This population, as you know, is heterogeneous, with a wide range of health care needs and

13 disabilities, including mobility and cognitive limitations, difficulty with self-care, and difficulty participating

14 in everyday activities. It includes persons with disabilities acquired at birth, such as Down syndrome,

15 persons with traumatic brain and spinal cord injuries, and persons who become disabled from degenerative

16 diseases, chronic illness, and serious mental illness.

17 So the need for a broad range of services stemming from the disability and, underlying diseases, adds

18 a dimension of complexity to assessing access for persons with disabilities that is not shared in considering

19 the situation of most other Medicaid enrollees.

20 Our literature review seeks to answer three broad questions related to access. What do we know

21 about the unique health characteristics of this population? What is the current knowledge about provider

22 availability, service use, and access to care for this population? And what future research is needed to

23 inform Medicaid policy?

1 Our study population is enrollees with disabilities covered by Medicaid but not Medicare, referred to
2 here as Medicaid-only enrollees. They constitute over 60 percent of individuals under age 65 who are
3 eligible for Medicaid on the basis of disability. And we have also excluded the institutionalized population.
4 Health services that we examined include acute care hospital services, physician services generally
5 including primary care, prescription drugs, imaging and laboratory tests, and medical care provided by
6 non-physician practitioners. So these acute care services account for nearly 75 percent of spending for this
7 population.
8 We did not examine access to long-term services and supports. However, we do acknowledge that
9 supportive services, such as transportation, mobility aids, and interpretation services do help patients access
10 acute care services.
11 So we reviewed quantitative and qualitative research on the topic of access to care for persons with
12 disabilities. In some areas, research on Medicaid enrollees is scarce, so recent research also is presented
13 that examines the experiences of all persons with disabilities.
14 You've seen this before. The access framework that was previously developed by the Commission
15 informs our assessment of the literature. The framework, the access framework, recognizes three main
16 elements of a health care coverage program as essential to the examination of access to care. Those are the
17 unique characteristics of enrollees, provider availability and other health care system arrangements, and
18 service use.
19 We first briefly highlight some unique characteristics of this population and then look more
20 systematically at the current knowledge and supporting evidence of the factors influencing provider
21 availability and service use as they relate to enrollees with disabilities.
22 In the section on unique characteristics of the population, we emphasize that persons with
23 disabilities, first of all, have the same need for health prevention services as persons without disabilities,

1 such as cancer screenings. Another aspect of wellness important to persons with disabilities due to their
2 thinner margin of health is, of course, maintaining function and preventing functional decline.
3 And then in terms of acute care, the nature of a disability and the co-occurring risks it presents may
4 increase the need for acute care and pose additional challenges to providers. So some examples include
5 subpopulations that show atypical manifestation of illness, have difficulty recognizing and communicating
6 symptoms, or have high susceptibility to certain conditions, such as osteoporosis or dental disease.
7 And then, finally, we shouldn't forget that people with disabilities are among the poorest in Medicaid
8 and have fewer resources to overcome barriers to care.
9 In the next section, we summarize findings on access. Evidence on this subject is based primarily
10 on four kinds of data sources: Large-scale population or health access surveys; provider surveys and other
11 provider and stakeholder data; consumer interviews and other qualitative data from consumers; and State
12 Medicaid program data.
13 So while a great number of topics are covered in the chapter, today, we highlight findings with some
14 of the stronger evidence, and these findings either have been substantiated by multiple quantitative research
15 studies, or, where there is more limited quantitative data, the findings are supported by wide
16 acknowledgment among a broad range of stakeholders. And then we briefly summarize areas where there
17 is weaker evidence. We don't mean to say that access problems don't exist in those weaker evidence areas,
18 but quantitative studies may not exist or have shown conflicting evidence.
19 So the first major finding based on stronger evidence is that Medicaid provides a significant
20 protective effect from unmet need for persons with disabilities. This finding is supported by analyses using
21 three national surveys that compare Medicaid enrollees to people with disabilities covered by Medicare only,
22 private insurance, or who were uninsured. And together, these studies show that, first, the share of
23 Medicaid enrollees with disabilities that have a usual source of care or regular doctor is no different from

1 those covered by Medicare only or have private insurance. And this share is much higher than among the
2 uninsured disabled.
3 And, second, these studies show that the share of Medicaid enrollees with disabilities reporting
4 unmet need, an unmet need due to cost, is much lower than those covered by Medicare, by private
5 insurance, or those who are uninsured.
6 The second major finding is that medical schools do not adequately train physicians with disability
7 competence. In a 2009 report, the National Council on Disability concluded "the absence of professional
8 training on disability competency issues for health care practitioners is one of the most significant barriers
9 that prevent people with disabilities from receiving appropriate and effective health care." Disability
10 competency refers to training on basic procedures, such as how to safely transfer a medically fragile patient
11 to an exam table, culturally competent communication, and disability-specific clinical training.
12 This conclusion is substantiated by the NCD's extensive literature review and interviews with
13 Federal agency officials and health care practitioners, other provider surveys and interviews, and consumer
14 surveys in which people with disabilities report trouble finding a doctor who understands their disability to
15 obtain appropriate care.
16 The third major finding is that inaccessible medical equipment and lack of accommodation in
17 service delivery processes persists as a barrier to care. Consumers interviewed in depth report exam rooms
18 too small to accommodate a wheelchair; exam tables and diagnostic equipment that are not height
19 adjustable; weight scales that do not accommodate a wheelchair; lack of interpreters; staff untrained in the
20 use of TTY phone systems for the deaf; and staff untrained in culturally competent care. Provider surveys
21 and interviews on the accessibility of facilities and practices also substantiate this finding.
22 Fourth, multiple studies raise concerns about difficulty getting appointments and receiving timely
23 care. In one national study, one-fourth of adults with disabilities covered by Medicaid reported postponing

1 care. However, I should note, a much larger percentage of those covered by Medicare only or private
2 coverage reported postponing care.
3 People with disabilities interviewed in depth provide many different reasons why scheduling
4 appointments takes additional time and why care is not timely. These reasons include difficulty finding a
5 doctor who accepts Medicaid or finding a doctor who understands their disability; fear or mistrust of
6 providers due to prior negative encounters; lack of communication aids; and delays in scheduling
7 interpreters, among other reasons.
8 Fifth, preventive services are potentially under-used in subpopulations. People with disabilities
9 covered by Medicaid use many different acute care services heavily relative to other enrollees, but the
10 exception to this pattern may be preventive services. National studies have found low use of cancer
11 screenings, such as mammography, among persons with disabilities in Medicaid relative to persons without
12 disabilities. And consumers interviewed in depth described several reasons why it can be difficult to access
13 prevention services. They describe mammography equipment as inaccessible; technicians as untrained in
14 culturally competent care; consumer misunderstanding of the purpose of preventive tests; and prior negative
15 encounters. However, studies have not compared directly the experience of persons with disabilities
16 enrolled in Medicaid to similar individuals with private insurance to determine if there are program-level
17 factors for low preventive use.
18 In several lines of inquiry, quantitative studies have either shown conflicting evidence or data is not
19 available to quantify access levels. And nonetheless, these areas may still be of concern to many different
20 stakeholders.
21 So, first, the impact of Medicaid managed care. Only two national studies have examined the
22 impact of Medicaid managed care on people with disabilities. These studies report conflicting results.
23 Only one Statewide study was I able to find, and that was a study in California of the voluntary Medicaid

1 managed care program, which found no effect.

2 Second, access to dental services has been raised as a concern in qualitative studies of consumers
3 and also by subject matter experts, including members of our Commission. Experts attribute poor access
4 to the small number of dentists who are trained to provide specialty care dentistry to persons with
5 disabilities, particularly developmental disabilities; inadequate training in general dentistry education on
6 treating persons with special health care needs; and the high incidence of oral disease in this population.
7 State Medicaid adult dental benefits are limited to emergency services or no benefit in about half of the
8 States, so service use cannot be observed in Medicaid claims. And we know that the primary factor
9 impacting access in Medicaid, then, is the absence of a benefit. So adult dental services in Medicaid will be
10 addressed in future MACPAC reports.

11 And then, lastly, the accessibility of medical facilities, and I mean it defined as physical entry to
12 them, has not been quantified recently or widely. Studies have been non-representative or qualitative, but
13 they do raise concerns and more current data are needed.

14 There are major limitations evident in the literature. In many cases, studies examine access issues
15 for all persons with disabilities and do not provide evidence specific to Medicaid enrollees or Medicaid
16 providers. This is a major limitation in the evidence of the availability of accommodations and provider
17 practices and the disability competency of providers, as well as the performance of Medicaid managed care.

18 Second, certain barriers to care have been identified through qualitative research, yet have not yet
19 been quantified within Medicaid programs. So an example would be the lack of access to interpreters
20 among persons who are deaf, or difficulty finding accessible mammography equipment as a reason for low
21 use of preventive care. Thus, the prevalence of access problems in the Medicaid population is unknown.

22 Third, there are a few published studies examining access for this population in State Medicaid
23 programs, and the representativeness of these program experiences is unknown. Studies do not compare

1 the experience of Medicaid enrollees to other disabled persons in the community and do not measure
2 service use prior to and after enrollment. So the impact of the program itself cannot be assessed.
3 And then, finally, the most recent data on some topics is over ten years old.
4 So this leaves us with several outstanding questions of importance to Medicaid policy makers, and I
5 name just a few. What factors are responsible for access levels in Medicaid? Are these community-level
6 or program-level factors? Do they vary by subpopulation or by State? Do Medicaid program and health
7 plan services, such as transportation, sign and oral interpretation services, or choice of provider networks,
8 make a difference? And then what is causing the under-use of selected services, like prevention?
9 We conclude our chapter by describing areas of research especially critical for building an evidence
10 base to support Medicaid policy. These include establishing trends in access to care for Medicaid
11 subpopulations, disabled subpopulations, including State-level measures; testing the impact of program
12 changes on the use of primary and specialty care; quantifying access levels among participating Medicaid
13 providers and Medicaid beneficiaries, especially in the areas of disability competency among clinicians and
14 accessibility of equipment, practices, and office processes. And then, finally, evidence from best practices
15 and service delivery would be helpful, because many of the factors influencing access appear to be rooted in
16 the patient-provider relationship.
17 So this concludes my presentation. I look forward to your comments on the draft chapter and
18 comments about the direction of future work by staff on this subject.
19 CHAIR ROWLAND: Thank you, Anna.
20 Trish.
21 COMMISSIONER RILEY: I wanted to beat Patty.
22 [Laughter.]
23 COMMISSIONER RILEY: I think this is -- Anna has a tough challenge here, because this is

1 extraordinarily difficult work, given the complexity and diversity of the population, so I really applaud you
2 for this.
3 I do think, though, that for me, the big issue is the PMPM for this group. This is an extraordinarily
4 expensive group. They're also extraordinarily disabled, so you would expect that. But what we don't
5 know about this could fill this room and then some, and you point that out with the lack of research. So I
6 think a big piece of what we have to be about is what needs to be known.
7 And I think the biggest piece is, what are the expected outcomes by these major population groups?
8 What do we want to see? Is it maintenance care? Is it rehabilitation? What are our reasonable
9 expectations for these various disability populations, people with disabilities? And once we know that, I
10 think we have a better way to measure services against it.
11 I was disappointed to see that we weren't -- you did talk about we will look at support services later.
12 You notice that 74 percent of spending is on the traditional sort of services. Within that is the
13 non-physician practitioners. I'd love to see that broken down. What is that? Who are those
14 non-physician practitioners? What are we buying for that and what are we getting for that?
15 And then I don't think we can leave out the 26 percent, and I don't think you intend to. I think
16 that's the supportive services. But, to me, that may be the place where there's the biggest bang for the
17 buck, if you will, the biggest place to intervene, is what are those supportive services? What are we buying
18 and what are we getting, and I think we're in uncharted territory, so whatever we do in that regard will be
19 extraordinarily important to the field.
20 MS. SOMMERS: Can I ask a clarifying question? When you're making reference to supportive
21 services, are you referring to long-term care, or are you referring to things like transportation --
22 COMMISSIONER RILEY: What is the -- 74 percent of funding, you point out, is acute care. I
23 want to know, within that 74 percent, what are the non-physician practitioners. Then the remaining 26

1 percent of funding, what is it? What are we buying?

2 COMMISSIONER ROGERS: Is it therapy or --

3 COMMISSIONER RILEY: It's community supports. It's therapeutic horseback riding. It's --

4 COMMISSIONER ROGERS: It's a whole lot of things.

5 COMMISSIONER RILEY: It's PT/OT. It's speech therapy. It's a huge array of services, I'm

6 sure, but I want to see --

7 CHAIR ROWLAND: And here, we're talking about adults. It's not children, primarily.

8 MS. SOMMERS: Yes, we're talking about adults.

9 CHAIR ROWLAND: Richard.

10 COMMISSIONER CHAMBERS: Thanks. Great chapter. All the stuff that you point out in

11 the limited data that there is or studies is all the challenges in delivery of care. You know, you see it at the

12 local level, is inaccessibility to doctors' offices, not being able to get on exam tables, mammography

13 machines. All those things are really common.

14 The thing is that where you have the findings, weaker evidence is about Medicaid managed care, and

15 it's just there's been few inconclusive studies. The one you say about California was the one on the

16 voluntary program. That probably is not worth the paper it was written on, because, quite frankly, as a

17 voluntary program which ran for a number of years, there's less than ten percent of the ABD population

18 voluntarily enrolled. So it was really a mismatch as to -- you know, it wasn't really a cross-section of the

19 disability community. As we found out in the mandatory enrollment, the State, when they set up their

20 capitation rates, with the help of Mark's former employer, they said, oh, the mandatory enrollment is going

21 to be exactly the same as the voluntary enrollment, and they found out dramatically they were not the same

22 in their medical conditions and needs.

23 The issue that Trish raised about funding for the program is in that same issue with California, is

1 that the State assumed great savings right from the beginning of the program, and particularly when they're
2 looking at fee-for-service data of access for this population, I think they grossly underestimated it because I
3 think there's circumstances where there's not access to services so services are not utilized. And when you
4 put it into a managed care setting and if you impose a rigorous State monitoring and oversight requirements
5 on the contract, suddenly, you're building a much more perfect system -- not a perfect, but more perfect -- is
6 that costs and need for access, a lot of the flaws in the system come out. But at the same time, as people
7 get access to services maybe they didn't have before.
8 So I look forward to this continuing to develop because I think it's populations we don't know a lot
9 about, and I think, if nothing else, this recommends where there are weaknesses and the need for further
10 studies, particularly with the fast conversion of this population to managed care settings, is what we do
11 know, and what we do know in the sense of where there are any studies or best practices, as we've said in
12 previous meetings and reports, of the need for rapid dissemination of information, is to be able to either do
13 studies or just disseminate information for implementation of new programs. Thanks.
14 CHAIR ROWLAND: Mark, then Robin.
15 COMMISSIONER HOYT: If I had some way to channel Sara, then I would, but my brain is not
16 big enough. So my comment was -- well, it's not like she wouldn't have good comments on the other
17 sections, but that just seems like a particularly strong area for her, that she's pretty passionate about. Just
18 make sure you connect with her at some point. I'd want to hear from Sara on this topic.
19 CHAIR ROWLAND: Robin. Robin is passionate about this topic, too.
20 COMMISSIONER SMITH: I am passionate, but, you know what? I'm having a really hard time
21 zeroing in on any one thing because it is so complex and you have so many varieties of what's going on.
22 I'm the mother of an 11-year-old who was a very pre-term birth, medically complex, and
23 developmentally disabled, and I can think just what would be going on with him if he didn't have our

1 support, you know, us making decisions for him. And so you get into the adult category and I just wonder
2 who's supporting -- who's providing the support? Who's helping make the decisions, if that's necessary?
3 For some them, it will be necessary, not for everybody. It's just so complex, I feel like I need to chop it
4 into smaller --
5 I mean, the chapter is great, because we have to start. But I think going forward, as we look at this
6 complicated issue and the money that goes into this population and how maybe we could use it better or
7 more efficiently and get better outcomes for them is so important. I've said this a million times before.
8 I'll say it again. There is no other population that is more impacted by the decisions made within this
9 medical community for them. It impacts every aspect of their life, whether they can get up and work,
10 whether they can get up, whether they can eat or have a G-tube or -- you know, it's just really, really
11 complicated and I hope that we take the time to break it down and get into the weeds, I guess, dig deeper.
12 Thank you, Anna.
13 CHAIR ROWLAND: Robin, I think you also raise an important point as we move forward and
14 we look at the CHIP reauthorization issues and children's issues within Medicaid, that we need an equal
15 focus on the children with complex health needs, the special needs children within the Medicaid program
16 and those who now get some coverage through CHIP and what direction to go with them. I would hope
17 that there might be somewhat of a richer literature on taking -- on the access to care and the services for
18 that population, but I don't know.
19 MS. SOMMERS: Yes, I would say that it is a bit richer. There certainly is more literature related
20 to the experience of children with special health care needs and managed care, also specifically to Medicaid.
21 But, again, I didn't focus on children in my literature review, so I can't speak very comprehensively about it.
22 CHAIR ROWLAND: Robin.
23 COMMISSIONER SMITH: Just a quick follow-up. You know, my passion is the children, but

1 he's 11 -- my son is 11 now. He's almost ready for middle school. And I'm finding, I think the need
2 becomes greater to find the supports because most children have support, be it a biological family, foster
3 family. As people start to age out, they're not so cute. You know, people aren't as excited about being
4 around them, and they really, really, really need more support. So I'm kind of glad we're really looking into
5 the adults now.
6 CHAIR ROWLAND: Well, it's also an issue as you age off of the EPSDT coverage as a child onto
7 becoming an adult person with disabilities, the benefits and the arrangements change, which is another
8 linkage that we might look at, is how do you smooth that transition or improve it.
9 MS. SOMMERS: Yeah. The National Council on Disability in their 2009 report specifically
10 identify youth transitioning to adulthood as an especially vulnerable population, and it's because of that
11 recognition that the pediatrics specialties, including primary care, receive specialized training in medical
12 school on how to treat children with special needs and also get that included in their residencies. And then
13 adult care clinicians do not. So as children transition from one set of providers to another, they not only
14 lose the support services around them that are the educational and the caregivers. They also enter a
15 different set of providers -- a different provider network that doesn't have the exposure and experience and
16 training that the pediatric community does.
17 CHAIR ROWLAND: Donna, did you have a --
18 COMMISSIONER CHECKETT: You know, it strikes me, you know, it's a very interesting
19 chapter, really important chapter, just the incredible complexity of this population. And again, as we said,
20 it's not, number-wise, that many, but not only are they very expensive, but they're very, very diverse. And
21 so I think at some point as we lay out our longer-term research agenda, I really like the idea of digging in on
22 children because I think it's a very special and unique group. You know, we could have waivers, Diane, to
23 help with that transition program, and I would be in favor of that.

