Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

Horizon Ballroom
Ronald Reagan Building and International Trade Center
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Washington, D.C. 20004

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9:34 a.m.

COMMISSIONERS PRESENT:
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1 P R O C E E D I N G S [9:34 a.m.]

2 CHAIR ROWLAND: Okay, if we could please convene. We have a very full agenda for this
3 meeting of the Medicaid and CHIP Payment and Access Commission, and we're going to begin our meeting
4 today with a topic on a lot of minds around D.C. and the country, which is the future of CHIP and to
5 discuss some of the CHIP policy issues that we're dealing with. But today we also intend to move to look
6 at behavioral health issues in the Medicaid program, which is an incredibly important area that has often
7 been overlooked in the policy discussions.

8 We want to also take on the access component of our title and look at the standards for access to
9 care and Medicaid managed care, to delve a little deeper into those issues, and to take the payment side of
10 our title and look at a framework for evaluating Medicaid provider payment policy in our afternoon session,
11 as well as an update on the Medicaid primary care payment increase, which was part of the Affordable Care
12 Act.

13 But we're going to begin this morning with an overview of our CHIP Analysis Plan from Chris
14 Peterson. So, Chris, start us off.

15 **### THE FUTURE OF CHIP**

16 ***### SESSION 1A***

17 **UPDATE ON CHIP ANALYSIS PLAN**

18 * MR. PETERSON: Thank you, Diane. Good morning.

1 Before I turn it over to Ben and Joanne on their substantive discussion of CHIP benefits and cost
2 sharing, I just want to briefly update you on the current status of CHIP and a possible extension, and then
3 to review with you the key policy questions for addressing the post-CHIP landscape, and update you then
4 on the CHIP Analysis Plan for the current report cycle, keeping in mind that whereas the current focus of
5 the Hill is on the extension of CHIP, our analyses are also looking past that and what happens in the
6 post-CHIP landscape, whether that's in one year or current with our -- aligned with our recommendation in
7 three years or five years, depending on what Congress does.
8 The current status of CHIP is that we are now in fiscal year 2015, so under current law those last
9 allotments under current law have been distributed, and states are projected to exhaust all of their CHIP
10 balances in 2016. So in about a year from now, they will be running out -- some states will begin running
11 out of their CHIP funds.
12 There is no new congressional activity to report on extending CHIP besides what we had talked
13 about in our last meeting, and it's important to note that states are now beginning their planning for state
14 fiscal year 2016, which in the vast majority of states begins in July. So it is important for them to know the
15 status of CHIP funding.
16 Our endeavor in this meeting cycle is to bring to you first off the -- to summarize for you the issues
17 and what is known. And so in this meeting cycle, this report cycle, in this particular meeting we are going
18 to begin -- Ben and Joanne are going to talk about covered benefits and cost sharing and how will those

1 change in a post-CHIP landscape.

2 We have not yet talked about coverage for CHIP enrollees, what they will be eligible for in a

3 post-CHIP landscape and how premiums will change, if at all. Obviously we talked about these issues in

4 our March report and our June report. But in terms of this report cycle and delving into those issues in

5 greater depth, we have not done that as of yet, and the plan is to do that in December once we've got the

6 results from the modeling that is underway by the Urban Institute in collaboration with the Agency for

7 Healthcare Research and Quality that we are supporting.

8 In our last meeting, we did summarize some consumer protections and whether those are adequate

9 for children as they move between sources of coverage, and we will be talking about that more in the

10 December meeting as well to summarize those issues. And also in our last meeting, we talked about the

11 impact on particularly state budgets if federal CHIP funding is exhausted, and we will be bringing more

12 information to you in December once we have the updated numbers. So that will be important to look at

13 that point.

14 What you also have, just for the Commissioners, is kind of our aspiration of the first column

15 showing what is known, summarizing what is known and what the issues are, and then after that we're

16 hoping to look at a broad range of options and then move toward recommendations, but that gives you

17 some additional flavor on that point.

18 So before Ben and Joanne came up, I wanted to give you kind of an update on that.

1 CHAIR ROWLAND: Thank you, Chris.

2 Ben and Joanne?

3 ### *SESSION 1B*

4 **COMPARISON OF SEPARATE CHIP AND QHP AFFORDABILITY & BENEFITS**

5 * MS. JEE: Good morning, Commissioners. This morning we're going to talk with you about the

6 latest research on affordability and the covered benefits in CHIP and the QHPs. We've spoken with you

7 about this before, and the June 2014 report lays out some of MACPAC's early findings and some of the

8 issues.

9 Following that report, staff went back and thought about what additional analyses would be needed,

10 and we learned that the availability of the data and the data itself really raised some complexities and

11 challenges to doing that kind of work. But, fortuitously, in June -- or, excuse me, July 2014, two new

12 reports were issued that addressed this issue, so we wanted to spend some time discussing those with you

13 this morning.

14 We're going to talk about the findings related to affordability and the use of cost sharing. We'll

15 also talk about the covered benefits findings. Specifically we'll spend some time talking about pediatric

16 dental coverage, which we know has been a big issue.

17 Following that, we're going to engage in a policy discussion of some questions that those two

18 reports raise, and we'd like to hear from you on those options and those questions to help us move forward

1 in December.

2 So the first report we wanted to let you know about was completed by the Wakely Group. They
3 studied the 35 states with separate CHIP programs and compared the benefits and cost sharing in those
4 CHIP programs to the QHPs. And they studied them at two income levels, at 160 and 210 percent of the
5 federal poverty level.

6 A couple of notes about those income levels. Almost 90 percent of CHIP enrollees have incomes
7 below 200 percent of federal poverty, and 8.6 had incomes between 200 and 250 percent, so they're
8 capturing a large population there. Additionally, families at these income levels would be eligible for
9 premium and cost-sharing subsidies in the exchanges.

10 A couple of additional footnotes to keep in mind as we talk about the studies relating to
11 affordability. The Wakely study focused mostly on -- focused primarily on cost sharing and didn't really
12 address the question of premiums. And there are some limitations to the study such as with the available
13 data sources. So we just wanted to keep you -- to make sure that you were aware of those, and those
14 limitations are described further in your meeting materials.

15 The second study was developed by the National Alliance to Advance Adolescent Health. It's a
16 much smaller study. They focused primarily on five states, which are listed on this slide, and they looked at
17 the child-only plans in the exchanges and compared them, both benefits and cost sharing, to the QHPs in
18 those states. So the findings in that report are largely consistent with those of Wakely, but because the

1 Wakely report encompasses so many more states, we're going to focus on that one today.

2 So what can we say about the Wakely findings? Well, first, in general the findings are consistent

3 with the Commission's report in June, so we think that's a good thing, and it adds additional data, which is

4 very helpful.

5 This chart here shows that the CHIP and QHP actuarial values, or the AVs, and how they relate.

6 You'll see that the AVs for the CHIP plans at both income levels are higher than the AVs for the QHPs,

7 and the QHP AVs here do account for the cost-sharing reductions, or the CSRs. And as a reminder, the

8 AVs measure the percentage of covered health care expenses for a typical population on average, and

9 individual costs, of course, will vary depending on one's health care usage.

10 And the CSRs, again, are a mechanism for addressing affordability, and what the CSRs do is increase

11 the AV of the health plan -- of silver-level plans by lowering enrollee out-of-pocket costs, and the CSRs, of

12 course, are available in the exchanges. So --

13 VICE CHAIR SUNDWALL: What's CSR? [off microphone]

14 MS. JEE: The cost-sharing reduction.

15 VICE CHAIR SUNDWALL: Thank you.

16 MS. JEE: And all states had CHIP AVs above 94 percent of federal poverty, so you'll see the

17 range there shows 88, but most of the states are above 94 percent.

18 The Wakely analysis also concluded that the average annual cost sharing is lower in CHIP than in

1 the QHPs. This table shows what the cost-sharing levels are at, again, both income levels. But what's not
2 shown in this table are the states' specific cost-sharing levels, but in every state studied, the CHIP cost
3 sharing was lower than that of the QHPs. And, again, cost sharing includes what enrollees pay for covered
4 services typically in the form of co-payments, deductibles, and co-insurance.
5 The study also found that when cost sharing is required, there were differences in the type of cost
6 sharing used between CHIP and the QHPs, with CHIP tending to use co-payments and QHPs tending to
7 use co-insurance or deductibles.
8 Wakely looked at three specific benefits: dental, dental checkups; eyeglasses; and routine vision
9 screening. As I said, we're going to talk about dental later, but I wanted to just mention eyeglasses.
10 So CHIP programs are less likely than QHPs to require cost sharing for eyeglasses. For example,
11 at 160 percent of poverty, CHIP programs in 84 percent of states had no cost sharing. In contrast, QHPs
12 in less than half, or 44 percent of states, had no cost sharing. So there is a difference in the use of cost
13 sharing between the programs. To give you a state example, Montana is a state with no co-payments in
14 CHIP, but a 30 percent co-insurance in the QHPs.
15 So this table here shows the out-of-pocket maximums and shows that the CHIP out-of-pocket
16 maximums are lower than those of the QHPs. Out-of-pocket maximums limit what enrollees have to pay
17 in cost sharing before the health plan begins to pay for all of the costs of the covered services. There are
18 some differences in how CHIP programs determine the level of the out-of-pocket maximum. Some states

1 determined that level as a percentage of income. That's most states. And other states determined that
2 level based on a fixed dollar amount. But in either case, the CHIP out-of-pocket maximum is lower than
3 the QHPs.
4 To give you an example, in Utah, at 160 percent of FPL, the CHIP out-of-pocket maximum is $650;
5 whereas, in QHPs the maximum is between $3,500 and $5,000.
6 So those are the findings on the cost sharing, and with that I'll turn it over to Ben to talk about the
7 benefits.
8 * MR. FINDER: So with respect to benefits, the Wakely analysis was largely consistent with what
9 we've reported in the past, and that is that all core services are covered in both programs, with some
10 variation around how benefit limits are applied.
11 Core services include things like physician services, inpatient hospital services, lab and radiology,
12 mental health services, prescription drugs, and emergency medical transportation. And these services are
13 very important for children, but they're not exclusively pediatric services. And like I said, there are modest
14 differences in how they apply benefit limits. In some cases QHPs are less likely to use benefit limits than
15 in CHIP programs. For example, QHPs in all states cover physician services without limits, compared to
16 CHIP programs in 97 percent of states. For inpatient hospital services, QHPs, again, cover without
17 benefit limits in all states compared to CHIP programs in 95 percent of states. On the other hand,
18 separate CHIP programs are less likely to use benefit limits for benefits like durable medical equipment and

1 emergency medical transportation.

2 But there are some variations that emerge when we think about some specific benefits. For

3 example, all but one state cover hearing aids, while QHPs in 46 percent of states do not. All states in

4 CHIP programs cover hearing aids while QHPs in 46 percent of states do not.

5 The Wakely report also found that separate CHIP programs and QHPs in most states covered

6 autism services, and only a few states did not. However, separate CHIP programs were more likely than

7 QHPs to cover these services without limits. And the limits, when they are applied, are difficult to

8 compare because they can be different types of limits. For example, some limits are hours per week,

9 others were visits per year, and there were actually some annual dollar limits per year as well. They can also

10 vary by age.

11 And the same is true for ABA therapy. CHIP programs are more likely than QHPs to cover them

12 without limits. A nearly equal number of states indicated that they did not cover ABA therapy at all in

13 either separate CHIP programs or QHPs.

14 And there are certain benefit categories that are more likely to be covered by separate CHIP

15 programs than in QHPs. These are benefits like enabling services, non-emergency medical transportation,

16 and over-the-counter medications. But it's important to note that your coverage for these things varies

17 highly by state, like all things in Medicaid do. For example, kids in Idaho or Kansas are more likely to have

18 all three of those services than some of the other states available.

1 There are significant differences in coverage of dental services in the CHIP program in QHPs, and
2 this reflects the different approach to benefit design. Remember that they're mandatory -- pediatric dental
3 benefits are mandatory in CHIP. But QHPs can choose not to embed coverage in states where
4 stand-alone plans are also available in the exchange. The Wakely report found that in 60 percent of states,
5 QHPs did not include embedded dental benefits. So families in those states must buy stand-alone plans in
6 order to have coverage for these services. That means that families face additional premiums which can
7 also vary by state.
8 Wakely also found that CHIP programs are more likely to provide dental coverage without cost
9 sharing than QHPs with embedded dental coverage. But, again, the Wakely analysis was only among plans
10 that did not -- sorry. They only included QHPs with embedded dental, which means that it doesn't include
11 some of these stand-alone plans which are able to establish separate cost-sharing requirements and separate
12 out-of-pocket maximums.
13 So ultimately for those purchasing stand-alone dental plans, premiums, cost-sharing requirements,
14 and coverage limits are likely to have an effect on affordability and access to dental services.
15 MS. JEE: So to summarize for you the latest in the research on CHIP and QHP cost sharing and
16 adequacy of benefits, the paper in your meeting materials begins to identify some possible approaches for
17 addressing some of the issues related to that for children who are currently enrolled in separate CHIP
18 programs and who might transition to coverage in QHPs. And the paper also lays out some factors that

1 Commissioners may want to keep in mind as you consider those options.

2 Some of the options that might be considered are to provide additional cost-sharing assistance

3 through mechanisms such as increasing the CRSs, or the cost-sharing reductions, or providing a

4 wrap-around benefit for cost sharing.