1 CHAIR ROWLAND: Okay.

2 COMMISSIONER CHECKETT: That's a good --

3 CHAIR ROWLAND: And then as soon as they're proven --

4 COMMISSIONER CHECKETT: -- that's why we need waivers, or a plan amendment. But I
5 really would like to start maybe digging in and picking out which are the populations we're most concerned
6 about, not that they're not all important, and do a deeper dive on that. I do think children is one of the
7 ones we should look at.

8 And then the other, you know, the theme in every discussion, I think, we've had today, in some way
9 or another, the inadequacy of the providers. Whether it's just providers to treat Medicaid or dentists or
10 allowing practitioners to practice at the top of their license, it has really come up in every one of our
11 discussions. I don't know that that is something that Medicaid is set up -- I don't think it is set up to
12 address, but in some ways as we grapple with access, I think we're going to have to circle back to it, whether
13 we want to or not, so --

14 CHAIR ROWLAND: Maybe we should --

15 COMMISSIONER CHECKETT: -- this is really good, Anna. Thank you.

16 CHAIR ROWLAND: Maybe we should make a recommendation that the Workforce Commission
17 be funded.

18 [Laughter.]

19 COMMISSIONER CHECKETT: You know, that might be a good idea. I really think we're
20 going to have to wrestle with it.

21 CHAIR ROWLAND: I think --

22 COMMISSIONER CHECKETT: But it's not Medicaid's job to solve that problem.

23 CHAIR ROWLAND: -- as we weave through all of the workforce issues, that that might be an

1 area to at least flag, is we can make a lot of other changes in the program, but if you don't have the capacity
2 to deliver the services, it's not just payment that matters.
3 COMMISSIONER CHECKETT: I agree. I agree.
4 COMMISSIONER ROGERS: I think this is one area that you could really come out strongly and
5 say that the care of these individuals needs to be intra-professional because it's going to require a mixture.
6 It's not just that -- you know, when we talk about the M.D. doesn't know but the nurse does know because
7 the nurses are the ones that actually have all this, but then you need all the other components of it. And I
8 think that we should really look at the treatment of them being intra-professional and not separate entities.
9 When I'm talking about intra-professional, I'm talking about a team approach.
10 CHAIR ROWLAND: Judy.
11 COMMISSIONER MOORE: Not to pile on. This is a good chapter and I think it's a great place
12 to start. But we talked a lot about the complexity of the adults and children that need to be served, but
13 there's also a huge difference between and among the States in the kinds of services they offer and the way
14 they offer those services through managed care or not managed care, for certain populations and not for
15 other populations, and who they contract with and how they contract for them, so that down the line as
16 we're laying out long-term agendas, really, we need to look at the difference between and among States in
17 terms of the benefits and coverage and contracting.
18 CHAIR ROWLAND: Trish.
19 COMMISSIONER RILEY: I think Judy is 100 percent right, and I was pleased to see the further
20 research noted would be evidence from best practices. But, again, in that evidence, we said across a variety
21 of access, quality, and health outcomes, and cost is missing. So I think we have to add the cost of that.
22 CHAIR ROWLAND: Okay. All right. Thank you very much. Anna, I think you've got a lot
23 of additional work on your plate that we've just proposed. But I do think that continuing to work on the

1 issues around Medicaid's role for both children and adults with disabilities is critical.

2 So we'll take a ten-minute break and then we'll reconvene to do the great topic of program integrity.

3 [Recess.]

4 CHAIR ROWLAND: If we could please reconvene, we're going to now turn to the Draft Chapter

5 on Program Integrity, and I hope that we can have Moira Forbes, who is joining us really at the table for the

6 first time, to walk us through the chapter on program integrity that she's been pulling together.

7 Thank you.

8 **### DRAFT JUNE REPORT CHAPTER ON PROGRAM INTEGRITY**

9 * MS. FORBES: All right. Thanks, Diane.

10 So, hi, everyone. I'm Moira. I'm also representing -- you can say Moira or Morra [phonetic], but

11 don't worry that you're going to offend me if you say my name wrong. I'll answer to anything probably

12 with an M. It always seems to be an issue when we get to the Q&A part.

13 So I'd like to cover three things today. I'd like to provide you an update on the Commission's work

14 on program integrity since the last time this was on the agenda. It's been a while. So I'll just provide a

15 little refresher, go over the proposed content for the June report chapter, and then I'd like to get your

16 feedback on the draft chapter and some of our ideas for future work in this area.

17 In terms of what we've been doing, it's been about a year since program integrity was on the

18 Commission's agenda, so in terms of this, just a quick update on what we did last year and where we are.

19 Last March, there was a chapter in the report to the Congress on program integrity. It described

20 several Medicaid program oversight activities, the extent to which they were or were not coordinated

21 amongst themselves or between state and federal agencies.

22 As a consequence, that chapter identified a number of challenges associated with implementation of

23 an effective and efficient Medicaid program integrity strategy. It talked about challenges in quantifying

1 program integrity effectiveness, issues with the data available to support analysis and audits, and just general
2 issues of duplication and overlap.
3 And based on the findings in the chapter, the Commission made two recommendations. The first
4 noted that the Secretary should ensure that current program integrity efforts make efficient use of federal
5 resources and do not place an undue burden on states and providers. And the second suggestion
6 suggested that the Secretary should do a better job supporting the states by developing methods to better
7 quantify the effectiveness of various PI activities and improving dissemination of best practices, the
8 availability of training, and so on, to really help the state part of that relationship.
9 So that was a little over a year ago.
10 Starting at the beginning of this year, we've picked up some of this work again, starting with really a
11 broad review of the current literature on Medicaid program integrity, which is really primarily a gray
12 literature. We looked at a lot of papers and presentations put out over the last year. Folks from CMS
13 have been asked to testify on the Hill several times, and we went back through all that testimony. There
14 have been several GAO reports; we looked at all of those. And we also spoke to CMS staff from the
15 Medicaid Integrity Group, which is part of the CMS Center for Program Integrity.
16 And information from all of this sort of broad review has formed the basis of the draft chapter for
17 the June report, which covers three main topics:
18 A status update on changes made to the federal level. They are in the process of really revamping
19 their approach, and we provide some information on that.
20 We present a comprehensive picture of Medicaid program activities from a state administrative
21 perspective, which I'll explain more in a minute.
22 And we discuss opportunities for future work and how the Commission can continue to support
23 efficiency and effectiveness in Medicaid program administration.

1 So, as I mentioned, CMS is in the process of updating its comprehensive National Medicaid
2 Program Integrity Strategy. They're required to put one out, which they originally did after the Deficit
3 Reduction Act and the creation of the Medicaid Integrity Group in 2005. They've updated it several times
4 but not in a few years, and they're in the process of releasing a new version. It's in clearance now, and it
5 should be out later this year.
6 The recommendations the Commission made last year, which focused on improving effectiveness
7 and efficiency, were echoed by many other organizations, including the National Association of Medicaid
8 Directors and the GAO which actually put out a report that said CMS should take steps to eliminate
9 duplication and improve efficiency, which was pretty much exactly what this Commission's
10 recommendation was. And CMS, in its new strategy, is really taking some steps in the direction indicated
11 by the Commission.
12 Their new approach is really based on the lessons they've learned from various initiatives
13 implemented over the last eight years since the creation of the Medicaid Integrity Group. Their intent, as
14 described to us and also as mentioned in some of their testimony and their response to the GAO, is to
15 move away from an initiative approach where they are sort of siloed, and focused.
16 There's a group that focuses on PERM, and there are people that do the Medicaid Integrity Group
17 audits, and there are people who do MEQC and different things.
18 Now they will really think about program integrity more in terms of how do we think about provider
19 enrollment and how do we think about beneficiary enrollment and how do we think about claims.
20 And, to really try and think about it more in terms of outcomes and efficiency and effectiveness and
21 less around compliance with individual statutory requirements.
22 They're also focusing a lot more on working in collaboration with the states. They're finding better
23 ways to use state data, which they're finding to be more effective. They're providing a lot more resources

1 to support state priorities.

2 They're developing Medicaid-specific tools instead of trying to take Medicare tools and apply them

3 to Medicaid.

4 So they're really -- they've heard, they've gotten the feedback, and they are moving forward in the

5 new direction.

6 So states and CMS are continuing to refine their program integrity strategies in order to more

7 efficiently allocate program resources although -- something we certainly see in everything we read, everyone

8 we talk to -- is this is challenging for a lot of reasons.

9 CMS, obviously, is trying to balance compliance with the rules on the books. There are lot of

10 existing statutory and regulatory requirements, and there have been a lot more added over the past several

11 years. So they're trying to balance compliance with a goal of making efficient use of federal resources and

12 avoiding undue burden on the states and providers.

13 And another thing we see is that states and CMS are both sort of continuing to be challenged by

14 designing an approach that puts an appropriate amount of focus on the integrity of each Medicaid program

15 function. There's eligibility. There's claims payment. There's provider enrollment. There's managed

16 care. And it's not -- there's no clear right way to do that or right amount of attention.

17 There's no evidence. There's not necessarily a lot of best practices in some of these areas. And

18 Medicaid is dynamic. Things are changing. So it's sort of a constantly -- it's a moving target, and that's

19 something states and CMS are both working towards -- what are the right things to do?

20 CMS and the states are continuing to try and sort out the effective division of responsibility between

21 them -- between the federal oversight and between what the states are responsible for. It is explicitly the

22 responsibility of both the federal government and the states. There are regulatory and statutory

23 requirements that overlap in some cases. There are also places where they're just not aligned well, and it

1 really complicates their ability to jointly administer a program integrity strategy.

2 So, if you had a chance to look at the chapter, the bulk of the chapter looks at Medicaid program

3 integrity activities from the point of view of state program administration, which we divide here into these

4 seven areas. We included both broader program management areas that have a program integrity

5 component, such as beneficiary enrollment, provider enrollment, service delivery, the claims processing

6 system, as well as the activities that you normally think of as program integrity, like post-payment review,

7 recoveries, reporting and follow-up, things like that.

8 Where program integrity is one aspect of a broader function, what we're trying to show is that the

9 states struggle with finding -- you know, there's a fundamental tension between having tight controls, which

10 would sort of support program integrity, and other program goals.

11 And, in fact, Dr. Dickinson referenced one of those this morning when he was talking about trying

12 to enroll in the Virginia Medicaid program as a dentist. You don't want to let people who are not

13 appropriate providers enroll in the program and serve beneficiaries and bill inappropriately or provide poor

14 quality care. At the same time, you want to have a lot of good quality providers. You want to have

15 access for beneficiaries. States are always trying to find out where do you draw that line.

16 And so part of the reason that we are looking at what we would consider to be more program

17 operations and not specifically program integrity is to look at some of those areas where there are front-end

18 controls, to help understand:

19 Where do you balance that in terms of your program?

20 And how do you balance your front-end control with where you have the more retrospective kinds

21 of reviews?

22 And is there a good place to draw those lines that helps you achieve all of your goals -- that you have

23 an effective and efficient program with appropriate program integrity, but you're also supporting access,

1 quality, ease of access for your providers and your beneficiaries, and so on?

2 So we're trying to look at the whole thing.

3 We're also trying to show where the states and the federal government have shared responsibilities

4 or shared policymaking responsibility, to show the division of effort and opportunities for drawing those

5 lines more clearly, again to try and make sure everyone is sort of working as efficiently as possible, not

6 duplicating things, also not letting things slip through the cracks. So that's the intent of taking this more

7 programmatic view of things.

8 We want to identify specific opportunities to streamline regulatory requirements, eliminate

9 redundant functions, promote greater integration of state and federal activities where that's appropriate and

10 helpful and where investment of additional resources may be helpful.

11 So, in terms of our program integrity agenda going forward, obviously, there are still a lot of

12 opportunities to improve Medicaid program integrity. Starting with the administrative perspective outlined

13 in this chapter, we would like to look for opportunities to improve efficiency by clarifying the federal and

14 state roles relating to Medicaid program integrity, isolating some specific areas of overlap and redundancy

15 that can be eliminated and identifying areas where a more rationale allocation of state and federal

16 responsibilities can result in greater effectiveness and efficiency.

17 One specific example are the Medicaid integrity contractors, which are federal contractors, and the

18 recovery audit contractors, which are state contractors, both of which are required by statute, and appear to

19 have very similar responsibilities. Are there better ways to either clarify those roles or find ways to

20 fine-tune them that sort of maximizes the resources available, to make sure that we're not looking at the

21 same thing twice but maybe looking at a broader range of things, if that's appropriate?

22 We also want to look at the effectiveness of current efforts, evaluate the information that's available

23 on the effectiveness of various program integrity initiatives, identifying successful initiatives that can be

1 expanded and possibly programs that are not cost effective and should be eliminated.

2 I think what we're probably likely to find are areas where either better performance measures or

3 improved data are necessary to even evaluate the effectiveness of a certain activity, and April will touch on

4 that a little bit more when she talks about data later today.

5 And, finally, we want to think about where there are openings for additional guidance, not that we

6 want to pile even more on the states or the feds, but we can look at the program integrity activities

7 associated with various program areas to determine if there are areas where additional guidance or greater

8 cross-state consistency would support overall program integrity.

9 One thing I don't like to hear -- I think Dr. Glassman was talking about telemedicine and how they

10 had a program idea and a payment strategy and a service delivery approach, which they implemented, and

11 then a couple years later someone came in and looked at it from a program integrity perspective and was

12 like, oh, this didn't follow the rules; we want the money back.

13 These things need to work in concert.

14 And we all know there are a lot of program changes happening, particularly over the next year or

15 two, both in eligibility and in payment. And are there opportunities to weigh in now about what an

16 appropriate payment or an appropriate eligibility decision should look like and how we can all be on the

17 same page around how we validate that so that someone doesn't come down two or three years from now

18 and say, this money went out the door; where did it go?

19 So that's something I think the Commission can be helpful in thinking about -- the lessons learned

20 from past initiatives and where we see vulnerabilities going forward so that we can just get in front of that.

21 So those are the things -- that's what we tried to set up in the chapter. That's where we think we

22 would like to take this over the next year.

23 What I'd like to know from you is:

1 First of all, do you have comments or suggestions regarding the draft chapter?

2 Is there additional information that you think would help inform your deliberations about how to

3 improve this going forward?

4 And do you have other ideas about what kinds of activities we might think about over the next year?

5 CHAIR ROWLAND: Do we have any data that show how much is spent administratively on

6 program integrity activities versus on program administration?

7 But especially, a lot of the activities that are being funded on the program integrity side are not

8 embedded in the Medicaid agency itself, and it would be very important, I think, to look at how much we

9 put into the program integrity side versus what we know has been shrinking in terms of state capacity to do

10 the administrative work that would set up the program's operations. So I think any statistics or

11 information you could provide on that would be very helpful to us.

12 MS. FORBES: Sure.

13 COMMISSIONER RILEY: [Off microphone.] Match rates.

14 MS. FORBES: Yes, yes. Thank you. Match rates.

15 CHAIR ROWLAND: Trish put in the different match rates even though her mic wasn't on.

16 MS. FORBES: No, that is -- I mean that is

17 VICE CHAIR SUNDWALL: I came in late, so if I missed this I apologize, but -- is there a

18 capacity to separate out their efforts to get billing and coding errors, up-coding, what have you, versus

19 criminal behavior?

20 Because the politicians are under enormous pressure to document that they care a lot about waste,

21 and so they will do an effort to address fraud but primarily to embarrass provider who, I think, are not

22 always doing anything intentionally wrong but in fact are coding maybe like they shouldn't. But that's, to

23 me, in stark contrast with the Medicaid mills or those people that really have criminal intent, or at least that's

1 what they're doing.

2 Is there any way to distinguish between those various levels of fraud or abuse?

3 One is fraud. One is abuse. Or, one is ignorance.

4 [Laughter.]