5 With respect to coverage of benefits, again, a wrap-around could be an option for consideration, as

6 well defining pediatric services more explicitly so that it includes services that maybe are deemed inadequate

7 in the QHPs or for which there currently are gaps in coverage.

8 I also wanted to mention child-only plans in the exchanges. Child-only plans are currently a

9 coverage option in the exchange, but we do know that there are some policies around it that potentially

10 restrict how the child-only plans are used. They need to be offered at parity to the standard QHPs or the

11 "not child-only QHPs." So, you know, might there be some opportunity there that the Commission

12 would like to explore? And, you know, what are those?

13 Another policy question we'd like some input on is whether the policies to address affordability and

14 adequacy of benefits, whether they should be designed for all children or for a subset of children. We've

15 been thinking about these options in terms of those separate CHIP enrolled children who would be

16 transferring or potentially moving into exchange coverage, but some of the options would reach more than

17 just that population of children. And there are nearly 500,000 children currently enrolled in the exchanges.

18 So, Commissioners, something to consider is whether options should be targeted to certain

1 populations, just the CHIP kids, or maybe some of the CHIP kids based on income or possibly by health
2 status. For example, families with incomes higher than 250 percent of the federal poverty level are not
3 eligible for the cost-sharing reductions, or the CSRs. And some families are caught in the family glitch,
4 which we know many people are thinking hard about.
5 Another option would be to target policies to children based on health status, such as children with
6 special health care needs who are more -- who are likely to experience higher out-of-pocket costs or exhaust
7 benefit limits, who are more likely to do those things than children with just more routine care needs.
8 So I also just wanted to mention that we are aware that there are some pretty major financial
9 implications to any of these options as well as policy and operational factors that would affect the ease and
10 complexity of developing and implementing any one of them. And we plan to address those issues to the
11 extent that we can in the next -- in December.
12 So with that, I'll turn it back over to you all.
13 CHAIR ROWLAND: Andy.
14 COMMISSIONER COHEN: Thank you, and such nice and thorough and clearly presented work.
15 I was struck when reading your paper and in this presentation. I have a set of sort of thoughts
16 about scope, and it wasn't really in the scope of what you were trying to do, but I do think it's important for
17 us to remember, because while we are thinking, you know, sort of at all points until there is a change in the
18 law, we will be thinking about what our recommendations and perspective on this really sort of tough set of

1 issues, is how our children kind of best and most appropriately served by various public programs.

2 But the scope of what you looked at is very focused on what the state is of CHIP plans today, and it

3 doesn't really take into account the fact that there's really substantial latitude in the law in CHIP in terms of

4 what states can do and what they sometimes do do in times of economic downturns and other things. So

5 we're not quite as much in that right now.

6 So we are sort of doing a comparison at a point in time, but I think we just have to be really

7 cognizant of that fact, because one of the key differences between federal programs and mostly federally

8 financed -- entirely federally financed and administered programs and state ones is that there is much more

9 variation in policies over time and in economic downturn.

10 So I just want to make sure that in our writing and thinking about this that we are remembering that

11 fact. It is one thing to look at a point-in-time analysis, but we have to remember that we are in a particular

12 sort of point in time, and the law allows more flexibility.

13 CHAIR ROWLAND: And you mean for things like the ability that states could impose waiting

14 lists on the CHIP program.

15 COMMISSIONER COHEN: Waiting lists, benefits, all sorts of things. There is a wider range of

16 what is sort of possible than what is sort of the case at this moment today. So we just have to sort of

17 remember that, that there are limitations to the point-in-time analysis in terms of thinking about where kids

18 are best served over the long term.

1 VICE CHAIR SUNDWALL: Thank you. It was a good presentation.

2 I have a question about the market for these child-only plans. I think it was the hope of the
3 authors of the ACA with the exchanges that it would stimulate more creativity and more competition in the
4 private sector to provide, come up with plans that would be competitive and helpful, and you've obviously
5 pointed out there's a difference at this point in time as far as cost sharing and what have you.

6 But what is the market for these child-only plans? Is it vigorous or robust, or is it very thin? Can
7 you say something about what the ACA has done to the market for children-only health insurance plans?

8 MS. JEE: At this point, I'm not sure that we have data on enrollment in the child-only plans. I
9 mean, they certainly exist. Any issue of a QHP is to also offer a child-only plan, but at the same actuarial
10 value of that QHP, but we have not seen any data on that thus far.

11 MR. FINDER: Yes. We mentioned earlier that about 500 -- about a half a million kids are in the
12 exchanges right now. I think that we don't know the breakout of how many of those kids are in child-only
13 plans versus other health plans.

14 VICE CHAIR SUNDWALL: Okay. Then one follow-up. Was your comparison for the
15 children in these exchange plans not just limited to the children's-only? In other words, the cost sharing or
16 their kind of narrower benefits, was that just children in the exchanges, not just children in pediatric-only
17 health plans?

18 MS. JEE: So the analysis that we discussed today was conducted by the Wakely Consulting Group,

1 and they looked at a CHIP plan in their state, in each of those 35 states, and compared it to the EHB
2 benchmark. So it's the benchmark but not specifically a child-only plan.
3 VICE CHAIR SUNDWALL: Thank you.
4 CHAIR ROWLAND: Judy has a comment on that point, and then I go to Burt.
5 COMMISSIONER MOORE: Just a quick follow-up. So I am assuming that you also don't
6 know anything about the range of benefits in the child-only plans, either, in terms of other data. I mean,
7 we don't know what's included in terms of benefits in a child-only plan, whether it's a richer benefit package
8 or whatever.
9 MR. FINDER: Yeah. We did some sort of looking into this a little bit earlier on, but we haven't
10 done a more comprehensive look at all of the child-only plans.
11 By statute, they are required to be the same actuarial value as the other plans. The statute doesn't
12 actually call the other plans "adults only" or "family plans." They're just referred to as "other plans." So
13 they are the same actuarial value.
14 When we looked anecdotally, they looked very similar, but again, I said that was earlier. We haven't
15 done a more comprehensive or thorough review at this point. We looked for more research on this and
16 haven't found anything, either.
17 COMMISSIONER MOORE: We can get back to this because I think it's important to deal with
18 the specifics, but I continue to believe that somewhere along the line, maybe not MACPAC, but the