5 MS. FORBES: We can certainly look.

6 I mean, there's information on improper payment rates, which do look at things like claims

7 processing errors, and those rates in Medicaid are extremely low. They specifically do not look for fraud

8 when they're looking at improper payments.

9 And then there are, obviously, statistics on how much fraud is identified.

10 So we can, I think, show those two pieces of information. I don't know that we can show how

11 much the overlap or don't, but yes, that's -- and I agree that those are different --

12 VICE CHAIR SUNDWALL: It would be a service, I think, for us to point out these difference in

13 the effort. And it's my impression that our collective efforts probably cost more than we recoup, but I do

14 think it's important to make that distinction.

15 CHAIR ROWLAND: Patty.

16 COMMISSIONER GABOW: I hesitate to say I have a number of comments because Sharon

17 reprimanded me for having four comments.

18 [Laughter.]

19 COMMISSIONER GABOW: But I do have a number.

20 CHAIR ROWLAND: Sharon wants me to let you do one and then go to another person and

21 come back to you.

22 COMMISSIONER GABOW: Okay. So to David's point, I do think that pointing out waste

23 versus fraud and abuse is a very important distinction because I don't think they think much about waste,

1 and yet our lean work has showed us that 60 to 90 percent of every process is waste. The Toyota literature
2 has verified that percentage, and I suspect that this has done less than that.
3 So I think trying to find out how much effort is really on waste versus fraud and abuse -- so that's
4 the first point.
5 The second is I'd like Steve to talk -- and maybe Mark -- about if we have Watson now, the
6 computer who can put all this data in and give you a diagnosis, I think we're underutilizing technology in
7 mining data to actually get this as opposed to human effort to do all these audits, which are redundant --
8 often taking a sample of 10 and saying well, if you had 1 error in 10, we know that your overall error rate is
9 10 percent, so that's the recoup.
10 But I think better use of technology to really understand where is waste, fraud and abuse, especially
11 to use it to pick up fraud, which I think is easier to do technologically.
12 The other point that Moira you brought out, that came up this morning, that I think we should
13 emphasize is the timeliness of looking at the integrity program. I think people are very reluctant to get into
14 something and find out that when they get around to looking at 2007 in their integrity program then you
15 owe 5 years of back, whatever. That's a show-stopper for a lot of people, and it certainly doesn't make
16 people feel like they want to jump into this terrain when the look back can be so long and so untimely.
17 And then on this table, table 2 -- the table that was in the previous one showed a lot of the overlap,
18 and somehow, while this table is good and lists state activities and federal activities, it isn't clear where the
19 overlap is, where the duplication is. And so, I think that would be important to -- somehow, whether it's
20 by highlighting or some other methodology, so we know where could they do a better job of not
21 duplicating.
22 CHAIR ROWLAND: Judy.
23 COMMISSIONER MOORE: Thanks, Moira.

1 I think this is a hard subject for us because there is so much between the federal government and
2 the states, and it's hard to know where the lines should be drawn. And as Patty was saying, we've had a
3 chart that showed the overlaps, and now it looks clearer than it probably is.
4 But it seems to me that one of the places the federal government ought to be focusing a lot of
5 attention is in developing models, best practices -- maybe technology-related, maybe not -- highlighting that
6 states are doing.
7 And I don't know whether this is a role for us to actually take on ourselves or to encourage CMS or
8 others in the executive branch to do, but it just seems like there really ought to be templates and models and
9 state-based efforts that are going here or there or somewhere else.
10 I mean, they do this in their training center, I think. They try to highlight these kinds of things.
11 But it seems like there's always so much reinvention of the wheel that goes on within Medicaid programs,
12 whether you're talking about program integrity or enrollment systems or contracting or whatever.
13 This one just seems like a prime example of something within Medicaid that should be shared more
14 widely and more systematically. And if we can play a role in something like that, I think it would be
15 valuable.
16 CHAIR ROWLAND: Andy.
17 COMMISSIONER COHEN: I kind of got the feeling, but correct me if I'm wrong, that a lot of
18 what -- that part of what you were saying is that because the program integrity programs have been
19 developed often legislatively because of their budgetary value, and it's been layered -- you know, like one
20 year Congress needs some money to fund an initiative, so here's a program integrity effort. And then they
21 need some more money, and here's another program integrity -- and they're layered.
22 And they -- it sounds like the statute -- maybe that's over years, and it sounds like the statute needs
23 some sort of cleaning up and that that's something that is -- there probably is a lot of common ground

1 among experts in sort of understanding which initiatives are better than others, but it's also like politically
2 challenging to say we are going to eliminate a program integrity initiative.
3 So, to me, this seems like kind of if we have the expertise to do it -- in you, Moira -- and it sounds
4 like we do, to bring the right people together, I think it's an important area for us as our next step, to just
5 dig in and try to do that analysis about the overlap and try -- you know, it seems like we can really, I think,
6 do a service in trying to dig deep without politics, look at programs, see where there's overlap and make
7 some kind of common-sense recommendations.
8 So I guess I just sort of encourage -- the framing is great, but I encourage as our next step just sort
9 of like diving down and looking at the overlap with these programs and trying to cull out some
10 common-sense recommendations because my sense is it's not that there's a tremendous amount of
11 disagreement even necessarily. It's just sort of a challenging thing to align a program that has a lot of -- it's
12 hard to pull back on a program integrity effort even if what you're really trying to do is streamline and make
13 the whole thing more comprehensive and fix it.
14 So I think that's a perfect place for us to try to engage and figure out where our expertise can be
15 helpful.
16 CHAIR ROWLAND: Donna.
17 COMMISSIONER CHECKETT: And along those lines -- and this might be really more for
18 things to look at in the future rather than this chapter necessarily -- I think it's really important work, maybe
19 not the most exciting, but yet really critical to the political support of the program and to ensuring our
20 dollars are being spent wisely.
21 But one of the things that I observe, being now in the private sector after so many years in the
22 public sector, is that in many ways the public sector really lags on the use of technology. One aspect for us
23 to explore -- because I don't know the answer -- is when we look at all the program integrity, is there an area

1 for us to recommend for an improved use of technology?

2 Like a little example would be audits. Well, often still in the public sector that means people are

3 flying in from other states. They have to have a special conference room. They sit in there with lots of

4 paper and meetings. It's just very, very expensive. Really, in the day of technology, you can do any of

5 that from an office some place.

6 And I think we just -- I don't know where the states are on that, but that would be an area of this

7 that I think might really be worth exploring. It probably would be a cost-saver, but we just need to make

8 sure that in this area that all the possible benefits of technology are being brought to play.

9 CHAIR ROWLAND: When we talked about this previously, too, we looked at Medicare and the

10 procedures Medicare has in place, and Medicaid. And I think it would be useful to try and identify places

11 where there could be better coordination.

12 I know you talk about sharing of data, but I thought I recall that there was a provision that if a

13 provider was kicked out of the Medicare program they weren't necessarily kicked out of the Medicaid

14 program, and other issues.

15 So I think it would be really worthwhile to see whether there are any economies of scale or

16 efficiencies between the two programs.

17 And I think this is going to be increasingly important as we see the attempt to integrate care and

18 provider networks between the Medicaid and Medicare dual eligible population and what some of those

19 issues may even raise for the conflicting sets of activities going on right now.

20 Sharon.

21 COMMISSIONER CARTE: Diane, I think that changed. I think that if you are kicked out of

22 Medicare, you are kicked of Medicaid. I think we're asked to make that assurance.

23 But I still think that when we talk about the administrative burden that the states have to bear and

1 do they really have the capacity to engage in program integrity, and with the advance of IT systems and the
2 ability of people to pull money fraudulently out of these systems, that probably we should ask the question
3 of whether or not the federal authorities should bear more of that burden to do that, where these complex
4 IT systems come into play, also because it catches those activities up front.
5 CHAIR ROWLAND: Trish.
6 COMMISSIONER RILEY: Maybe we should end this where you began because I think the
7 critical issue for this -- this is my hobbyhorse, I know, but I hate program integrity because it stands alone,
8 without an understanding of the management. We just don't invest in the management in this program.
9 And I'd love to see this chapter framed around the notion of what it takes and look at the discussion
10 we had earlier about the payment rate increase, that nobody thought about what it takes to manage the
11 program, and to talk about the kinds of activities states need to engage in that could prevent fraud and abuse
12 and waste -- better contracting.
13 And to go to Diane's point about the numbers, what do we spend on administration versus the
14 incredible focus on this area?
15 Wait until the whole -- all the horses are out of the barn and then think about how to close the door.
16 And that's really how we've structured our commitment to administration in the Medicaid program.
17 CHAIR ROWLAND: I think that's a pretty good ending for what -- I think we want to make sure
18 that program integrity is not a standalone activity and an after-the-fact activity.
19 And you've talked here about trying to make it more involved in the up-front part. But if the
20 administration of the program doesn't have the capacity to design good contracts, then going in to find out
21 who abused that contract is almost impossible. So I do think linking both sides of that equation together
22 would be a real contribution to really put the program integrity activities in context of the whole program.
23 Okay. Thank you.

1 MS. FORBES: Thank you very much.

2 CHAIR ROWLAND: And we really began, at the beginning of MACPAC, talking about would we
3 have the data that we need to be able to drill down and look at how the program operates and to make
4 recommendations to change some of the problem areas.

5 We have through our MACStats, I think, offered tremendous insight into how the Medicaid
6 program operates, using existing data, but we've also charged April to help us figure out how to make better
7 recommendations on what kinds of data should be collected and how they should be organized to both
8 minimize -- and this is for Trish, to minimize -- some of the administrative burden on states yet to get the
9 kind of effective information that we need to be able to know really what's going on in the program and to
10 be accountable.

11 So, April.

12 **### DRAFT JUNE REPORT CHAPTER ON DATA**

13 * MS. GRADY: Thank you, Diane.

14 So today I want to review with you our previous Commission chapter in our first report to
15 Congress, where we talked about federal data on Medicaid and CHIP. I'll talk about the current draft
16 chapter have we have proposed for the June report and take any of your comments.

17 And I'll say we're happy to have provided the background information that's in the draft chapter
18 right now. It's an open question about whether you feel this issue arises to the level of inclusion in the
19 June report, and so we'll be glad to have your feedback on that.

20 Before I review our previous and our current chapters on data, I want to emphasizes that a key
21 motivation for the Commission's interest in data has been the use of those data for answering policy and
22 accountability questions, and as the timeliness, the quality and the availability of data improve, so will our
23 ability to answer some of these questions.

1 And I think you have a good flavor of the kinds of things we can and can't do right now, but I'll just
2 hit on a couple of issues.
3 One is the issue of fee-for-service, managed care and delivery systems and whether enrollees are
4 receiving appropriate care in those various settings.
5 And encounter data is something we've covered again and again here during the Commission
6 deliberations. They provide one example of an area where we've historically been lacking. Historically,
7 the data were underreported by states, and their quality and completeness at the federal level went largely
8 unexamined.
9 But we know from our interactions with the states that all of them with managed care programs
10 have their own data that they're collecting at the state level. Many of them have had years of experience in
11 using those data for a variety of purposes that include rate-setting, calculating performance measures,
12 generating ad hoc reports for their own state agencies, their legislatures and external constituencies. And
13 the ongoing use of those data at the state level has provided a check on their quality and their usefulness.
14 The issue is that at the federal level we have not been using those data, and we are just now
15 beginning to explore what the quality and the completeness of those information sources are.
16 Excuse me. I'm sorry I'm having trouble with my voice today. I've been sick.
17 Another policy question that is of great interest to the Commission is provider participation in
18 Medicaid. Right now, we don't have great information on the providers that are in the program and the
19 extent to which they're surveying enrollees. Again, that has been improving but is still lacking.
20 Another issue we have, as you discussed earlier, is that we sometimes don't have data available to
21 assess the impact of policy changes, such as the current increase in payment rates for certain primary care
22 providers in a timely manner. So the timeliness of data is an ongoing issue.
23 And although not noted on the slide here, Moira did talk to you about program integrity in the

1 previous session, and those are certainly issues that are informed by data at both the state and federal levels.

2 In our March report, as you know -- in our March 2011 report -- we noted that we have a statutory

3 charge to review national and state-specific Medicaid and CHIP data and to submit reports and

4 recommendations based on those reviews. As outlined in our March 2011 report to the Congress,

5 Medicaid and CHIP data are collected from states in a variety of formats, at different times, for different

6 purposes, and states report some information on their programs more than once. As Diane alluded to,

7 there is some duplication and overlap in these efforts. And in addition to the redundancies, there are also

8 gaps that limit the usefulness of the various data sources that we outlined in the March report.

9 And to that end, we noted a number of areas where better federal administrative data on Medicaid

10 and CHIP were needed, and we provided examples of how improvements in these data could allow for

11 better analysis of policy and program accountability issues.

12 And the areas of need that we identified in particular were, as I mentioned, the ability to understand

13 service use among managed care enrollees and also among children who are eligible for EPSDT benefits

14 and children in separate CHIP programs. Another area of need that we identified was improvement in the

15 timeliness and the consistency of various data sources. And we also noted the need for information on

16 state program policies to delineate what's going on at the state level.

17 For our June 2013 report, we're proposing to provide an update on the issues that were raised in the

18 March 2011 report. We'll describe the recent efforts to improve timeliness, quality and availability of the

19 federal data on Medicaid and CHIP. And we'll address both federal and state perspectives here.

20 Again, as I mentioned earlier, states have their own detailed information on their individual Medicaid

21 and CHIP programs, and the issue that we have here at the federal level is that we need comparable

22 information in a standard format that allows us to compare the information that states hold individually for

23 their own programs.

1 I'm not going to go through all of these CMS initiatives in detail because you did hear from CMS in
2 our February meeting, but I just want to raise a couple of things that are mentioned in the chapter.
3 One is the MACPro initiative that CMS has going on right now, which is a web-based system to
4 collect state plan waiver and other programmatic documents in a structured and consistent format. As you
5 know, many of these documents are paper-based right now, available on the CMS website but not
6 consistently organized, not always complete. That has been improving, but this new system is intended to
7 provide everything in one place in a very structured and consistent way.
8 The other initiative you heard about was T-MSIS, which builds on the existing person-level and
9 claims-level data that we've used in our many of our own Commission analyses here.
10 And another initiative that CMS didn't talk too much about in the February meeting but is also
11 relevant is called the Medicaid Information Technology Architecture, or MITA, initiative. That's working
12 with states on the front end to design the systems that they use at the state level to process their claims, to
13 do their eligibility determinations. And CMS is making a real concerted effort to work with states on the
14 front end to design those systems to output the new data that CMS is looking for in these T-MSIS and
15 MACPro initiatives.
16 After the meeting, we did follow up with CMS so that we'd have some more time to discuss issues
17 that were raised in the public meeting. And, as you'll see in the draft chapter, we also wanted to be sure to
18 acknowledge the state perspectives on these initiatives.
19 For example, we know that states have had some concerns about the time and the expense
20 associated with submitting this expanded T-MSIS data and that one of the concerns that has been raised
21 about MACPro is the potential for reopening issues that might have been considered settled in the past.
22 By converting state plan documents into this new system, will questions be raised about things that were
23 considered settled business in the past?

1 So, in the chapter, we note that this is a huge effort that's underway.

2 And clearly, CMS is taking steps in the right direction, but it's going to take some time to implement

3 these changes -- as you heard in the February meeting, perhaps up to two years or longer in some cases.

4 And, with T-MSIS in particular, CMS is working hard to provide states with technical assistance to

5 implement these changes, and they're also trying to hold them accountable by making T-MSIS a prerequisite

6 for receiving enhanced federal funding for their upgrades to their technology systems.

7 So there are carrots. There are sticks. They're trying different things.

8 Still, there is a concern that if these data aren't used for a clear and compelling purpose -- federal

9 reimbursement of state expenditures being one of them -- there are going to continue to be, potentially,

10 issues with the completeness and the quality of these data. There is only so many carrots and sticks out

11 there.

12 Of course, there are tradeoffs associated with making the federal data better. That comes at a cost

13 for states and for the federal government, and one could argue that a lot of that is up-front cost and that

14 you'll see benefits on the back end. But again, as we know, state budgets are difficult right now and this is

15 not a time of a lot of disposable resources for them.

16 So the chapter would recognize, again, that there are competing pressures and that some of these

17 initiatives may be seen as a low priority depending on what else is going on at the state level.

18 So I welcome your comments on the draft chapter that we've provided, and question, do you want

19 to see this chapter in our June report, and if so, do you have suggestions fore revision or expansion of the

20 chapter as it is now?

21 Thank you.

22 CHAIR ROWLAND: Thank you, April.

23 Andy.

1 COMMISSIONER COHEN: Great chapter, super concise, and that's great.

2 I have a question about timelines. I'm not sure if this is appropriate, but I'm going to throw it out

3 there as a suggestion.

4 I think in our various presentations from CMS they've given us sort of -- I don't know if it would be

5 fair to call them timelines -- projections for when different things will be done. And I think it would be

6 good in our report to refer back to them and just sort of compose a little -- I know this is a lot of pressure,

7 but I mean we should.

8 Like if they said they were going to get something done in a certain amount of time, we should at

9 least just reference it. There may be great reasons that it can't be done. But I do think that that is a

10 function that we can serve to kind of keep the timeline in line.