1 insurance world at large and the advocacy community for children needs to look at an appropriate pediatric
2 benefit package, and I just want to put that out as a talking -- as a subject we need to talk about at some
3 other point.
4 CHAIR ROWLAND: Burt and then Richard and then Sharon.
5 COMMISSIONER EDELSTEIN: I thank you both for attending to the question of dental
6 coverage in the changeover for those kids who would go from CHIP to the ACA, and I want to clarify and
7 extend a couple of remarks that you made.
8 The first is with regard to core benefits. As one of the essential benefits, dental is a core benefit,
9 and it wasn't in your list, so let's always keep it in the list, as it is a mandated service under the provisions of
10 the essential benefits.
11 However, as essential as it is, it is not required. So, Ben, you had mentioned that parents who
12 secure their primary coverage through a health plan that does not embed dental must purchase a dental plan,
13 but in fact, it is not a "must," it's a "may" purchase. And that is an inadvertent consequence of the penalty
14 for not securing coverage.
15 So while the law anticipated that dental coverage would be mandated and would be essential and
16 would be included, in fact, it is possible and even likely for families to secure their health coverage without a
17 dental benefit and leave the exchange with no penalty for not obtaining the dental coverage, except currently
18 in the State of Connecticut where all health plans must include the dental benefit.

1 But I want to extend our concern about dental, as well, because it truly is the poster child for
2 problems that arise when children lose CHIP coverage and find themselves instead with coverage through
3 the Affordable Care Act.
4 The first extension of your remarks is that, effectively, there is no assurance of dental coverage, the
5 issue that I just described. So right off the bat, we have a problem that a core benefit, an essential benefit,
6 in fact, may not be secured. So, on the face of it, that's a critical, critical problem.
7 The second is the comprehensiveness or the quality of the benefit itself. CHIP legislation,
8 CHIPRA, much more thoroughly and in much more detailed way describes the nature of the dental benefit;
9 whereas, the language in ACA is much more general.
10 The third issue is access to coverage itself, and, Joanne, you mentioned the family glitch, and here's a
11 place where the family glitch glares and shows up as a real problem.
12 The fourth is one that I think, Ben, you covered very well, which is the affordability. Premiums,
13 cost sharing, and total out of pocket all add up to a real barrier to securing dental care, something that kids
14 in CHIP don't face that would, more than likely, be a significant barrier for kids in the ACA.
15 The fifth is premium assistance. Issues around premium assistance essentially boil down to
16 inadequate subsidy for families being able to secure the dental benefit, especially if they buy it separately.
17 And the last is consumer choice. In general, it appears that there is more choice in CHIP than in
18 ACA offerings with regard to dental care.

1 I'll just throw in one more that affects coverage, whether secured through Medicaid, secured
2 through CHIP, or secured through the Affordable Care Act and the exchanges, and that would be the entire
3 and ongoing question of network adequacy, which, of course, flows after you first have coverage. And
4 that is an issue that is a serious problem in dental.
5 So I think that the Commission can feature the implications of kids losing CHIP coverage as an
6 exemplar in its work, demonstrating what the consequences are for families that may lose CHIP coverage
7 and have to switch over to either being uninsured or being dentally uninsured, as is so likely to happen to so
8 many kids.
9 Thank you.
10 COMMISSIONER CHAMBERS: Thank you, Ben and Joanne, for laying out these policy
11 considerations.
12 I think my question is more a point of clarification for myself and probably more appropriately
13 directed to Diana and Anne. It is just to understand. As you talk about some of the policy options have
14 very significant financial impacts, which would potentially be on exchange programs, my question is, as we
15 do policy considerations, we don't have jurisdiction over making recommendations for changes in exchange
16 coverage. Is our goal to enrich the debate? Is it to be able to make not recommendations? I just am
17 curious as to where we go at the end of the day on the policy considerations.
18 CHAIR ROWLAND: I certainly think that one of our tasks is to look at how to adequately

1 provide health insurance coverage to insurance, whether they be on Medicaid or on the CHIP program, and
2 so, certainly, if we are going to make a recommendation that has implications that require additional federal
3 spending or state spending, those would have to be considered in our recommendations, even if it goes to --
4 which would be a modeling issue for us, since we don't have capacity to model the cost in the change. But
5 I think we would have to clearly indicate that there would be cost to the federal government of some of
6 those changes.
7 COMMISSIONER CHAMBERS: Thank you.
8 CHAIR ROWLAND: Sharon and then Sarah and then Donna.
9 COMMISSIONER CARTE: Thank you, Joanne and Ben, for this great data comparison.
10 We see here clearly that the actuarial value is lower for the QHPs than the CHIP plan, and that's a
11 measure of how much covered service is available to the members. But not only is that lower, but then in
12 addition, it's compounded by the problem of higher cost sharing, as well. And I think that that is a really
13 critical issue, since the value of a pediatric-centered benefit would be to provide preventive services to
14 children. And I would be very concerned that children in QHPs are not going to get those key preventive
15 services.
16 And I wonder if it is possible at this time -- it may not be, but I know that the CHIP and Medicaid
17 plans currently report their quality measures, such as well child visits. Would it be possible to find QHPs
18 that report quality measures such as well child visits? Because I'm sure that we will see and access barrier

1 as a result of these cost-sharing provisions.

2 MR. FINDER: I think that is something we can look into. I haven't seen quality data from some

3 of the plans yet, and given that there are state-based exchanges and federal exchanges, I'm not certain how

4 much data there might be out there to find at this point.

5 COMMISSIONER CARTE: Thank you.

6 EXECUTIVE DIRECTOR SCHWARTZ: I just want to point out for Commissioners that I

7 don't think it -- the presentation touched on it a little bit, but Table 5 in your paper that talks about the

8 other benefits, not what Ben was originally talking about core benefits, but things like autism services and

9 therapies.

10 One important takeaway from this table is that the numbers are all lower. If your plans, CHIP or

11 QHP, cover these, then services like physician services and hospitalizations -- and I think the situation of

12 making the comparison between CHIP and QHP varies very much, depending upon where you live.

13 So, for example, on applied behavioral analysis, if you are a kid in the 26 percent of states that cover

14 that, you're probably better off than the kid in only 9 percent of the states are covering that, but fully 42

15 percent is not covered in CHIP, either. And so this is a place where I think on the benefit side, the story,

16 while having some advantages for CHIP, it's not completely clear.

17 So I just want to make sure that that came through, as opposed to on the cost-sharing side where I

18 think it's much starker, and that might have implications for you in thinking about these issues around

1 policy fixes for adequacy.

2 COMMISSIONER ROSENBAUM: I actually was going to raise the point that Anne just raised,
3 which is that we have -- and we know we've had -- a very stark picture on the cost-sharing side, and I think
4 it's fair to say a somewhat muddier picture on the benefits side and not just the benefits that are covered,
5 but coverage exclusions, for example, which are very hard to see. We don't really know.