11 CHAIR ROWLAND: Mark.

12 COMMISSIONER HOYT: Question for you, April, or maybe Donna or Richard. I'm not sure.

13 Are there specific data reporting requirements for the plans that offer in the exchange?

14 The states are going to provide subsidies to people up to 400 percent. I wonder if we're going to

15 have any level of data reporting for those people so we can use that to assess risk or premium adequacy

16 there.

17 COMMISSIONER CHECKETT: I just want to ask a clarifying question -- that the exchange

18 boards are asking the carriers to submit a certain type of information? Am I understanding the question

19 correctly?

20 COMMISSIONER HOYT: [off microphone.] Similar to data reporting requirements for the

21 [inaudible].

22 COMMISSIONER CHECKETT: I have not heard that. I will ask somebody in my office, but

23 I've not heard that.

1 They've asked for a lot of things, but I've not heard data reporting.

2 MS. GRADY: I would just say there will be a risk adjustment among the plans in the exchanges.

3 So there will probably have to be some level of reporting, but I haven't seen anything specific about that.

4 COMMISSIONER WALDREN: Yeah, I mean I like the chapter.

5 I was thinking about this, what they brought up again when we were talking about the program

6 integrity, but one thing that we didn't kind of talk about is -- and I don't think we need to add it for this

7 chapter, but just something as we think forward. There are additional data that we need to be able to

8 drive, and I think there are some data that CMS has.

9 I know there's a new department, the Office of Information Products and Data Analytics, and

10 they're looking at trying to create a strategic plan to create products from CMS.

11 But I'm just wondering if we start to think about what do we need and what potentially could CMS

12 have, that we could lever from a data perspective, especially if we start talking about the program integrity

13 stuff.

14 Well, some of it you can look at from a fraud perspective because what you could do is you could

15 look at the data and do some clustering analysis. And you look for outliers and say, ah, that's where I need

16 to spend my time going to look and see if there's fraud.

17 But if waste is pretty uniform across the population, nobody is going to cluster. They're all going

18 to be pretty the same.

19 The other is we start looking at some of the things beyond just like elective cesarean. You need to

20 figure out, okay, well, is there a clinical indication for doing something?

21 So, just a little bit of experience -- when my wife had an issue, in the claims there were at least four

22 or five diagnoses that she didn't have. But it's because she had other things that normally you see--you

23 normally see those other diagnoses as an indication for doing these other things. So they were

1 automatically added to the bill.

2 So, when you then look at it from a program integrity perspective, you say, oh, yeah, somebody had

3 atherosclerosis at a CABG. Makes sense.

4 So I wonder about the limitation of looking at those current data sources through that.

5 So can we start to look at, what are some other more clinical-related data, like the PQRS data that

6 Medicare is doing with meaningful use?

7 Medicaid entities now have to submit quality data. Are we going to be able to get any access to

8 that and some of those certain things?

9 Again, I don't think it's anything for this. I think this is good, but as we look forward to the future.

10 COMMISSIONER HENNING: I was just going to say that -- and then we're going to change to

11 ICD-9/10, and that's going to be -- for us that are actually seeing patients, it's going to be another major

12 change when it comes to coding our encounters correctly.

13 CHAIR ROWLAND: I noted at the end that it says the Commission also urges CMS to assess

14 whether its available resources will be sufficient for this purpose. That's kind of a nice way of saying, do

15 they actually have the resources and the capacity to do what they're charged with?

16 I think if we think this is so important we should be saying that it's critical that the resources

17 necessary to make this actually work -- so that it's not kind of a patchwork that goes halfway -- be provided

18 so that the best data and information can be provided in the most simple and direct way.

19 And that would also include stressing the use of technology to have some of these data reports and

20 whatever just be spun off. I mean, I know that's their goal, but I think we should really emphasize the not

21 having to go in and manipulate the data but to have key indicators and other information be transmitted in

22 the most -- whatever the right terminology is -- direct electronic manner.

23 I mean, if we could sit here and look at our iPads and read reports and whatever, shouldn't some of

1 the technology for that be also transmitted to the data systems?

2 And I just got the sense when CMS was here that they're still designing bigger and bulkier

3 information systems.

4 And I think we really want to point to figure out what you need, how to evaluate the program, how

5 to pay for the program effectively, but let's not have data that just clutters up the system.

6 Steve.

7 COMMISSIONER WALDREN: Yeah, just about the cluttering up, I think one approach could

8 be just making sure that they get those real-time feeds. So however good or bad the data are, but those

9 feeds are flowing in, in a timely manner, to some place that is going to look at that.

10 So if this is this new department at CMS that's managing a lot of the large databases, as they start to

11 look at that and say, okay, well, here's all this data. What good data can we pull out of that and how can

12 we automate that in a timely fashion?

13 I think that's one approach and probably going to get at something tangible more quickly than the

14 other approach, which is saying -- which kind of looks at the MITA stuff -- okay, well, what's the data set

15 that we really need to really drive program integrity and make sure that access is good, make sure that the

16 quality is good? What's that data set?

17 And then say, okay, now how do we go out and put the information systems in, put the incentive

18 structure in, to be able to collect that in a way that does it routinely and good quality data, to drive that?

19 That I see as something that's probably decades away because they're trying to do that in the clinical

20 space right now and they're not making a lot of progress.

21 CHAIR ROWLAND: But we want them to move toward that.

22 COMMISSIONER WALDREN: Yeah, but that's what -- my only point was that it's just -- I mean

23 at this point we're at with technology and the cloud and the bandwidth that we have, submitting all that

1 real-time data to a place.

2 I mean you have the security issues that you have to deal with, but I don't think it would clutter

3 things up or clog things up.

4 You would start to have somebody, though, that could start to look at that and say, well, what can

5 we pull out of that that's usable and timely, not saying, okay, well, let's get it right, but to get it right it takes

6 us five years; so here's 2007 data.

7 MS. GRADY: I think CMS was explicit in talking about assessing what they have and not waiting

8 for perfection and using that to inform the analysis that they can do -- assessing what's there and then

9 figuring it out.

10 And I think just to clarify -- so we're talking about not just the data itself but a tool or some

11 software, something that helps us better access and make use of that information. Okay.

12 CHAIR ROWLAND: Trish.

13 COMMISSIONER RILEY: It's not related, but it's the end of the day.

14 It strikes me that there's been a theme through this discussion and today's discussion about the

15 waivers. When you think about all the criticism that's launched at CMS and at the Medicaid program, and

16 how much it needs to change, and when you think about what's going on in the last five years in the

17 Medicaid program -- a new IT center, a new Innovation Center, dual eligibles actually happening -- there's

18 been enormous change in this program.

19 And at some point it might make a nice fact sheet to just sort of talk about where the program has

20 been and where it's going and these data efforts are really a step in the right direction after 40 years of

21 really the same old, old sameness. There's been a really extraordinary amount of change that's gone on,

22 and I think it might be valuable to document that, especially if we're about to have a conversation about the

23 old Medicaid program and it needs to change because it's really pretty clear to me that it's changed quite a

1 lot, pretty quickly.

2 CHAIR ROWLAND: All right. Thank you, April.

3 And we will take any comments if anyone from the public wants to offer us an insight or a

4 comment.

5 We're not at adjournment time yet.

6 **### PUBLIC COMMENT**

7 * MR. SCROGGS: Yeah, that's right. You're not even in overtime yet.

8 Is this on? Hello?

9 Okay, I got it.

10 Yeah, so I've introduced myself to a few of you, and I knew a few of you before. I'm James

11 Scroggs. I work for the American Congress of Obstetricians and Gynecologists.

12 So there's more than one person here today who's happy that you're talking about the maternity care

13 in Medicaid. I know you've been talking about it in some way or form for the last couple of years. I

14 come to a lot of these meetings.

15 We agree with the comments that have been made by the commissioners regarding the -- well, that

16 there were a lot of problems with the primary care fee bump for two years. I knew about that from the

17 beginning, and so did you.

18 But we're also concerned that they're excluding providers of obstetric and gynecologic care from the

19 list of primary care providers in the Medicaid population.

20 I mean, are there any mothers here? You know?

21 Who provided the primary care for you during pregnancy? Who coordinated that care? That

22 would be an obstetric provider.

23 And it's also true that anybody who does OB/GYN care provides care -- many other patients are

1 relying on them for their primary care.

2 And, I mean, the National Ambulatory Medical Care Survey of 2009 indicated that about 20 percent
3 of the visits to OB/GYN physicians are primary care visits for -- I mean that's where they are providing the
4 primary care for that physician.

5 So we would like to see this group -- because you have the ear of Congress -- point that out and to
6 let them know that whenever they're looking at primary care and people who coordinate care, it's not just
7 family physicians and general internists. So that's one of the points I wanted to make.

8 And also, OB/GYNs should not be restricted from serving as leaders of things like primary care
9 medical homes and accountable care organizations, that sort of thing.

10 So that was the first point I wanted to make.

11 Also, to a point that was made during the presentation on OB care, or maternity care, we do support
12 legislation that has been introduced in the House and the Senate to support state and local maternity and
13 perinatal care quality collaboratives, and this addresses exactly the question that you were talking about.
14 There are a few collaboratives that exist. They've been shown to reduce the pre-39-week elective
15 inductions, they've reduced NICU admissions, and they increase the likelihood of breast feeding.

16 And there are a few of these cases. We actually contracted with Avalere to summarize the findings
17 or the results of these collaboratives, and we'd be happy to share that with you. I'll send it to your staff.

18 CHAIR ROWLAND: Thank you. That would be great.

19 MR. SCROGGS: Yeah. And, finally, just I wanted to make a quick comment about the
20 Affordable Care Act and the confusion about those benefits. I was sort of pleased to see that everybody is
21 confused about that.

22 [Laughter.]

23 CHAIR ROWLAND: But we're going to figure it out. We'll let you know next time when we

1 figure it out.

2 MR. SCROGGS: [off microphone.] Yeah, I've already heard that before.

3 MS. INGHAM: Hi. My name is Amy Ingham. I'm with Medicaid Health Plans of America.

4 Just on background, MHPA is the largest national trade association solely representing Medicaid

5 health plans. We have 117 member plans in 33 states and D.C.

6 And my comment is regarding the primary care physician payment increase. I know that there was

7 a lot of discussion about how complicated this is in the Medicaid program, and I know that Commissioner

8 Chambers discussed a little bit about the extra complexities in managed care.

9 But I just wanted to let the Commission know that MHPA has done a lot of work with our member

10 plans to discover what some of those specific complexities are, and I just wanted to offer us as a resource to

11 the Commission as you look at little deeper into the specific complexities.

12 Just to give one example, some of our member plans have identified that the reporting is going to be

13 difficult when it comes to showing that the correct provider got the enhanced payment -- like if they are

14 contracting with a large hospital or a group practice, they're required to show that the correct physicians,

15 who are eligible and delivered those services, got the enhanced payment, but once that payment is given to

16 those hospitals or group practices, our plans don't necessarily have the information that they need to show

17 that the payment increase actually went to that provider.

18 They can see that the services were provided and which providers provided them, but they can't see

19 that the actual payment went to that specific provider. And so they're faced with issues like wondering if

20 they need to have some kind of auditing system in place, which would add a huge cost to the companies.

21 And the states and CMS have been helpful. We've had a lot of conversations as a national

22 organization with CMS. They've done a really good job in answering our questions and staying in

23 communication with us on the issue, but there are just some complexities that we haven't gotten to the

1 bottom of that I think are going to be very administratively burdensome, complex and costly.

2 So I already gave my information to Ben Finder. And I just wanted to let the Commission know

3 that we've done a lot of work on this, we have a list of different complexities and some of the related costs,

4 and we would just like to be a resource to the Commission on that managed care aspect, and really not just

5 on this issue but any issue that the Commission is interested in learning a little bit more.

6 Thank you.

7 CHAIR ROWLAND: Well, thank you very much.

8 And I think you've just shown how all of the discussion today has kind of linked back around

9 together. We started with the primary care bump-up, and we kind of ended this session before with

10 program integrity and then with data. And so, obviously, all of it interrelates to how we make the program

11 simpler, more efficient and more effective.

12 Well, thank you all very much for being with us today.

13 We will reconvene tomorrow morning at 10:00?

14 VICE CHAIR SUNDWALL: 10:15.

15 CHAIR ROWLAND: No, 10:00? 10:30?

16 EXECUTIVE DIRECTOR SCHWARTZ: 10:15.

17 CHAIR ROWLAND: 10:15 for a public session to both look at enrollment and managed care

18 plans first and then add some additional dual eligible issues afterward.

19 Thank you very much.

20 [Whereupon, at 4:37 p.m., the meeting was recessed, to reconvene at 10:15 a.m. on Friday, April 12,

21 2013.

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

Hall of States
National Guard Association of the U.S.
One Massachusetts Avenue, NW
Washington, D.C. 20001

Friday, April 12, 2013
10:19 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
RICHARD CHAMBERS
DONNA CHECKETT, MPA, MSW
ANDREA COHEN, JD
BURTON L. EDELSTEIN, DDS, MPH
PATRICIA GABOW, MD
DENISE HENNING, CNM, MSN
MARK HOYT, FSA, MAAA
NORMA MARTINEZ ROGERS, PhD, RN, FAAN
JUDITH MOORE
TRISH RILEY, MS
SARA ROSENBAUM, JD
ROBIN SMITH
STEVEN WALDREN, MD, MS

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

Session 8: Plan perspectives on state enrollment policies for Medicaid managed care..... 144

Janet Grant, Executive Vice President of External Affairs and Corporate Compliance Officer, CareSource..... 145

LeAnn Behrens, Chief Executive Officer, Amerigroup Texas..... 152

Session 9: Care coordination for people dually eligible for Medicare and Medicaid

Ellen O'Brien, Director of Long-term Services and Supports 173

Public Comment Day 2..... 188

Adjourn..... 188

1 P R O C E E D I N G S [10:19 a.m.]

2 CHAIR ROWLAND: Thank you, and let's open this session of the Medicaid and CHIP Payment
3 and Access Commission. We are very pleased this morning to be able to discuss how enrollment practices
4 for Medicaid in managed care are working, and we have with us a panel to share their experiences, and I will
5 turn to Molly McGinn-Shapiro to introduce the panel.

6 **### PLAN PERSPECTIVES ON STATE ENROLLMENT POLICIES FOR MEDICAID**
7 **MANAGED CARE**

8 * MS. McGINN-SHAPIRO: Thanks, Diane.

9 So as we reviewed in our last meeting, states are increasingly interested in using managed care
10 arrangements for populations with extensive health care needs. After I presented the preliminary findings
11 from our case study of ten states and their managed care enrollment practices and policies during the
12 February meeting, you expressed interest in hearing from Medicaid managed care organizations on their
13 perspective of state enrollment policies.

14 This session includes panelists from two Medicaid managed care plans that have extensive
15 experience in enrolling Medicaid populations, including enrollees with disabilities and dual eligibles. The
16 panel's bios are included in your binder under Session 8, but just as a brief intro, first we will have Janet
17 Grant, who is executive vice president of CareSource, which is a Medicaid managed care plan with
18 experience in providing coverage to Medicaid enrollees in several states that are at various stages of using
19 Medicaid managed care, including Ohio, certain areas of Indiana and Kentucky, and they have just left
20 Michigan after nine years.

21 And LeAnn Behrens is CEO of Amerigroup Texas, a Medicaid managed care plan that has extensive
22 experience in enrolling beneficiaries with complex needs. Texas recently expanded its managed care into
23 several rural regions of the state, which included expanding managed care for persons with disabilities in

1 that region.

2 We hope that the key points from this panel discussion will be folded into the Commission's

3 continuing discussion of managed care for high-cost/high-need populations, and I anticipate bringing the

4 final findings from our report on the case studies of the enrollment policies to the May Commission

5 meeting.

6 Thank you. Janet?

7 * MS. GRANT: Good morning. It's a pleasure to be here. Thank you for your focus on this very

8 important topic.

9 First of all, I just want to introduce CareSource, tell you a little bit more about who we are. We are

10 headquartered in Ohio and got our start really with the original pilot for Medicaid managed care in the State

11 of Ohio, in the Dayton area, in 1989. And we've been operating in the State of Ohio continuously since

12 then, have almost 900,000 members in the State of Ohio today.

13 We're a nonprofit organization and very much mission driven, focused on serving our members and

14 really partnering with safety net providers. We do believe that wide access is important in a Medicaid

15 managed care plan, and so we are contracted with significant numbers of providers with significant

16 relationships with FQHCs and other safety net providers.

17 One distinction about CareSource is that we really operate what we believe is our mission in our

18 practice with a best practice administrative cost structure. We operate very efficiently with about a 5

19 percent admin structure so that we can put more dollars into care.

20 Just to expand on what Molly said, I am really speaking today with a perspective from enrollment

21 practices in four states -- in the State of Ohio from 1989 to present. Originally, Ohio really focused its

22 Medicaid managed care program on the TANF and CHIP populations, in 2007 started enrolling ABD adults

23 into Medicaid managed care; and we are in the middle right now, so very relevant for this topic, of enrolling

1 ABD children into Medicaid managed care with eligibility starting in July. And we are working with the
2 state and CMS on a dual demonstration that right now is envisioned to start enrolling dual-eligible
3 consumers in September of this year.
4 We just launched in an alliance with Humana, we launched a Medicaid managed care plan in the
5 Louisville region of Kentucky, have been operating there since January, and Kentucky really does have a
6 broad spectrum of Medicaid consumers enrolled in managed care, and so we have just been through that
7 kind of enrollment process with all those populations you see there.
8 We operated in the State of Michigan, owned a nonprofit health plan in the State of Michigan, up
9 until we sold that to another nonprofit in Michigan last summer, and, again, a wide spectrum of populations
10 enrolled.
11 More recently, the dual-eligible population was enrolled just on the Medicaid side in Michigan, and
12 foster children were enrolled just in the last couple of years in Michigan. So I can speak to that if you have
13 questions.
14 And then we had a short stint in Indiana --
15 CHAIR ROWLAND: Could you clarify for those who do not know what ABD children stands
16 for?
17 MS. GRANT: Oh, sure. I'm sorry. In Ohio, we used the term "ABD" versus "SSI," and so it's
18 the disabled children. They had been carved out of Medicaid managed care in Ohio and now are being
19 carved in starting in July. Thank you for the clarification.
20 And then just Indiana, we served for just a short time in Indiana, and that program focused on the
21 TANF and CHIP populations.
22 So I wanted to share with you from our perspective a couple of kind of the best practices that we
23 believe we've seen across the states that we've operated in. And the first is really the use of an independent

1 enrollment broker. We do have one state that we've operated in where the state itself did enrollment, and
2 we've really seen the benefits of having that expertise of an independent enrollment broker -- both the
3 systems that they have, the ability that they have to focus on best practices of enrollment, as well as really
4 providing multiple access points. So Internet, phone, and in-person is really a best practice that we've seen
5 in the State of Ohio when enrollment broker personnel are available at events and those kinds of things to
6 interact directly with consumers.

7 The second point would be really tools to encourage active selection. We really want consumers to
8 make active, voluntary selections of the best plan for them versus being auto-assigned, and so when states
9 offer those kinds of tools that consumers can really make selections, to compare between plans. And
10 some of those include to really be able to easily identify network differences, where their historic primary
11 care or hospital providers are contracted, where states offer information about enhanced benefits for
12 comparison, and then certainly looking at more performance-based kinds of criteria, things like HEDIS and
13 CAHPS scores, and offering that information to consumers.

14 In terms of auto-assignment itself, we really believe that a best practice is that initial algorithm really
15 being focused on network match. So, again, where there's historic primary care or other kinds of specialty
16 providers for the individual or in the case of families, some kind of an algorithm, and we've seen some states
17 do that, to be able to take into consideration kind of across the family the best match.

18 We believe in terms of auto-assignment that certainly looking at performance-based auto-assignment
19 among health plans rather than just a round robin assignment is certainly more appropriate.
20 Auto-assignment, first of all, provides real value to a plan, and so it should be used as an incentive for plans
21 to focus on those areas for performance improvement.

22 The best state we have seen really do that is the State of Michigan. They really align incentives
23 across both auto-assignment and other performance-based kinds of metrics and really incent plans to

1 improve. And if you've looked at some of the plan rankings in the State of Michigan, you know that
2 they're one of the higher rates states for Medicaid managed care. So using things like, again, HEDIS and
3 CAHPS metrics, administrative metrics, things like maybe prompt pay, again, looking at network kind of
4 access. In the State of Michigan, one of the algorithm elements is your primary care capacity metric as a
5 plan.

6 And the last one I would really call out is data sharing with plans. This is really critical for plans in
7 terms of transitions, as consumers come into our plans to really be able to provide for transitions of services
8 as well as really be able to identify those consumers that have the highest needs so that we can really reach
9 out from a care management perspective. So having that claims history timely, not, you know, months
10 later, having the information about open prior authorizations, both on the medical and the pharmacy side.
11 Health risk assessments, the State of Ohio provides us kind of a mini-health risk assessment for consumers
12 that have interacted with that enrollment broker, so we know pregnant women, we know some of the
13 children with special health care needs are already identified at that point so we can prioritize.

14 And the last one I would say is the redetermination date. We have not seen a best practice on that
15 in any of our states, but we continue to really advocate for that information so that we can take a proactive
16 role in terms of trying to reduce churn, which is a very significant issue in Medicaid managed care.

17 I included here just a couple of examples from some of the states that we've operated in. This is a
18 consumer piece that goes out to consumers as they're selecting in the State of Michigan. So you can see
19 how they use HEDIS and CAHPS scores here in a fairly consumer-friendly method with star ratings. So
20 for a consumer that really has no other gauge for making a selection between plans, obviously those kinds of
21 ratings help them in making a selection.

22 This is just a little snapshot of a piece that Kentucky used here as we implemented the Louisville
23 region for January 1st, and this just showed it was a consumer piece that, again, showed a variety of plan

1 comparisons. This happened to be -- this section was focused on the enhanced benefits that each plan was
2 providing.
3 And, lastly, this is an example from the State of Ohio, a very consumer-friendly tool that the
4 enrollment broker provides for a consumer to put in their network concern, whether it be primary care or
5 hospital, and their zip code and, you know, up pops the network providers that are contracted for a
6 particular plan. So that is really important in terms of, again, supporting consumer choice.
7 In terms of enrollment of special populations, a few things that I'll touch on here, and this is, again,
8 based on our experience really more recently with the special populations that Ohio is in the middle of
9 enrolling right now.
10 The first thing is really stakeholder engagement is really critical. First of all, just basic education of
11 those stakeholders. Many of these stakeholders do not have experience with Medicaid managed care, have
12 a lot of fear about Medicaid managed care, maybe some myths. And so a lot of education that both the
13 plans can certainly be participating in, but having the state really take an active role in supporting that as well
14 is important. And we've had a number of forums, for instance, that the states facilitated between the plans
15 and various stakeholders as we are enrolling the disabled children in Ohio that have been very helpful.
16 Obviously, this is a good group also to engage in terms of outreach and materials for consumers,
17 both strategies and the actual materials. They provide expertise, and it also serves, again, for buy-in of that
18 very important group.
19 And the last is around enrollment support. These stakeholders can really help with consumers
20 navigating the enrollment process and, again, are critical to that.
21 For special populations, data sharing beyond what I already just mentioned is really important.
22 First up front, even at the time of a bid process, is really getting aggregate utilization and network
23 information. What that does is it helps a plan really identify who are the providers that are historically

1 providing the services for these special needs consumers so that we can really try to reflect them in our
2 networks and lessen the transition kinds of issues. So having that information earlier so that we can use
3 that in building network is important.
4 And then certainly at the time of enrollment or ahead of time, for instance, just this week -- two days
5 ago, I think it was -- we learned the first 2,000 children that are going to be enrolled in CareSource starting
6 July 1. So that gives us an opportunity to outreach to them, but getting historical information on those
7 children to allow that outreach is important.
8 Care treatment plans, we're in a conversation right now for the dual-eligible demonstration, about
9 what that's going to look like, in particular for waiver services, IEPs for disabled children.
10 Guardians is an important issue for both who to reach out to as well as deal with HIPAA kinds of
11 issues, and particularly for foster children really having access to who those caseworkers are so that we can
12 coordinate our services with them.
13 And the last point I'll make is around plan advisory councils. At CareSource for the last about year
14 and a half, we've had advisory councils focused on both the disabled children coming into managed care and
15 another one in terms of the dual-eligible demonstration. Before those were really even bid out, we put
16 together advisory councils of stakeholders to really provide input to the plan as we design our programs.
17 The State of Ohio has actually now required plans to have advisory councils, so that's an interesting
18 practice, and we'll see kind of how that works out. But for the disabled children plans, starting July 1 we'll
19 be required to have family advisory councils and have recommendations on a regular basis that are
20 integrated into our programs, and similar for the dual demonstration is envisioned a consumer advisory
21 council in each region that we serve.
22 Again, just a couple of examples here. On the left are some communications that have gone out to
23 stakeholders around the disabled children at various points along the way, to those stakeholders. And on

1 the right is an initial stakeholder communication that has been used with the dual demonstration in Ohio.

2 And then very lastly, I just wanted to point out a few issues that we have identified over the years in

3 terms of enrollment practices. The first one -- and I'm sure you've discussed this at length in past sessions

4 -- is really the eligibility churn challenge that we have in Medicaid. It is not unusual on a monthly basis in

5 the State of Ohio for just our plan to have churn of about 20,000 members. And that, obviously, you

6 know, impacts continuity of care for consumers, those gaps of care, gaps of our care management efforts

7 with working with in particular those with special needs. And so, you know, certainly efforts --

8 PARTICIPANT: Twenty thousand out of?

9 MS. GRANT: Out of about 900,000. And so, anyway, you know, efforts to look at things like

10 continuous eligibility would be helpful here.

11 COMMISSIONER ROSENBAUM: Those are involuntary disenrollments?

12 MS. GRANT: Yes. Yes. And many come back on, but it's back on in two or three months,

13 and we've had, you know, a gap in care during that time.

14 Lag of time from eligibility to plan enrollment is another challenge, and the states have been trying

15 to really focus at trying to shorten that. Sometimes it can be as much as three months. I know the State

16 of Ohio has tried to really get it down to more like 45 days, and this is really concerning. Usually, services

17 are available in fee-for-service during that time, but for, again, special needs consumers to be able to be

18 really engaging, in particular pregnant women, to be able to get into care, high-risk pregnant women into

19 care management, those kinds of gaps are concerning.

20 We just implemented presumptive eligibility in the State of Ohio, and we thought that was going to

21 be a help, and actually that may actually lengthen the time between eligibility and coming into the plan. So

22 strategies to look at reducing that are important.

23 Adverse selection, I just want to mention this because it is an issue in terms of enrollment. In the

1 State of Ohio, because of the size of CareSource as the statewide program was implemented back in 2006,
2 we were held from auto-assignment for a two-year period to allow other plans a chance to grow, and that
3 ultimately impacted us very negatively financially, and so really threatened our plan. So we're a big
4 advocate of a balance of voluntary and auto-assignment, needing to have that balance for viability of plans,
5 or looking at risk adjustment strategies to be able to deal with that.
6 And the last point I'll make is in terms of marketing rule enforcement. Three of the four states
7 that we have operated in have really had issues. There have been issues with what I would call "white coat
8 marketing" issues where providers on the behalf of certain plans have really gone outside of, way outside of
9 marketing rules. And states have really struggled with that, struggled with how to deal with both enforcing
10 it at the plan level and at the provider level. So those are some of the issues that we've seen in terms of
11 enrollment.
12 So, with that, I will turn it over to hear the Texas experience.
13 MS. BEHRENS: Thanks, Janet. I appreciate that.
14 Let's see if we can get my presentation up.
15 CHAIR ROWLAND: I'd like to make one clarifying point before we go on. You mentioned that
16 you thought presumptive eligibility was going to be a help, and then it has turned out to not be. Could you
17 explain that just a little?
18 MS. GRANT: Yeah. What has happened is presumptive eligibility is happening in various
19 settings -- hospitals and clinics and so forth. But the period of time then to actually follow through and get
20 enrolled has actually been kind of lengthened versus, you know, accessing directly eligibility. And so all of
21 that time is ending up in fee-for-service before the process even starts for managed care enrollment.
22 CHAIR ROWLAND: Thank you.
23 * MS. BEHRENS: Good morning and thank you for inviting me to come and share my experience

1 from Texas with you.

2 We're going to start kind of like Janet did, just a little bit about Amerigroup and who we are. We
3 have been in this business for about 17 years and Amerigroup has about 2.7 million members in 13 States.
4 We were one of the very first companies to really start serving the ABD population, aged, blind, and
5 disabled, and doing integrated care between acute and long-term services. And we actually started in Texas
6 with that program back in 1998, and so have extensive experience with a very high-needs population in
7 Medicaid.

8 Many of you have probably heard, but last year, in 2012, Amerigroup was acquired by WellPoint and
9 Amerigroup is now the arm of WellPoint that runs all of the Medicaid business. So with Amerigroup and
10 WellPoint combined, we're serving almost five million members in 20 States.

11 And specifically in Texas, which is where I know the most about because that's where I've spent the
12 last 15 years for Amerigroup, we have approximately 800,000 members. We operate in 230 counties, many
13 of which are very, very rural. I tease some of my West Texas staff that there are more cows in their
14 counties than there are people. So it's very rural in parts of the State, which provides lots of difficulties for
15 service, as you can imagine. A significant network and almost 950 associates in Texas.

16 So, really, what I wanted to focus on today primarily is around the ABD population and the
17 struggles that we see, really, enrolling that population and keeping them enrolled.

18 One of the things that I found interesting -- and the first two bullet points on this slide reference a
19 study that's actually footnoted at the bottom of the slide, if you're interested in reading it -- around the
20 confusion in the consumer population and just what exactly are the benefits that I have. Which programs
21 do I belong to? Do I have Medicaid? Do I have Medicare? Do I have both? And that confusion
22 really permeates itself in the enrollment process and you see decisions being made by consumers that
23 sometimes are not the most educated and not the most well informed.

1 The bullet point about Texas, just to give you some clarity, STAR+PLUS is the ABD population in
2 Texas, so when you see that, it's really the SSI/ABD. Both kids and adults -- kids are voluntary, however.
3 The STAR population is your primarily women and children's program, so TANF-based enrollment.
4 I find this to be fascinating, that of your special needs population in Texas, you have a much smaller
5 percentage of them that actively select a health plan, only about 66 percent of them, compared to pregnant
6 women and children, which is in the 80 percent range. Now, remember, we've been operating
7 STAR+PLUS for many, many years, since 1998, and that number has not significantly moved.
8 So you have a group of individuals, some of which are very active and very engaged, some of whom
9 have very active and very engaged caregivers, that know how to work the system. And then you have a
10 population that it is a confusing process and it is a difficult process. And you add that to the medical
11 issues they have and it can be overwhelming for them.
12 And Janet spoke a lot about this. I'm not going to spend a lot of time on it. But just to kind of
13 reinforce, there are lots of things that happen to the member when they encounter a poorly functioning
14 enrollment system. The thing that concerns us the most is the lack of continuity of care for the consumer.
15 So if you're on this month and you're not on next month, then your case manager doesn't know where you
16 are and what you're doing. If you have long-term support services, those may get stopped. And if you
17 depend on long-term support services to remain independent in the community, that will threaten whether
18 or not you can live independently. And so that impact on the consumer is overwhelming.
19 I'll share a little personal story here because I think it sometimes helps put this in perspective. I
20 have an autism spectrum disorder child. I've been in health care for 15 years. I'm married to an attorney.
21 I can't tell you how overwhelming the system is for us and the things you worry about on a daily basis. Are
22 they going to change the formulary? Am I going to have to get a new doctor? All those sorts of things
23 that you deal with.

1 Now, back that up. If you're poor and you are concerned about keeping your electricity on this
2 month, this issue becomes absolutely critical and you need an advocate. And I think -- and I absolutely
3 believe this -- that managed care companies can be that advocate. We can provide that service
4 coordination that ensures that folks keep their continuity. And I think we can provide some solutions in
5 the enrollment system, as well, and I'll speak about that momentarily.
6 Some things that you might not have thought about. Churn is a big issue for providers. You
7 know, not knowing who's going to be on your panel this month, not knowing what has happened to them,
8 which health plan they're going to be on, or if they're going to be back in fee-for-service. And there's a lot
9 of administrative cost for providers. They file a claim with one health plan, it gets denied. They have to
10 file it with fee-for-service. In the meantime, maybe the member has been retro-re-enrolled, and so they
11 have to refile with the original health plan. So lots of provider impact that we don't even think about
12 sometimes.
13 And then, of course, there's health plan impact, as well, as terms of lapse in coverage, and again, the
14 administrative costs that can be associated with the churn in the system.
15 These are some things that Amerigroup does, and certainly, we don't necessarily have any special
16 secrets on how to do this, but I think that our experience with a population, these are some things that
17 we've tried that we hope help the process.
18 I would say the biggest -- if you leave here with nothing from me, my biggest issue with keeping
19 people enrolled is ensuring that they have education. And again, Janet showed you some great education
20 pieces that health plans as well as States have tried. But it is ongoing education, and it's education not just
21 to the member, but to the members' caregivers, to the members' advocates, and to the members' providers.
22 And when I say providers, not just acute care. Not just the folks we think about. Not just PCPs. But
23 the personal attendant that comes in every day to help the member. Those folks need to know exactly

1 how to ensure that continuity continues.

2 So things we do, we do a lot of that kind of education. We pull in a lot of the family members and

3 the caregivers to ensure that they're involved in the process, that they understand the process.

4 Obviously, culturally competent is very, very important, and a lot of -- in almost every State that

5 Medicaid serves, but in Texas, certainly, we have lots of populations that we have to reach out to in

6 appropriate means.

7 And then we also do a lot of work with our provider community. We ensure that the providers

8 know on a monthly basis, based on their panel, exactly what dates the members' eligibility is going to be due

9 so that they can do the education, so that they can remind members, you're going to get your packet in the

10 mail. Make sure you send it back. So I think a lot can happen on the provider community, as well.

11 Again, as already has been discussed, a lot of outreach with the State, with the enrollment broker.

12 All that outreach is very important.

13 We also do a lot of member surveys to ensure that, at the end of a phone call, the member

14 understands and knows what's going on. We spend a lot of time really talking to everyone in the process,

15 whether it's a call center, to the nurse who's the case manager, ensuring that at each touchpoint in the

16 process the member is informed of, you do realize your eligibility is going to end in June of 2013. Do you

17 know how to ensure you don't have a gap in care? So every person that talks to the member is reinforcing

18 that.