6 But my question is actually a little bit different, and it sort of keys off of the observation that Andy
7 raised. So this is CHIP today, and it seems to me -- I mean, in our June report, we talked about being in
8 sort of a fork in the road here. Do we keep going with a separate CHIP program? Do we try and think
9 about raising the bar on pediatric coverage more generally?

10 Assuming for the moment that we are inclined towards thinking, as we said in June, that for at least
11 some period of time, we need separate financing, because things are too uncertain on the exchange side of
12 the ledger, the question is what do we need to recommend to hold this high-water mark. So this is the
13 high-water mark, and already, we can see that there are benefit limits and holes on the CHIP side. The
14 cost sharing is much, much better.

15 So if we just focused on the cost sharing, in 2016, if the great enhancement that was envisioned for
16 federal funding for CHIP is not on the table, would anybody expect at that point that states would continue
17 on with a high-water-mark plan, or would we begin to see degradation of the coverage? And do we have
18 to think about what to recommend to Congress about both maintaining the CHIP funding beyond -- into

1 2016 and then enhancing that funding, or are we saying that states can just -- you know, will just go on
2 paying this high-water mark, even though they could in theory let go of the program and send at least some
3 of the families, most of the families who don't run into the family glitch to the exchange?
4 So I just think that all this shows us is that we have to think hardest in a CHIP world about whether
5 it's enough to simply extend the money or whether we really have to think about the tension of bumping up
6 against a fully federalized exchange subsidy system.
7 COMMISSIONER CHECKETT: A couple of comments. Thank you for a very good paper and
8 a good presentation.
9 I actually want to circle back to something that Anne had raised about Table 5, and then I will get to
10 my other comment, and Judy had brought up this question about do we look at recommending a benefit
11 package for children, and just to add to the complexity -- and Table 5, I guess I'd look back at.
12 So we have, I think, particularly for non-clear-cut health-related medical benefits, so those enabling
13 services, things that become really standard with Medicaid, non-emergency transportation, all types of
14 community support, ABA therapy in many, many states who are under Medicaid. Those things stop being
15 covered under CHIP in a lot of states. We see that getting narrower, and then we are looking at the chart
16 on QHPs, and it looks like it's getting narrower.
17 And then I want to point out, you can have a state mandate. For instance, the state can say all our
18 insurers have to cover ABA therapy. That would be a real hot button, but that actually is only going to

1 apply to people who are not on Medicaid and CHIP, who are buying a fully insured product, and when you
2 look at it -- and I know this is getting a little bit off Medicaid and CHIP, but when we look at coverage for
3 children, there are a large number of children and probably children of many people at this table and in this
4 room who are actually getting insurance through self-funded insurance products.
5 So my company self-funds their insurance coverage for their employees. I guess the federal
6 government probably does, and that actually means that all those state mandates don't apply at all. And it
7 is a real hole for children with disabilities or special needs in particular, and I think that's why you actually
8 see children who are otherwise -- parents are getting commercial insurance, actually wind up getting onto
9 Medicaid at some level.
10 So I am just putting it out there to really add to the complexity of the discussion and looking across
11 the row here at where children are getting their insurance and what that means for them in terms of
12 benefits.
13 My actual original question was, if I could find it --
14 CHAIR ROWLAND: Donna, if I could interject for a minute. I think you are raising a very
15 important point that as a Commission on Medicaid and CHIP, we're sort of missing here a piece, which is
16 that we ought to really be showing what coverage in Medicaid does, because among those children at
17 different income levels, there are some who are getting the full Medicaid benefits, and to the extent that we
18 can, to also look at not just the QHP, but to add in a little bit about what's going on in the employer sector

1 for those children who would be going to ESI as opposed to be going to the QHP.

2 So I think a broader look at sort of how are benefits generally provided to children and especially

3 the role of Medicaid versus CHIP is a really important piece for this Commission to keep in mind.

4 COMMISSIONER CHECKETT: Great. Thank you.

5 I guess I will circle back. I think people really often -- I know it was a long time before I

6 understood that just because a state mandates a benefit coverage, it doesn't mean all the children in the state

7 are remotely going to get that coverage because of ESI and the way that ERISA mandate works for that.

8 My question on Slide 10, under the policy questions, could you help me understand better what you

9 mean by wraparound coverage for cost sharing or benefits?

10 Thank you.

11 MS. JEE: Yeah. So a wraparound benefit, there are models for wraparound benefits already in

12 Medicaid, but it would just be an additional benefit provided to the enrollee to help either with, say, cost

13 sharing to pay for premiums or other out-of-pocket costs in addition to their health coverage through, say, a

14 QHP.

15 COMMISSIONER CHECKETT: And so if it's a wraparound coverage for cost sharing -- so walk

16 me through that. I don't get it. I'm sorry. Am I the only one who doesn't get it?

17 EXECUTIVE DIRECTOR SCHWARTZ: It's almost like a secondary insurance, probably.

18 CHAIR ROWLAND: Do we have any evidence of how well the existing wraparound programs

1 have worked or how they are structured?

2 MS. JEE: I don't, off the top of my head, know, but there has been some work looking at

3 wraparound coverage programs, and I think in Medicaid, so we can look into that further.

4 COMMISSIONER CHECKETT: Well, I think in particular, I understand the wraparound

5 coverage more easily than I understand wraparound cost sharing, so thank you. If you could just help me

6 understand it a little bit better at our next meeting.

7 CHAIR ROWLAND: I think -- don't we have -- we are going to later talk about the Medicare

8 savings programs, and to some extent, that's where Medicaid is wrapping around the Medicare program.

9 So I think it would be similar to that, Donna, and then you could get into payment levels.

10 Sharon.

11 COMMISSIONER CARTE: I just wanted to follow up on Donna's observation about self-funded

12 programs, because I think the last time -- I believe it was the last time we met, we heard a presentation

13 about premium assistance, and just to mention that CHIPs did not go into premium -- have not gone into

14 premium assistance heavily, which I had thought maybe would happen when I first became a CHIP

15 director. Part of it is the administrative complexity, but also, if you are in a state that has a lot of

16 self-funded plans, it really just doesn't make any sense. And I think that the Commission should look

17 more at the presence of self-funded plans throughout the states.

18 CHAIR ROWLAND: Judy.

1 COMMISSIONER MOORE: Just having listened to this discussion, it seems to me I want to
2 make a more affirmative statement about coverage of children.
3 It seems to me that as a nation, we need to make sure that kids get a basic level of coverage or
4 perhaps more than a basic level of coverage, certainly more than an adult level in many ways, because it
5 matters to our future.
6 And the subject of pediatric benefit packages, I think is one that we may not be able to coverage
7 short term, but that MACPAC should pay attention to long term.
8 CHAIR ROWLAND: Norma?
9 DR. NAYLOR: I just want to quickly -- thank you for your presentation. It was very good.
10 You know, in Texas, because we have the highest rate of uninsured children, it would really concern
11 me if, even with CHIP, we still don't have our children covered, and that we go to QHP, because we have
12 to mandate that. I can promise you that people that don't take advantage of Medicaid CHIP programs are
13 not going to get QHPs. It's just not going to happen, so we're going to end up having even more
14 uninsured, is what I see happening for Texas, especially with our new upcoming governor.
15 VICE CHAIR SUNDWALL: Are you making a prediction?
16 [Laughter.]
17 CHAIR ROWLAND: Okay. Other comments? Richard.
18 COMMISSIONER CHAMBERS: Just as I think about this, we made the recommendation earlier

1 this year about extending CHIP for two years as we continue to look at long-term solutions. Some of the
2 commentary that has come along with that is others disagreeing with that. But I just hope, as I hear about
3 this, particularly about issues like wraparound coverage, wraparound cost sharing, is that I hope that we
4 always keep in mind creating simplicity and seamlessness and coverage for kids and benefits. And I just
5 hope, ultimately, that's the goal, because there's such a patchwork of coverage and benefits, and I just hope
6 that we keep that in mind as we're moving forward on policy considerations.
7 CHAIR ROWLAND: I also think that the issues you raised with regard to coverage for all
8 children, coverage for some children is a critical one, and this Commission really is focused on low- and
9 moderate-income children, but we know there is tremendous variation across the states in terms of the
10 income eligibility levels. And I think we really need to think about for children being covered at 300
11 percent of poverty, is that the same as what we would be recommending for children covered at 150 percent
12 of poverty.
13 Clearly, this analysis you presented starts to look at differences, and you're saying that most of the
14 children are under 200 percent of poverty. But we really need to think through an income-related way of
15 dealing with children as opposed to creating categories, since I think one of the great things the Affordable
16 Care Act tried to achieve was to make Medicaid coverage based on income and not on category, and we
17 ought to make sure that we're not re-creating those kinds of categories in the future. We should be looking
18 at what the best benefit package for children is, what differences in that package might be required for

1 children at lower incomes, which relates to the cost sharing.

2 And I think to Judy's point, the benefits ought to be the same, no matter what the income of the

3 child is, but the cost-sharing obligations ought to vary, and we ought to really do our analysis in that way.

4 Herman.

5 COMMISSIONER GRAY: I would certainly agree with that, and particularly the data points out

6 just how vulnerable or potentially vulnerable kids with special needs are, both in cost sharing and availability

7 of benefits. The notion of further segmenting the pediatric population by defining benefit coverage for a

8 particular group of kids, I think would be extraordinarily difficult, complex, and ultimately not serve kids

9 well at all -- or families.

10 The subtleties in diagnoses, the subtleties and as conditions evolve over time, medical conditions

11 evolve over time, a kid who today is in one category may be in another mere weeks from today, there's just

12 lots of issues with it that I find very troubling, and I don't think it would work particularly well.

13 The other question or comment, I guess, I would make is about wraparound services. There's

14 been lots of conversation about it, and there was a comment in the paper, in the draft, about the

15 administrative complexity, as well -- and to Richard's point -- of wraparound services and do families even

16 who have it, do they understand how to access it. So a program that is not embedded in the plan itself

17 strikes me as problematic for some families who may not have much health care literacy or understand how

18 to access what is even due to them in the limited number of states who even provide the benefit in the first

1 place.

2 CHAIR ROWLAND: Okay. Other comments?

3 [No response.]

4 CHAIR ROWLAND: I think you've got quite a charge. So we want you to come back and look

5 at what benefits all children should receive, how that should be related by income in terms of cost-sharing

6 obligations for families.

7 And then I think Herman has raised a very important point about how special needs children who

8 are really a part of this, both the Medicaid and the CHIP side, really get dealt with.

9 And, again, that brings us back to always keeping in mind the comparative differences between

10 Medicaid, CHIP and the QHPs.

11 So, with that, we'll have you begin to work busily for our next meeting, and we'll call Rob Nelb to

12 talk to us about the Secretary's report on CHIP.

13 ### *SESSION 1C*

14 **REVIEW OF CHIPRA MANDATED EVALUATION OF CHIP**

15 * MR. NELB: All right, good morning. My name is Rob Nelb, and I'm here today to review the

16 CHIPRA-mandated evaluation of CHIP, which was recently released by HHS in September of this year.

17 The evaluation provides a look back on the status and successes of the CHIP program prior to the

18 implementation of the Affordable Care Act, which I hope will be helpful for the Commission's ongoing

1 work on CHIP.

2 In addition, because this evaluation was submitted to the Congress, the Commission has a unique

3 opportunity to respond outside of the traditional report cycle, and so specifically, I'll be asking for your

4 comments today about feedback the Commission may want to provide in any future written response.

5 To kick off the discussion, I'll begin by reviewing the components of the evaluation and then

6 summarize the evaluation's seven main findings.

7 Then I'll identify some potential areas for comments that the Commission may want to consider in

8 its future written response to HHS and the Congress.

9 I want to emphasize that this presentation and the memo that you have is really a draft for

10 discussion purposes only, and I'll be listening to your feedback today to incorporate it in any future written

11 response that actually gets sent, to make sure it reflects all of your views, of course.

12 Okay, so let's begin.

13 In response to the requirements of CHIPRA, HHS contracted with Mathematica and the Urban

14 Institute to conduct a multi-modal evaluation of CHIP.

15 One of the key focuses of the evaluation was a close look at 10 states that were selected based on

16 diverse geographic representation and varied approaches to program design. So we have Medicaid

17 expansion CHIP programs as well as separate and combination CHIP programs in the study.

18 And the full list of the 10 states is in your packet.

1 Within those 10 states, the evaluators looked at CHIP in a number of different ways.

2 First, they surveyed the parents of CHIP enrollees to get their perspectives about their experience

3 with the program and the health status of their children.

4 In addition, the evaluators took a close look at the eligibility data within the state to get a better

5 understanding about how long children were enrolled and where they went after they left coverage.