19 Again, and I mentioned this earlier, but it goes well beyond the physician into the community, the

20 faith-based organizations, anyone that is a support for the consumer. In rural communities, we're finding

21 this is very important, that really reaching into the social service network and the faith-based network can

22 give you a lot of extra messaging for the consumer.

23 We've also really started trying to use various communication techniques. Obviously, web-based is

1 pretty common. We've started doing some text programming. We have an app for smart phones for
2 certain populations that they can actually download and utilize. So I think we're going to see more and
3 more of that with various populations as technology becomes more available.
4 And then, obviously, we really -- if we do get a member that comes on, that gets auto-assigned into
5 our health plans, and we learn that they have providers, and LTSS providers, in particular, that are not part
6 of our network, we aggressively work to get those providers in, because that's the way to ensure that they
7 don't have a gap in care.
8 Just some suggestions in terms of things we think help, and some of these already are happening.
9 But passive enrollment. Don't let the gap occur and really integrate it, obviously allowing opt-out as
10 needed to ensure that they can select if they don't like where they get put. But passively enrolling them
11 into the health plans.
12 And I would agree with Janet in terms of balancing that, in terms of the existing plans, and a mixture
13 of auto-assigned and selective is always good for a health plan from an economic standpoint.
14 One-stop makes it easy. With certain populations, I would even say that going to the home to
15 enroll the member may be an option. And this is one of the places I think we may be able to more
16 aggressively use the existing health plan. We send service coordinators into homes all the time in very rural
17 areas. Is there something we can do to facilitate, to ensure that the members' paperwork is being done and
18 they're not dropping off?
19 Obviously, we work a lot with FQHCs, and I heard Janet mention FQHCs, as well. A lot of
20 FQHCs, especially the more progressive FQHCs, have call centers. They're set up to outreach to
21 members. So I think aggressively using those, as well, may be helpful in ensuring continuity.
22 In Texas, you have 15 days to pick your health plan. I'm not convinced that that is long enough.
23 And so we do get a lot of auto-assignments that occur because of the 15 days. We went to 15 days in

1 Texas for the pregnant women, which makes sense. You want to get them into care as quickly as possible.
2 And we've extended it. So there may be some populations that it's appropriate for. Others, maybe it
3 needs to be a little bit longer.
4 We do support walk-in periods. Right now in Texas, each month, you can change health plans if
5 you want to.
6 And then, and I mentioned education earlier, but when you are implementing particularly an ABD
7 population for the first time, it is critical that you do the education well in advance. We started in Texas
8 probably six months in advance with education. I don't think that was long enough. I would say a year
9 to 18 months to help people understand what's coming, what to expect, what it's going to look like, where
10 you can go for assistance. And so I think an extended implementation period with education is helpful as
11 you're rolling out programs for the most needy of our consumers.
12 At the end of the day, this is all about the consumer and how do we ensure that they get the best
13 care, the right care, the right time, right place. Thank you.
14 CHAIR ROWLAND: Thank you.
15 I'll start with Robin, Mark, Sara.
16 COMMISSIONER SMITH: Well, I wish we could clone you and put you all over the country and
17 every plan would be as magnanimous as you are.
18 My fear, of course, is that there are going to be States who are going to allow plans that the
19 consumer is not the bottom line, and especially for the disabled population, the medically fragile population.
20 I have heard anecdotally in my State that they actually were not even notifying parents that they were being
21 passively enrolled. Therefore, they'd go to the doctor and find out, well, you're not with us anymore.
22 And I heard that through Family Connections, which is an agency. They sent out a mass e-mail. So I
23 don't think it was just one parent talking to the other. I think it was actually happening and the State said

1 they would try to do better.

2 So it just scares me that people are going to be stuck. I'm like a broken record. People are going

3 to be stuck with a provider they're not comfortable with, maybe who's just good enough.

4 I had a situation where my son, who's also on the autism spectrum, developmentally disabled,

5 medically fragile, a lot of issues, and top in their fields doctors, but what they were doing for him was not

6 appropriate and we had to change. It was hard, because we had to change within that practice. And

7 things did change. It changed his life. I mean, it wasn't just, we don't like his bedside manner. It was

8 actually -- my son was being lasered every three months and then had to go in the ICU overnight and scar

9 tissue would come back. So we finally changed to a doctor within the practice who never lasered him

10 again, did an airway reconstruction, and now every once in a while he gets a little balloon, but, you know,

11 since then, he's fine. I know we would have been back on a trach had that change not happened.

12 So I just want to make sure that there's a safety component across the board for everybody that they

13 can change if they feel that there's somebody out there that's more appropriate for their child, even if it's not

14 within the MCO. So that's my biggest concern.

15 The other you touched on is how hard it is for some people to understand what is going on, and I

16 don't think that they always know that they have options. Again, anecdotally in our State, apparently,

17 people didn't know, and these are very educated people, too, a lot of the time. I think they think there's no

18 hope. They do care who they see. It's not just that they want the bill paid. They care who they see.

19 They complain. They complain to each other. But they don't think that complaining to anybody else is

20 going to do any good, so they just sit in the system as is. They have no hope of changing or that anything

21 can be changed. I just think it's so hard for me to see that when I know that a change could make a big

22 difference in somebody's life. So that's my biggest fear.

23 I really appreciate what you're doing for your programs and I do hope that you can be a shining light

1 out there for all States. I think a lot of States, it's going to be the bottom line and not the consumer, and
2 that's my biggest fear. Thank you.
3 CHAIR ROWLAND: Mark.
4 COMMISSIONER HOYT: I had some kind of interconnected questions about the risk profile of
5 auto-assigners versus the choosers. I thought I heard Janet say that it hurt the plan when the valve was
6 shut off on auto-assigns, but LeAnn sort of made a comment that you wish the enrollment period was
7 longer because you're getting too many auto-assigns.
8 So I'd be interested in hearing each of your views on how you see the risk profile of people who
9 choose versus the ones who are auto-assigned, and then if you can unpack this, it seems like the churning
10 question is embedded in there, too. Does all the churning come from the ones who are auto-assigned?
11 And then the last question, and I'll stop. I think Janet gave us churning for her plan, but I didn't
12 hear a percent for Texas, so I --
13 MS. BEHRENS: It's very similar.
14 COMMISSIONER HOYT: Like two percent a month?
15 MS. BEHRENS: Yeah. It's very, very high on a monthly --
16 COMMISSIONER HOYT: Is that for a disabled population?
17 MS. BEHRENS: Uh-huh. And actually, across the board.
18 MS. GRANT: A little less in terms of the -- or a little less with the ABD population than it is for
19 TANF and CHIP, but still significant numbers.
20 MS. BEHRENS: Right. Do you want to start?
21 MS. GRANT: Yeah, I can start. You know, pretty clearly, and certainly we turned out to be a
22 case study on that, that voluntary selection is a higher-risk profile. Those are consumers that are making
23 active selections because they're probably using health care services. It's very important to them to make

1 sure that they have the network providers, et cetera.

2 So from our perspective, we're very proud of the high voluntary selection rate that we do have as a

3 plan and we encourage that, but there does need to be a balance because of the financial implications of

4 that.

5 COMMISSIONER HOYT: I meant to ask that, if I didn't. So what percent for both of you

6 choose the plan and then what percent are auto-assigned?

7 MS. GRANT: Umm --

8 MS. BEHRENS: Well, I gave you those on a slide. About 66 percent of ABD actually select, and

9 around 80 percent of the TANF population makes an active selection.

10 MS. GRANT: Yeah, and that is high. In the State of Ohio, I would say it's closer to 50, between

11 50 and 60 percent, maybe. Again, I think it's higher for the disabled population than it is for TANF and

12 CHIP.

13 MS. BEHRENS: And in terms of the comment I made about extending the selection time period,

14 I think it was a little different than what Janet was talking about. That's really to ensure that the consumer

15 does make the choice, that they're not forced into an auto-assignment situation. So I think a little different

16 than what she was referring to, because there is a difference in the risk selection between someone that

17 picks and someone who's auto-assigned. I think we consistently see that.

18 CHAIR ROWLAND: You can, Robin.

19 COMMISSIONER SMITH: Is there any follow-up, you know, once somebody's enrolled, and I

20 assume that they get the information as they're enrolling about the options, is there any follow-up if they

21 haven't picked?

22 MS. GRANT: In most States, there's usually a series of contacts with consumers. One thing in

23 the State of Ohio which actually may kind of skew the numbers is that on, I think it's the second of three

1 letters, they're told which plan they're going to be auto-assigned into if they don't select. So if that really is
2 the plan that they prefer, they can do nothing.
3 Now, what happens is we don't have the benefit of that contact with the enrollment broker and so
4 some of that initial health information, et cetera. And so, again, I think it's beneficial to have practices in
5 place that really encourage that selection.
6 COMMISSIONER SMITH: As a follow-up, so is it basically letters that is the contact?
7 MS. GRANT: That's been historically true. The State is looking right now at a variety of
8 methods to have more personal touch for the disabled children that are now being enrolled and definitely
9 with the dual on demonstration.
10 MS. BEHRENS: And I would agree. I think you're seeing a movement towards a more personal
11 touch. Letters have historically been the way. They send the letter. If you don't respond, you get
12 auto-assigned. We're seeing a lot more phone calls, a lot more outreach, a lot more community events
13 where people can be face-to-face with an enrollment broker. All of those absolutely help the process and
14 ensure that you get some uptick in the numbers.
15 COMMISSIONER SMITH: What's driving that, because I know that often for States, they like to
16 be able to put someone into what would be their choice. So what would be driving the push for a more
17 personal touch? Is it the consumers or the States or --
18 MS. GRANT: No. I mean, I have to say, my experience is very different. I'm sorry to hear
19 about your experience.
20 COMMISSIONER SMITH: It wasn't mine.
21 MS. GRANT: The four States that we've operated in, all of those States have been very committed
22 to consumer choice and really, you know, facilitating that process. Certainly, there's administrative
23 challenges to be able -- and cost challenges to be able to do as much personal touch as they would like.

1 But they have built in lots of checks and balances so that if a selection is made and there's an issue, that
2 there's options to be able to make other selections.
3 MS. BEHRENS: But there's also some costs to the State from churn.
4 MS. GRANT: Absolutely.
5 COMMISSIONER SMITH: Sure.
6 MS. BEHRENS: Yeah. If you have a member that gets auto-assigned into one and then they
7 decide they want another, I mean, all of the paper, all of the integration that has to happen between those,
8 the State or their enrollment broker are going to have to handle that. And so there is cost to the State to
9 churn. I didn't mention that, but, obviously, there is, so --
10 COMMISSIONER SMITH: And, by the way, I didn't say this up front, but I was a foster parent
11 for 17 years and that's why we had medically fragile children and children with disabilities who use foster
12 care and adopted some, so I really appreciated hearing about that in your programs. Thank you.
13 CHAIR ROWLAND: Okay. So now I have Sara, Richard, Patty, and Norma.
14 COMMISSIONER ROSENBAUM: A couple of quick questions. Should we at MACPAC be
15 thinking about this issue -- I couldn't tell really from your remarks -- as a more mature versus less mature
16 market? I mean, for example, in Medicaid markets where a new kind of managed care -- managed care is
17 extended to a new population or new kind, I assume you get a lot more auto-assignment because the
18 voluntary enrollment system is just not mature yet. But I would be interested in knowing whether, in fact,
19 in highly mature markets, you still see, for example, a 50-50 split. Number one.
20 Number two, I wonder if there's anything to suggest that at least with the low-income population, so
21 not the population of adults or children with special needs, but the low-income populations, whether there's
22 any evidence from CAHPS or any other quality measurement that people who are auto-assigned versus
23 those in select report different experiences with their plans. Number two.

1 And number three, I've always been struck by why -- and I don't know the answer -- why States
2 divide the Medicaid eligibility determination from the plan selection. Why don't you just as part of the
3 eligibility determination process either select your plan or be told, if you don't select, we'll select a plan for
4 you, so that the gap goes --
5 MS. GRANT: Away.
6 COMMISSIONER ROSENBAUM: -- away much faster. I mean, that's how it works in an
7 employer plan. You're an eligible person. They have you sign up for your plan. And even in the new
8 exchange, I mean, you're going to make your plan selection and your subsidy application simultaneously.
9 So what's the thinking here about separating the two?
10 MS. GRANT: Well, I'll start with that first. I think the challenge there is how eligibility happens
11 and the expertise of the person that's there in terms of really being able to help educate a consumer about
12 those choices. And it's varied across the States we've operated in. Some States, the county-based
13 eligibility workers aren't even State employees and so there's challenges even educating them on basic
14 eligibility kind of practices, much less kind of the more complicated piece in terms of enrollment. So I
15 think that's been the divide.
16 Are there ways to try and bridge that, I think would be certainly something to look at in the future.
17 COMMISSIONER ROSENBAUM: Let me just note for the MACPAC staff that I think one
18 thing we want to look at is the streamlining provisions in the Affordable Care Act. I can't think sitting
19 here whether there's anything in the streamlining provisions that addresses this issue of the bifurcation of
20 eligibility and plan enrollment, but we ought to take a look at that.
21 MS. BEHRENS: Yeah. I would just add, I think that you could do it. I don't see why you
22 couldn't. No, absolutely. And I think that you might get some efficiencies in the system by doing that.
23 Absolutely.

1 MS. GRANT: To your other question, I have not seen data. It would be interesting to look at
2 our data. We've looked at it because of the adverse selection issue in terms of kind of medical costs and
3 experience, but we haven't looked at it in terms of other kinds of satisfaction piece. And I agree. I think
4 there are different practices. Certainly, States are at different places overall in terms of their maturity
5 around Medicaid managed care and then certainly as they bring in more complex populations.
6 MS. BEHRENS: Yeah, and I think the fact that MACPAC is looking at this is a first step. I
7 mean, a lot of times, people don't want to get into the operational details of how do people get into health
8 plans. I think this is a huge first step, that you're addressing it, that you're looking at it. And the idea of
9 having recommendations for brand new plans versus really experienced plans that maybe can do it a little bit
10 better, I think that's a perfect idea. And I don't think I've ever seen quality metrics around it, but I'm
11 curious, so I'll go back and look and see if I find anything.
12 CHAIR ROWLAND: Richard.
13 COMMISSIONER CHAMBERS: Good morning, both of you. Thank you for being here today,
14 and listening to your presentations, I thought as if I was in your seat I could say all of the same things from
15 the experience from fellow plans in both Texas and Ohio.
16 One of my frustrations has always been, as you both talked about the education materials, and
17 particularly when states impose mandates on reviews of language and what needs to be in there. Any
18 suggestions as to what the Commission can do as advice or recommendations to states as to how that could
19 be improved? Because oftentimes, again, my experience as what I hear from community-based
20 organizations and advocacy organizations is that either potential or current members are flooded with
21 mailings, with language they can't understand, that is in the wrong language, that is of the wrong reading
22 level. Just curious as to what we as a Commission can do in recommendations as to help improve that
23 process and what would really improve it. So I'm curious to hear your observations.

1 MS. GRANT: I guess the first comment I would make, Richard, is back to one of the comments
2 made in terms of having stakeholder involvement. You know, the State of Kentucky, as they rolled out
3 this latest region here starting in January, made a real conscious effort to have all the materials actually prior
4 to use reviewed by a large coalition of advocates, and I think that helped. They were much more kind of
5 normal, you know, consumer-friendly kind of language.
6 The State of Ohio has that packet of three series of letters that go out, and Legal Aid has been the
7 primary reviewer of that. It's very legalistic, and you get that, and it's not a very consumer-friendly kind of
8 -- so in terms of the state pieces, I think, again, the stakeholder review, appropriate stakeholder review and
9 input would be helpful.
10 MS. BEHRENS: And I think that's exactly right on target. You operate in Texas, so you know
11 the review process for materials is exhausting from a health plan perspective. They go through a number
12 of layers of review before they actually ever get published.
13 I think sometimes, though, the state doesn't do the same to their materials, and so maybe saying --
14 you know, along that line, can we suggest gently that there are ways to review the materials, again, with
15 stakeholders, with the consumers? Does this make sense to you? Is this something that you would
16 utilize? So some of that same process might be helpful.
17 MS. GRANT: The other thing I would add is some states have streamlined more what the plans
18 are required to communicate right out of the gate, so that, again, it can be more meaningful for a consumer
19 and given options like having -- instead of a big provider directory that arrives, you know, that it could be
20 on a desk or it could be online or available on request. You know, some options like that I think are
21 helpful, too.
22 COMMISSIONER GABOW: Thank you both. That was interesting. My question relates to
23 the fact that Americans love choice, above quality often, and we know that there's a bell-shaped curve of

1 quality and value in American health care. I mean, this isn't Lake Wobegon, you know, where everybody is
2 above average.
3 So what do you think should be the line, the balance between somehow directing patients to
4 high-quality providers -- that's not their opinion, not the providers' opinion that they're high quality, but
5 data-driven level of being a high-quality provider versus the ability to choose a low-quality provider? Is
6 there some balance in this? How can we get to that without making people feel that they're being
7 oppressed or driven into the place they don't want to go? But somehow we have to think about value and
8 quality in this equation.
9 MS. GRANT: Well, that is the million-dollar question for the future, probably. You know, today
10 the way that we've always historically operated is to really try and ensure both choice, continuity of care,
11 wide access, but, you know, those are the things that we're grappling with as a plan. I'm sure all plans are,
12 and states are. We're having that conversation right now in several states around things like, you know,
13 payment reform kinds of conversations and how do you maybe have a more narrow, higher-quality network
14 or how do you incent consumers to, you know, select those providers that you know are higher quality.
15 I don't think there's any answers yet, but that's definitely, I think, the conversation in the years to
16 come.
17 MS. BEHRENS: And I would just add, I think from a health plan perspective we are really starting
18 to look at our networks a little differently. Generally, when you start a health plan, it's kind of all willing
19 providers; if you'll take Medicaid, we'll have you in our panel. And that may not be the best solution to
20 building high-quality networks. And so we're really looking at payment structures that reward quality
21 incentives.
22 And so I think you will see health plans being more selective in the future around who they are
23 doing business with and the expectations of what those providers can bring.