6 Within 3 of the 10 states -- Texas, Florida and California -- the evaluators also surveyed parents of

7 Medicaid enrollees to get a comparative view about how Medicaid compared to CHIP in those states.

8 In addition, the evaluators conducted a national survey of CHIP administrators and looked at CHIP

9 nationally, using some existing data sources such as the Current Population Survey, the American

10 Community Survey, and the National Survey of Children's Health.

11 I want to emphasize again that most of these data were collected in 2012 which, of course, is before

12 the full implementation of the Affordable Care Act. While the ACA didn't change too much for CHIP,

13 there are important changes in terms of eligibility and enrollment that are important to keep in mind as you

14 look at these findings.

15 Okay. So what did the evaluation find?

16 Again, I'm going to review the seven main findings just in brief detail, and more information about

17 these is in your materials.

18 First, using some of that national data, the evaluation found that CHIP contributed greatly to the

1 decline in uninsured rates among low-income children. In addition, the participation rate -- the proportion
2 of eligible children that were enrolled -- has increased as well, growing from 82 percent in 2008 to 88
3 percent in 2012.
4 As a result, the number of children eligible, yet uninsured, in CHIP fell from 4.9 million in 2008 to
5 3.7 million in 2012. While much progress has been made, the evaluation does note that there is a need to
6 continue to focus outreach efforts towards those remaining 3.7 million children.
7 The next set of findings come from a closer look at those 10 states.
8 Within those 10 states, the evaluation found that relatively few low-income children in CHIP have
9 access to employer-sponsored insurance. This is supported in two main ways.
10 First, they surveyed the parents of CHIP enrollees to find out whether they had access to
11 employer-sponsored insurance. About 40 percent of the parents of CHIP enrollees had some sort of ESI,
12 but only about half of them, 20 percent of the total, had access to employer-sponsored insurance that
13 covered their children
14 In addition, the evaluation looked at crowd-out -- the proportion of children that had private
15 insurance prior to enrolling and voluntarily disenrolled. The evaluation found a pretty low crowd-out rate
16 of 4 percent, which is much lower than other previous estimates.
17 I will just caution that these findings on employer-sponsored insurance are based on those 10 states
18 only and that the Commission is doing some more work using some national data to get a fuller look at

1 some of these issues.

2 Another finding in those 10 states is that Medicaid and CHIP programs worked as intended to

3 provide an insurance safety net for low-income children, especially during times of economic hardship.

4 This is supported by the fact that Medicaid and CHIP enrollment rose during the recent economic recession

5 and also by the fact that the majority of CHIP kids in these states were below 150 percent of the federal

6 poverty level.

7 The next set of findings comes from that focused look at eligibility data in those 10 states. I think

8 probably for the first time, at least that I've seen, they were really able to get at, with some strong evidence,

9 about how long kids were enrolled and where they went.

10 So, although more than half the CHIP kids stayed enrolled in public coverage, for at least 28

11 months, transitions between programs were very common and resulted in gaps in coverage.

12 There are two types of gaps I want to highlight.

13 The first is churning, which is the portion of children that leave Medicaid or CHIP and then

14 re-enroll within seven months. The evaluation found that churning rates were as high as 19 percent in

15 separate CHIP programs and as high as 36 percent in Medicaid in those 10 states.

16 Of course, the churning rates varied by state, but in general, the trend persisted that churning in

17 Medicaid was typically higher than churning that was found in separate CHIP programs.

18 Another type of gap in coverage is when children transition between Medicaid and separate CHIP

1 programs. Here, in half the states studied, the evaluation found that at least 40 percent of enrollees
2 transitioning between Medicaid and separate CHIP programs experienced a gap in coverage.
3 This also varied by states, and typically, the states that administered their separate CHIP programs
4 separately from the Medicaid agency had higher rates of gaps in coverage.
5 It's also worth noting that the gaps in coverage transitioning from Medicaid to separate CHIP
6 programs were generally much larger than the gaps in coverage going from separate CHIP programs to
7 Medicaid. It is, of course, hard to know exactly why, but the evaluation does point to potentially premiums
8 and waiting periods in separate CHIP programs as maybe some unique features that contribute to those
9 larger gaps when moving to separate CHIPs.
10 The final set of findings I will present come within those 10 states and from those surveys of parents
11 in those states.
12 First, in terms of access to care, the evaluation found that Medicaid and CHIP enrollees reported
13 better health care experiences than uninsured children and generally comparable experiences as children
14 with private insurance. However, about one in four CHIP enrollees surveyed reported some type of
15 unmet health need, which, again, was similar to private insurance but still an area to be cognizant of.
16 In terms of knowledge of the program, most low-income families reported knowing about Medicaid
17 and CHIP, but only half of new CHIP enrollees fully understood the renewal requirements of the program.
18 Okay. So now that I've reviewed the findings, it's your turn to provide some feedback on areas

1 where the Commission would like to provide some comments.

2 I'll just point out that, again, because this evaluation is a report to Congress, MACPAC is technically

3 required to review and comment on the report. Of course, it's up to you to decide exactly how you would

4 like to comment.

5 In its response to this evaluation, the Commission may want to choose to emphasize some of its

6 prior policy recommendations. This may be particularly important if Congress chooses to take up CHIP

7 legislation during the lame duck session of Congress since, again, this comment letter is sent outside of the

8 traditional report cycle.

9 The Commission could also use this opportunity to make some new comments based on the

10 evaluation's findings.

11 And so to jumpstart the discussion today, I've outlined five potential areas for comments, which are

12 outlined in more detail in your materials, but just in the interest of time I'll walk through them briefly before

13 turning it over to you.

14 First, the Commission may want to comment on the evaluation's findings about the status of health

15 coverage for low-income children prior to 2014 and the many successes that have been made. And, as the

16 Commission looks to the future landscape for children, it may want to point to the need to ensure that past

17 successes are not lost in those transitions.

18 The Commission may also want to comment on the evaluation's findings about some of the

1 transition issues between programs. In today's coverage landscape, as children not only have to transition
2 between Medicaid and separate but also transition to exchange coverage, some of those issues around gaps
3 in coverage during transitions may be particularly relevant.
4 Next, the Commission may want to comment about low enrollee understanding of renewal
5 requirements. As some of you may remember, at last month's meeting, we heard about similar concerns, a
6 similar lack of understanding about renewal requirements that MACPAC found in some of its focus groups
7 for newly eligible adults, highlighting that this is probably a widespread area for improvement.
8 Next, the Commission may want to comment on some of the gaps in quality and access to care.
9 Again, even though CHIP was generally comparable to private insurance, there are still areas for
10 improvement.
11 And, finally, the Commission may want to comment about state preparations for the future of
12 CHIP. One of the smaller findings from the report, from the survey of CHIP administrators, found that
13 most CHIP agencies had not made contingency plans for the potential expiration of CHIP funding, which
14 may be something worth noting.
15 All right. So, hopefully, this is enough to get you started today.
16 I'm here to answer questions, but mostly, I'll be here as a listener to get your feedback and make
17 sure it gets incorporated in any future response.
18 Thank you.