1 CHAIR ROWLAND: Norma is next.

2 COMMISSIONER MARTINEZ ROGERS: Thank you --

3 CHAIR ROWLAND: Norma's from Texas.

4 COMMISSIONER MARTINEZ ROGERS: Pardon me?

5 CHAIR ROWLAND: I said you're from Texas.

6 COMMISSIONER MARTINEZ ROGERS: Yeah, I am from Texas. And, actually, I was going
7 to add, I mean, Richard almost asked the same question I was going to ask, but I'm going to add to his
8 question, and that is, I know that you talked about the rural area in Texas and going to the rural areas, and
9 West Texas is very different from South Texas. And in terms of education, I'm wondering how you do
10 that educational material.

11 The other is that 50 percent of the Latinos in Texas drop out of school. Reading levels, if they
12 read, are probably second-grade level. And we have a high illiteracy rate, people that can't read or write.

13 So what do you do with that population? And I'm not sure about whether or not Ohio has to deal
14 with that issue, but I'm sure you do because I know that there's a Latino --

15 MS. GRANT: Different, right. Different populations.

16 COMMISSIONER MARTINEZ ROGERS: Yeah. But I'm wondering how you deal with it in
17 Texas.

18 MS. BEHRENS: A lot of that has to do with people that we hire. We are very selective and hire
19 folks that live in the communities that they're going to be serving. We work very diligently to do that.
20 We work a lot with the Promotora program in Texas, which you're familiar with, and those are individuals
21 that are actually certified through the State of Texas to work with specific populations, and they will go into
22 homes and into communities to ensure that the language barrier is overcome, the education issues are
23 addressed, the reading levels. A lot of one-on-one communication happens to ensure that individuals

1 know and have the choice that we want them to have.

2 So I think we've done a good job, and you're absolutely right, depending on which rural area you're
3 operating in in Texas, it's very different. And you can go 100 miles, and it will be different. So we've
4 addressed that primarily through staffing and the way we staff.

5 MS. GRANT: I would just add, obviously each state has various diversity kinds of challenges. In
6 a State like Ohio, we have a huge Somali population, we have a huge Russian population. So I would
7 concur with LeAnn in terms of -- certainly strategies in terms of materials and, you know, translation and
8 those kinds of things up front. But we've employed a patient navigation model where for our
9 community-based care management we're using lay folks from those communities to really augment what
10 the professional case managers are doing so that we can help bridge those gaps.

11 COMMISSIONER MARTINEZ ROGERS: So I am going to add to this something that Richard
12 asked in terms of educational material. What do you see the role of MACPAC with that, or do you, in
13 terms of recommendations or in terms of what it is that you think we should be looking at?

14 MS. BEHRENS: Well, I certainly think that -- again, I will reiterate, I think just having the
15 conversation and putting it on the table is the first step, but recommendations coming out of MACPAC that
16 really encourage cultural dynamics be addressed and that materials be at certain educational levels and
17 certain stakeholder involvement, some of the things that we've discussed, I think can certainly be good
18 recommendations to states and to MCOs who are new to the business as well.

19 So I think some of the issues we've talked about today, if those could be recommendations, would
20 be powerful.

21 COMMISSIONER HOYT: I'd be curious to know whether either or both of your plans are at risk
22 for the provision of behavioral health benefits, and if not, behavioral health drugs or all the drugs for the
23 disabled population, and just any observations you'd have in general about issues around the disabled

1 population getting, you know, appropriately connected with behavioral health providers.

2 MS. BEHRENS: Go ahead.

3 MS. GRANT: Well, I was going to say, every state is a little different about kind of what's carved
4 in and carved out. And we're having an interesting conversation in Ohio right now because right now
5 today the only thing that's carved out is what happens actually in a community mental health center. So we
6 are at risk for the behavioral health drugs, we're at risk for the hospitalizations, et cetera. And so we're
7 working very diligently to continue to improve the relationships that we have with community mental health
8 centers so there can be really good coordination. But we are believers in an integrated benefit so that that
9 can really take it to a next level.

10 In the dual demonstration that's going to happen in Ohio, behavioral health is going to be carved in
11 completely. So we'll be able to have direct contractual relationships with our community mental health
12 centers. So we believe that that will provide for more integrated care.

13 MS. BEHRENS: And in Texas we are at risk as well. Amerigroup has taken an approach that a
14 lot of managed care companies have not. We actually manage both our medical and our behavioral health
15 so we have teams that do both internally. We think that is an advantage and that you can really case
16 manage it appropriately across the two groups -- the medical and the behavioral health -- a more holistic
17 view of the consumer, and be more of assistance to them in that manner. So that's the model we have put
18 into place, and I think we've been successful with doing that, because it's certainly a difficult challenge,
19 ensuring that all the needs are being met across the spectrum.

20 CHAIR ROWLAND: Okay. I have Denise, Andy, Donna, and Burt, and then we're going to
21 wrap this up.

22 COMMISSIONER HENNING: One thing that I just would like plans in general to be cognizant
23 of is the geographic sensitivity when you auto-assign or even -- well, actually, if you selectively choose,

1 hopefully they know who's close to them. But the auto-assigned people that I get are driving 45 miles to
2 me when there's a provider across the street from them. And, you know, although I love to see them, it
3 just doesn't make any kind of sense to me.
4 And then the other issue that I have with the PEPW for pregnant women would be -- the way it
5 works at my health center, anyway, we have a Medicaid worker on site, and I am totally thankful for that.
6 The pregnant woman that comes in for her new maternity visit sees them first. She's automatically
7 assigned to Medicaid or whatever health plan she picks then, before I even see her.
8 PARTICIPANT: That's great.
9 COMMISSIONER HENNING: However, my PEPW ladies, which is about 50 percent of my
10 population that are undocumented immigrants, that are never going to have Medicaid, get PEPW coverage.
11 So those ladies are covered for two calendar months, so I don't see them until April 1st. I don't see them
12 March 31st. I see them April 1st so that they get the full benefit of the entire two calendar months during
13 the hopefully early part of their pregnancy.
14 However, if you actually speeded up that process, like you're talking about, you'd kick those ladies
15 off of the program.
16 MS. GRANT: Oh, interesting.
17 COMMISSIONER HENNING: So I just don't want any unintended consequences to come out
18 of speeding up PEPW, because for the ladies that I serve, PEPW is a lifeline to them.
19 MS. BEHRENS: I think pregnant women are maybe a category unto themselves because of the
20 timing and when you want things to happen. Texas took an interesting approach several years ago that
21 some of you may be aware of. They actually developed a CHIP perinate program for the undocumented,
22 and they have rolled folks into the CHIP program under the assumption that the unborn child is going to be
23 a citizen. And I think that's worked fairly well. You get longer coverage. Unfortunately, the types of

1 services that can be covered are slimmer, the benefits are much slimmer than under a Medicaid program.
2 But there are some things like that that can be considered for pregnant women, but I do think pregnant
3 women have to be considered differently because of the timing.
4 In terms of the auto-assigned, we mess up sometimes, I will tell you. Our systems do have logic
5 built into them. Generally, the first that our system -- and I'm sure yours is the same --
6 PARTICIPANT: Geography.
7 MS. BEHRENS: Well, ours is history. So if you have a PCP that we have claims that we've paid
8 on, that's where you're first going to be assigned to. And then geography is the second. But as I said,
9 they're systems and they do mess up from time to time. But I absolutely agree there needs to be some kind
10 of algorithm that assigns the provider to the member.
11 CHAIR ROWLAND: Donna and then Burn, and we really do need to wrap up.
12 COMMISSIONER CHECKETT: I'll pass.
13 COMMISSIONER EDELSTEIN: You mentioned holistic services, and you also mentioned
14 categories to themselves, which brings us to how your plans handle dental coverage, especially given that the
15 states you've mentioned have such a variety of adult coverage. So I'm curious about how the plans handle
16 the dental coverage, but more importantly, how does it play into plan selection and enrollment? Given the
17 high needs of the population, does it translate into people looking for some dental benefit within -- when
18 they compare plans?
19 MS. BEHRENS: I would say absolutely. Texas carves out dental, as you know. For most of
20 the population it's carved out to dental MCOs. But virtually every health plan that offers a STAR+PLUS
21 or an ABD population plan offers a value-added benefit around dental, because it is critical and they do
22 absolutely look for that and we do believe it is a primary driver of their selection process, because it is
23 important. So, yes, we do see that significantly.

1 MS. GRANT: Yeah, and I would concur. We have dental carved in, I think in all of our states
2 now, but, you know, dental coverage in particular for adults has been kind of this in-out, in-out, you know,
3 every legislative session. So we have as a plan, because of recognizing the importance both from a care
4 perspective and from a consumer selection standpoint, have usually maintained the benefit or enhanced the
5 benefit. Right now, for instance, for adults in Ohio, I think it is one preventive visit a year. We offer a
6 second preventive visit per year.
7 And we did do some consumer focus groups this last year and were actually quite surprised that the
8 number one selection criteria was dental.
9 CHAIR ROWLAND: Well, I want to thank you very much. Obviously, this is an issue that the
10 Commission is very interested in, and I don't think you've heard the last from us. Hopefully we'll continue
11 to be able to learn more from you and from others about how these practices are working, where the
12 glitches are, and where some of the especially education materials we might be helpful in, in kind of
13 identifying how to do that better. So thank you for coming to join us today, and we will continue to follow
14 your progress, and hopefully you'll follow ours. Thank you.
15 MS. GRANT: Thank you.
16 MS. BEHRENS: Thank you.
17 CHAIR ROWLAND: And now I'm going to ask Ellen O'Brien to come join us to review where
18 we are with our work on care coordination for the people who are dually eligible for Medicare and Medicaid,
19 some of whom have been in these plans, but others are being anticipated for these plans. Ellen? And
20 we're now at Tab 9.

21 **### CARE COORDINATION FOR PEOPLE DUALLY ELIGIBLE FOR MEDICARE AND**
22 **MEDICAID**

23 * DR. O'BRIEN: Thanks very much. This is an update on duals.

1 In our recent March report to the Congress, you'll recall that we provided information to the
2 Congress on the dual-eligible population and reported in that chapter a profile of dual eligibles focusing on
3 their Medicare and Medicaid service use and spending. And we identified, began to identify some different
4 subgroups for analysis, including the roughly 40 percent of all-year, full-benefit dual eligibles who rely on
5 Medicaid for long-term services and supports. We have also shown that a substantial share of full-benefit
6 dual eligibles, about 60 percent, do not use any long-term services and supports in Medicaid. They are
7 eligible for the full range of Medicaid-covered benefits but rely on Medicaid primarily for financial assistance
8 with Medicare as cost sharing. Our analysis showed that only a relatively small share of these full-benefit
9 duals use any Medicaid wrap-around services, such as dental, vision, or transportation services.
10 In that work, in the draft versions of those chapters, we listed some of the initiatives that have been
11 tried in managed care, in fee-for-service, in provider-based programs like PACE and fee-for-service, care
12 management, end-disease management. But I think we heard you say that we should take the next step
13 and do more than enumerate a list of programs and interventions, and specifically you asked what we know
14 about what works for duals to improve quality and lower cost.
15 That, of course, is a much harder question to answer than just giving you a nice descriptive list of
16 the programs, but we've taken a first pass at it in the discussion paper you have in your binder.
17 So just to reiterate why it's so difficult, you know, we began to identify these subgroups, but really
18 there are distinct challenges that likely arise for these very diverse subgroups of duals, including frail older
19 adults who live in the community and need long-term services and supports, people with serious mental
20 health disabilities who need extensive community mental health services and supportive services, and who
21 may have other medical needs such as heart disease and diabetes; people with intellectual disabilities who
22 have substantial needs for supportive services, habilitative services and employment services; non-elderly
23 adults who have physically disabling conditions resulting from disease or injury who need specialized

1 equipment, specialty care, and supportive services; and people who have multiple or serious chronic
2 illnesses. And as you're aware, in our work on the data, we are continuing to profile these kinds of needs
3 and distinction subpopulations.
4 In the background paper, however, in an attempt to give you a very high level lay of the land on the
5 kind of studies that are out there, the evaluations that focus on outcomes, we focus on -- we set out to
6 review reliable studies of strategies designed to improve quality and lower costs, and we were looking to
7 reflect a range of approaches, as I said, fee-for-service and managed care, those targeted to particular
8 subgroups, to give you that high level lay of the land.
9 And so what you see is very preliminary kind of selective focusing on some of the newest studies, in
10 fact, some that have been released in a preliminary form but aren't yet finalized. And so we can certainly
11 deepen this and expand it and look at other kinds of models. But in this paper, you see strategies evaluated
12 that are specialized Medicare managed care models, the D-SNPs and the I-SNPs that enroll duals. Then
13 we reviewed some that focused just on the Medicare side for duals, looking at Medicare high-cost care
14 coordination models. We looked at a few Medicaid LTSS model of those that focused just on the
15 Medicaid side. And we also focused on the integrated models that are out there that integrate Medicare
16 and Medicaid funding streams and services, both health plan-based models such as the fully integrated
17 dual-eligible SNPs and the provider-based models such as PACE.
18 When we looked at these -- these are studies, rigorous evaluation studies that look at models that
19 were designed to improve quality and cost for duals. And so they were designed to achieve these
20 outcomes, and these are the kinds of outcomes that are then evaluated in the studies. They tend to focus
21 on a relatively narrow but important set of outcomes, including emergency department use. Do we see
22 that in these coordinated or integrated models that duals used the emergency department less? Do we see
23 fewer potentially avoidable hospitalizations for pneumonia and other kinds of conditions that should be

1 manageable in the community? Do we see a reduction in the long-term use of nursing home stay, delayed
2 entry to nursing home with better community-based long-term services and supports? Do we see lower
3 mortality rates for people who are in these models? And do we see lower costs, lower expenditures -- I
4 mean lower costs due to lower use of services and program expenditures, but also net costs, lower costs
5 after accounting for the increased costs of the intervention, adding the care management services, for
6 example?

7 And perhaps we were sort of led in the direction of focusing on studies that -- looking at studies that
8 focus on acute-care savings, and we can come back and look at those. But most of the studies we
9 reviewed focused on opportunities to reduce acute-care savings.

10 So this is our very preliminary table, and I should give lots of caveats about what's in here, but you
11 will see down the left-hand side the names of the models that we reviewed and across the top the process or
12 outcomes measures that were evaluated and the cost measures.

13 The studies, obviously very long, a number of dimensions, including the design of the model. I
14 don't really have time today to go through all the descriptive work on what the models were and what they
15 entail, but we can go back and do more of that more slowly for you, if you'd like.

16 They vary in terms of the population targeted for enrollment. In D-SNPs, a broad cross-section of
17 duals may be enrolled. In I-SNPs, they target people residing in nursing homes. The fully integrated
18 D-SNPs may vary, with some enrolling elderly duals and others enrolling a broad cross-section of the
19 dual-eligible population. So we're covering lots of territory here.

20 The research designs also vary. As I said, they adopt a rigorous evaluation approach. Most of the
21 studies reviewed here are based on a matched comparison approach, for example. The outcomes for
22 people enrolled in the model are compared to outcomes for people with similar characteristics who are not
23 enrolled in the model. There's lots of discussion about how good those kinds of comparison studies are,

1 but the ones we picked here we think use the best methodologies, including a number of those that are, as I
2 said, recently funded by the U.S. Department of Health and Human Services and will be released later this
3 summer.
4 The Medicare care management demonstrations that are listed here in particular, these used
5 randomized controlled studies and produce good results.
6 The time period over which the effects of the intervention also vary, and those are not listed here
7 for you, but they're in the paper. That could affect the results. For example, outcomes, including
8 hospitalization rates, nursing home admission rates, and mortality rates. For people newly enrolled in
9 PACE during a five-year time period in a recent were compared to people with similar sets of characteristics
10 in terms of age, sex, health conditions, their enrollment in waiver programs, the PACE enrollees were
11 compared to this matched sample of non-enrollees to arrive at the results.
12 So some of these rows here reflect individual studies. Some of them reflect our kind of synthesis
13 of the available studies, but all that, again, is laid out in the paper.
14 In the table, a blank cell means that the outcome was not evaluated in the study. A cell with an
15 arrow or dash or text indicates that the outcome was evaluated and tells you what our assessment of the
16 result was. So some judgments need to be made, and synthesizing the findings of such a diverse set of
17 interventions, and as I said, this is simplified here to give you highlights. So let's just talk about this.
18 The results on D-SNPs, I-SNPs, FIDE-SNPs mostly come from MedPAC, and MedPAC, in
19 looking at these models, talks about the difficulties of comparing the findings in managed care to
20 fee-for-service, and a number of these comparisons are of the specialized plans for duals to other Medicare
21 Advantage plans. So on the D-SNPs they find mixed findings about whether D-SNPs improve quality as
22 measured in terms of the HEDIS and CAHPS scores compared to other managed care Medicare Advantage
23 plans, and they find that the costs in those plans tend to be higher.

1 I-SNPs, they find that the I-SNPs actually do significantly better than other SNP plans, than
2 D-SNPs. They find the FIDE-SNPS, the fully integrated SNPs, do better on quality measures. But
3 across all of these kinds of models, they find that Medicare costs are higher.
4 The life masters program was as program targeted to dual eligibles in the State of Florida, to dual
5 eligibles who had received care in the past year for a chronic condition, such as coronary artery disease,
6 heart failure, diabetes. These were duals who did not use long-term services and supports, and they were --
7 the intervention was care management intervention. People at high risk were given a nurse case manager.
8 People at lower risk had telephonic case management. And this was a carefully evaluated study, a federally
9 funded evaluation that found no impact on hospital admissions for these duals and higher costs because of
10 the -- you know, no reduction in the Medicare service use and higher costs of implementing the care
11 management intervention.
12 This row on Medicare care coordination really is a synthesis. There are a number of studies, 15
13 randomized controlled studies of Medicare care coordination demonstrations, which, you know, depending
14 on the model, find decreased hospitalization or no effect on hospitalization, but tend to find higher
15 Medicare costs.
16 The New York City Independence Care System is an example of a program that enrolls a substantial
17 number of duals, but also enrolls Medicaid-only persons with disabilities. This is a model targeted to
18 people who need long-term services and supports, who have physical disabilities, so physically disabled
19 adults in the community, many of whom rely on wheelchairs, who need supportive services.
20 This row here reflects the result of a study that's due to be released this summer from Mathematic
21 Policy Research. It was funded by the U.S. Department of Health and Human Services. It's a very
22 careful study that looks at outcomes over a five-year period during which people were enrolled in this
23 program, and found, however, that hospital admissions went up for this group, that ER visits went up,

1 especially in the early years of the program. Nursing home admissions, however, did go down. Mortality
2 rates weren't really affected, and Medicaid costs were higher.
3 The Arizona SNP model here, this is, again, a study from Mathematica due to be released this
4 summer that looks at seven different aligned SNP plans in the State of Arizona, those that were not fully
5 integrated perhaps into a single plan but where the Medicare and Medicaid services were provided by the
6 same plan, and found different results across the plans, with three plans having no effect on hospital
7 admissions, two plans achieving reductions, and two plans actually experiencing increased --
8 CHAIR ROWLAND: Ellen, actually since the studies are reviewed in your graph, why don't we
9 move more to what we're taking away from this review than going through them one by one.
10 DR. O'BRIEN: Okay. Sure.
11 So in terms of what to take away, we suggest that you do see improvements in quality across a
12 number of these models. Many of the models achieved reductions in potentially avoidable
13 hospitalizations. But there's less evidence of improvement on other quality indicators.
14 We also look at it and take away that these metrics tend to focus on the acute-care side. There's a
15 lot more we'd like to know about what's going on in these models, on the outcomes for duals in terms of
16 their supportive services, for example.
17 There's mixed evidence on net savings from care coordination with the costs of care coordination
18 often exceeding the savings from changes in service use and expenditures.
19 Again, the existing evidence points to the potential for acute-care savings, and we found less
20 evidence of savings from reduced use and spending in long-term services and supports.
21 The quality of the evidence does vary. Some of these studies look at longer time periods. Some
22 of them are based on randomized controlled, but -- and, of course, there are lots of gaps to fill in terms of
23 understanding what works for duals.

1 We also thought about what these findings might mean for policy and program design and just point
2 in a few directions that you may or may not want to go in. The evidence of a potential for acute-care
3 savings suggests that shared savings approaches may make sense, but there is, of course, these studies
4 suggest substantial uncertainty surrounding those savings, and that uncertainty would need to be a factor in
5 program design.
6 Targeting, we think in looking at these models that there may be a need to design a range of
7 alternative approaches that focus on specific subgroups of duals, and that with these kinds of tailoring and
8 targeting there may be greater potential to achieve savings.
9 We also think that efforts to evaluate existing programs are hampered by a lack of standardized data
10 that would allow ready comparisons across programs so we could look at performance measurement and
11 monitoring.
12 Here are some options for future work that we're thinking about, looking more closely in terms of a
13 qualitative project at care management and care coordination approaches, especially those tailored to people
14 using long-term services and supports in Medicaid. There's this thinking that duals need more care
15 coordination, but we think there's a lot of care coordination going on out in the world in HCBS programs,
16 in HCBS waiver programs, and for people with mental health disabilities, and we'd like to know more about
17 the features of those programs.
18 We think in terms of the metrics that are used to assess these programs that there may be a gap in
19 terms of HCBS quality. We have measures of the clinical quality of medical care that's provided. We
20 have not so great measures or maybe no measures of HCBS quality. And we also think it might be useful
21 to take a look at some of the integration experiments that haven't worked to see what design features might
22 have caused them to go awry.
23 CHAIR ROWLAND: Okay. Comments?

1 COMMISSIONER MOORE: It seems to me this is one of those areas which is frustrating
2 because it's so complex and there are so many different options of which way we could or should go. And,
3 in fact, we've already kind of focused in on duals, which is a subset of the larger group of people receiving
4 LTSS. So it's kind of a subjective exercise in some sense, but I would just like to weigh in on a positive
5 vote for looking carefully at HCBS quality in light of the fact that the population of folks in home and
6 community-based care is growing dramatically; institutional care is not growing dramatically; and there has
7 been a lot of lip service over the years to the need for good quality measurement and activities. And
8 there's some here and there's some there, and there's not probably as much as we definitely should have.
9 So I'd just weigh in on that one.
10 VICE CHAIR SUNDWALL: Just a quick comment. I want to thank you for this because this
11 has been of such concern on the Hill. I mean, I've heard it, we've all heard it. There's a lot of hand
12 wringing about the duals at the state and I think federal level and wondering why they're so costly and how
13 we can do a better job.
14 But I'm reminded that sometimes when I see patients and I tell them what they don't have, I've
15 earned my money, and that's disappointing to them. But this is kind of like your research has said. In
16 spite of our faith and hope that we would find some key answer and something we should promote, I'm
17 feeling like we don't have that yet. Maybe Judy is correct, we have got to focus on these quality measures.
18 But I do think we need to talk -- share this, of course, with the Hill and make sure that, as they are anxious
19 to do something constructive with duals, they understand that this research is here and it's not as easy as we
20 would have liked.
21 COMMISSIONER CHAMBERS: Great work on this, Ellen. I think your last two slides where
22 you summarized as policy implications, particularly, you know, the previous one with the shared savings
23 targeting performance monitoring, is that it's evident from everything that you have in the draft chapter so

1 far is there has been a number of efforts at trying to solve the problem of how you serve duals. And
2 oftentimes, as each one of the potential solutions is like a silo, and it was attempted, and it either failed or
3 didn't achieve cost savings that happen over and over again. I think the ultimate solution is going to be
4 having -- you know, serving the population with a number of solutions. There's no single one.
5 I remember several years ago I went to Wisconsin to study the Wisconsin Partnership program or
6 plan in Milwaukee, the organization that had both a PACE program and had developed the Partnership
7 Plan. And, you know, as we talked to them as to the design of the program, it was that the PACE program
8 was wonderful and what it was designed for, for a very small subset of the duals population, and it has been
9 successful. And as your chart with arrows and stuff showed, you know, high satisfaction, high outcomes,
10 saved money, reduced hospitalizations. But it doesn't serve the broader population. It's not a
11 cost-effective program for that.
12 And so they branched out and tried the Partnership Plan, which was essentially a PACE program
13 without walls. And so they told us when we went and talked to them about the challenges. It's a slightly
14 different model, and I was disappointed to see -- I didn't realize that they had actually stopped the program
15 for financial viability issues.
16 And I think it's just evident that everyone -- there's no silver single bullet that's going to solve the
17 problem. And I think we've just got to find ways to find the best parts of all these programs and make
18 recommendations.
19 And I think you're headed in the right direction, and figure out -- and then just one final comment
20 and then I'll stop and pass it on to somebody else. But we oftentimes get so caught up in the
21 cost-effectiveness of the programs, and when you're comparing it against fee-for-service, either Medicaid or
22 fee-for-service Medicare, as I always say, is that the yardstick against which we're measuring things? So
23 there was X number of dollars spent in fee-for-service on a population. Was it the right care? Did they

1 actually have access to the right care? Were the right options offered?

2 So I just think we've got to figure out what are the outcomes we're trying to achieve. If it's purely

3 just cost savings, we could just keep the current programs and reduce reimbursement by 5 percent and you'd

4 achieve cost savings. But what we're trying to achieve in independence and quality of care and longevity --

5 you know, in here it mentions about PACE programs, increase life expectancy by 1.9 years, what price do

6 you put on that? You know, but what are we trying to achieve?

7 And so I just hope as a Commission as we go forward, we can figure out how we can combine the

8 best parts of all these programs and options that this Commission can ultimately recommend going forward.

9 Thanks.

10 COMMISSIONER RILEY: I, too, think this is just where we need to go with this chapter. It's

11 much more analytical, and I thought it was a great way through some difficult territory.

12 It strikes me that one addition that would be useful is to take the new demos -- I know we have the

13 appendices with the long, detailed stuff -- and sort of understand the demonstrations in light of what the

14 history looks like. Do they look like SNPs? Do they -- somehow to sort of get a sense of where we've

15 been and where we're going with those demos would be really helpful in an evaluative piece.

16 The place where I think we have -- I have the most interest, and it may be simplistic, is around the

17 issue of case management and care coordination. It strikes me if you have a Medicare and Medicaid

18 dual-eligible population, you need one care plan, and you need one authorizer of care. And I don't think

19 that's what we have in most of these programs. I think what we have is, you know, nobody who is a dual

20 eligible will ever be lonely because they have so many care managers for each division and each part of the

21 program, and that's not care management by my definition.

22 So I think to really drill down it, is there a single overriding plan of care? Who authorizes services?

23 And can that service authorizer authorize services across payer? And I suspect that doesn't exist, but I

1 think that's what we need to get to. But I'd like to -- I'd really like a real nuts-and-bolts understanding of
2 how these case management programs and care coordination programs actually work: Who authorizes?
3 Where's the check and balance? Where's the accountability?
4 COMMISSIONER ROSENBAUM: I always have so much trouble with this issue. I think we all
5 struggle with this issue. And it seems to me that the focus on the clinical quality outcomes probably -- I
6 mean, the outcomes are fine, but I can't imagine that any entity, whether it falls into any one of those
7 categories, could do much of anything for anybody unless you deal with the quality of the housing and the
8 living arrangements, the nutrition that somebody's getting, and whether there's any opportunity for social
9 engagement. If you got those three things going for you and you're the care provider, I think you have
10 some shot at making a difference on the clinical health side.
11 And what I'm most curious about -- I mean, I realize, of course, the origins of PACE. I long ago
12 in my life was involved with the early On Lok program, so the origins of PACE were essentially an attempt
13 to get at those three things: home, food, social engagement.
14 And so I think we're just going to keep wandering around in the desert on this until we maybe try
15 and cluster some of these programs or talk to some of the clinical entities trying to do this work, whether it's
16 the plans in Arizona or anybody else, regarding what's the nexus between what you're trying to do and other
17 interventions that have to come alongside you? They may not be financed or organized by the Medicaid
18 program, but they have to happen at the same time for the same population for you to have a chance.
19 And somehow I think it may be very important for MACPAC to try and illuminate this issue for
20 Congress and for the administration about whether you're going to allow more expansive work in Medicaid
21 or have CMMI undertake a new generation of activities, that, you know, here are the bottom lines, here's
22 what you need have happening at the same time. And it doesn't all have to be under Medicaid, but it has
23 to be happening for this population at the same time. And I think the social contact is every bit as

1 important as the home and the food.

2 So I don't know whether there's a way to group these studies or get behind the studies on the

3 question of did they happen alongside other things or whether really all we've got at this point are

4 evaluations that keep looking at the same set of, you know, clinical interventions.

5 CHAIR ROWLAND: And you probably can't tell some of your factors from those studies.

6 COMMISSIONER ROSENBAUM: Right.

7 COMMISSIONER COHEN: I also really appreciate the work, Ellen. It's lots of streams of our

8 conversations over the years that have been really well organized in this work.

9 In terms of options for future work, I wanted to ask a little bit about -- I want us to do all of them.

10 I think they could all be valuable. I suspect that you have some specific ideas about the last one. If

11 they're easy to do, I would encourage you to do them. And I do think that the quality measures for home

12 and community-based services are incredibly important. So I sort of -- I do -- both there is very important.

13 But I wanted to ask you about the care management option, and I guess my question is -- I don't

14 think MACPAC is probably well situated to do a lot of the sort of original research about, you know,

15 different models of care management. Is there enough of that out there? I guess I'm sort of asking, like,

16 how developed is sort of like reviews and analysis of this stuff, and is it sort of developed enough that you

17 think we can do good, meaningful work in this area? Can it be more than descriptive? So I guess that's

18 kind of my question to you, because if you think we can, I think that it's critical. But I'm not sure that we

19 can, so I wanted your thoughts on that.

20 DR. O'BRIEN: I think there is descriptive work out there already on care management practices,

21 and SNPs, for example, profiling different kinds of SNPs. I think what we were thinking is that we'd like

22 to focus on the long-term services and supports side, the care management that's going on there, and how

23 that relates to a person's health plan, for example. If the long-term services and supports are in a Medicaid

1 waiver and fee-for-service, then how does that relate to acute-care management?

2 And, again, just getting at this idea that we think there is a lot of case management out there, a lot of

3 these duals are in these programs have a case management component as part of the long-term services and

4 supports benefit.

5 But we can certainly get some distance looking at the work that has already been done and identify

6 what kinds of issues, what design features are out there.

7 COMMISSIONER COHEN: Part of it would be a little bit of work sort of identifying where the

8 services exist and perhaps a little bit where they're duplicated or fragmented, and then maybe even drawing

9 some more conclusions than that based on -- yeah, I mean, I guess that's sort of my question: Is there

10 enough out there for us to draw on, to draw -- you know, to sort of add to the work on what's effective?

11 And may I just raise one other related point?

12 CHAIR ROWLAND: Yes, but --

13 COMMISSIONER COHEN: No? Yes?

14 CHAIR ROWLAND: Well, Patty is going to need to leave, so let me let Patty ask her question.

15 Then we can get back to you.

16 COMMISSIONER COHEN: Okay.

17 COMMISSIONER GABOW: We over the years at Denver Health have done a number of efforts

18 to create care coordination for the high utilizers. Most of these have been expensive interventions with

19 social work, nurses, physicians, teams. And one thing -- recently are engaged in a CMMI grant. And the

20 reason why I think this work that you're doing is very difficult is that it's hard to look at populations as an

21 aggregate, because the real issue that comes up with every one of these complex cases is: Is there

22 something that's specifically actionable for this given patient? And oftentimes -- I mean, one of our studies

23 that failed miserably, we found that the majority of the people were chronically mentally ill, homeless, and

1 substance abusers. And that combination was very hard to find what was actionable. And that's why I
2 think this work is difficult because no matter how small you create the aggregate, you know, we're only
3 going to look at this population, it's still diverse enough when you're really sick and complex. What do you
4 have that is actually actionable? And that's why even quality measures are elusive in this group.
5 So I think it's an area we need to look at, but I don't think the usual methodologies of examining the
6 data are going to be adequate.
7 CHAIR ROWLAND: Okay. Thank you, Patty.
8 COMMISSIONER COHEN: It is relevant [off microphone].
9 Sorry. I just -- in whatever future work you do do on care management, I just wanted to throw this
10 sort of comment or question out there.
11 I understand that CMS has become -- in a lot of reviews of Medicaid waivers and other
12 interventions and a lot of the new programs that they, you know, are implementing, there has been a lot of
13 discussion about what's called "conflict-free case management." And I'm just sort of -- and, you know, my
14 understanding is that is sort of not -- you know, sort of a principle that somehow the -- like no payer or no
15 provider should really be the entity doing the case management. So I would love some sort of exploration
16 of that, where it came from, whether that is, in fact, a good approach, because I think there are many --
17 many people would say, in fact, you very much need accountable entities to be the ones doing it, doing the
18 case management. But I think that's a really important issue for us to tease out.
19 CHAIR ROWLAND: So I think we clearly hear, Ellen, that we want much more work on what is
20 case management, on the home and community-based services, quality measures, and then what has worked
21 and not worked in the past and what lessons are there. So I think you've got a start in this chapter, but we
22 want to dig deeper, so thank you for offering the first level, and we'll go to the next.
23 **### PUBLIC COMMENT**

1 * CHAIR ROWLAND: And, with that, I would welcome anyone who has a comment from the

2 audience to come forward and make that comment before we adjourn.

3 [No response.]

4 CHAIR ROWLAND: Okay. Then I would thank you all, and we will adjourn this session of

5 MACPAC. Thank you.

6 [Whereupon, at 12:00 p.m., the meeting was adjourned.]