1 CHAIR ROWLAND: I gather from this report, obviously, there was no update of what the
2 Affordable Care Act has done to change CHIP in terms of the transition of children under 138 percent of
3 poverty or the outreach. As we see the new enrollment numbers coming in, we see a lot of children now
4 enrolling in both Medicaid and CHIP, who were previously uninsured.
5 MR. NELB: Correct. Yes, the evaluation -- again, most of the data was from before 2012.
6 There is a discussion, obviously, about some of the changes and potential implications, but there
7 isn't any data in this report about those.
8 CHAIR ROWLAND: And I would remind the Commission that when the hearing took place on
9 CHIP we did submit a letter then, outlining what our previous recommendations were. And some of our
10 recommendations, I think, do relate to some of the issues in this report that we might want to reiterate in
11 the response.
12 But I'll start with Judy and then Richard.
13 COMMISSIONER MOORE: I do think we should reiterate the positions that we've taken before
14 even if some of them don't match one-for-one with the information in here since this has just finished with
15 2012 and I think we're kind of beyond that.
16 And I think acknowledging the continued successes and applauding those is appropriate.
17 On the issues of transition and low understanding of renewal, to me, those are generic issues,
18 whether you're talking about just the CHIP program or in the wider, brave new world of QHPs and

1 exchanges and the marketplace issues, and people moving in and out, and off and on Medicaid and CHIP
2 and other plans.
3 And I think it would be appropriate to suggest that these issues should be addressed not only for
4 CHIP but generically across the board for all these programs. Renewal requirements and transition
5 problems are going to exist for the foreseeable future, and we really need to be addressing them all, not just
6 with CHIP but with the other programs as well.
7 COMMISSIONER CHAMBERS: Thank you, Robert. Very good presentation.
8 I was interested in the issue about the crowd-out. You mentioned that the rate was very low, the 4
9 percent, which was much lower than other studies have shown.
10 So I think what would be of great interest is what's happening with current, say, policies and
11 requirements on preventing crowd-out.
12 If the rate is, in fact, that low, like ultimately is there an opportunity for recommendations to change
13 that policy?
14 So I would be curious to see --
15 CHAIR ROWLAND: And actually, Richard, that does go with our early recommendation that we
16 eliminate the waiting periods for getting onto the program, which is a big obstacle within CHIP that we
17 don't have in other programs.
18 COMMISSIONER CHAMBERS: Good. So I think if, in fact, that does hold up, that it's that

1 much more of a justification or support for the recommendation, if the studies are showing so low.

2 So, thank you.

3 COMMISSIONER CARTE: Robert, you mentioned as an area for comment, gaps in quality and

4 access to care.

5 And I'd just like to note that an important component of the CHIPRA legislation was the creation

6 of the pediatric quality demonstration grants which are just now drawing to a conclusion. So I would hope

7 that we would be looking at the results of what evidence or where those demonstration grants have built on

8 our knowledge base.

9 And the issue for pediatric quality, I think, is one that often gets a secondary focus anyway, and I

10 would hope that we would, in the future, look at ways to reinforce that even in the absence of CHIP.

11 MR. NELB: I just want to point out I will be back tomorrow, presenting on the child core quality

12 measures, an update on that.

13 COMMISSIONER GRAY: The finding number 6 points out that 1 in 4 CHIP enrollees reported

14 some type of unmet health need. I'm curious about that, whether you can elaborate on it.

15 Is it because of the actual benefit coverage itself that's all over the place in those 10 states or all 50

16 states?

17 Is it because of cost-sharing?

18 Is it because expectations are too high?

1 Any sense of -- can you elaborate on that?

2 MR. NELB: Sure. So half of the unmet need was due to dental. So that's, I think, an important

3 area.

4 And let's see.

5 CHAIR ROWLAND: Burt is very surprised at that.

6 MR. NELB: Yes. And the next highest were prescription drugs followed by just other areas of

7 need as well, again, which is comparable to the private insurance but still an area to be cognizant of.

8 COMMISSIONER EDELSTEIN: Judy's comments and Herman's comments remind us of our

9 original model in which we considered coverage to be an important facilitator of access but not a complete

10 answer to access.

11 And so I'm anxious that we not mischaracterize the remaining high levels of unmet need.

12 Coverage has taken us in a significantly positive direction, but it hasn't solved all the problems of access and,

13 therefore, not all the problems of unmet need.

14 Looking at MEPs analyses, since 2002, dental utilization by working-age adults has declined steadily,

15 but the advent of CHIP has ensured that, according to MEPs, utilization by children has steadily increased.

16 So there's been a not quite linear but regular increase in dental utilization subsequent to CHIP.

17 I think the Commission needs to pay attention to both its coverage concerns and its access concerns

18 to realize that this is not -- the remaining high levels of unmet need do not reflect failure of coverage.

1 They reflect that coverage can only take you so far, and then we have to address the other issues of access.

2 CHAIR ROWLAND: In terms of some of the questions of unmet need, did behavioral health

3 come up at all? Is that not an area that varies tremendously across the states?

4 MR. NELB: Yeah, so behavioral health -- so, again, about 25 percent had unmet need. About 4

5 percent of that unmet need was behavioral health.

6 Again, this is sort of the parents' reporting about their child's health status, and I will be presenting

7 tomorrow on some more clinical quality data that I think might get at these issues more accurately.

8 CHAIR ROWLAND: We will be presenting on it in the next session, too.

9 MR. NELB: But, yes, yes.

10 CHAIR ROWLAND: One of the areas that I think would be important in a comment letter, in

11 addition to the ones we've just discussed -- the Department is now starting to put out enrollment statistics

12 with performance standards and has just recently added children to that, but I think it would be very

13 prudent for the Commission to use this opportunity to inform the Secretary as to what we think are some of

14 the measures that ought to be considered so that future evaluations have some data to draw upon.

15 Trish, did you have your hand up and I missed you?

16 COMMISSIONER RILEY: I was sort of where Herman was because I think finding 6 is

17 intriguing, recognizing that it's self-reported data from parents.

18 But the fact that Medicaid and CHIP enrollees report comparable experiences as children with

1 private insurance would fuel those who think it's a simple transition to simply move these CHIP kids into an
2 exchange product. And I don't think we should undervalue that perception, but we really need to weigh it
3 against the clinical data that we know exists.
4 But I think it's worthy of comment because, standing alone, it seems to me to suggest things that
5 may not -- it may suggest things that may not be documented in the evidence.
6 CHAIR ROWLAND: Sara?
7 COMMISSIONER ROSENBAUM: Yeah, I do; I have a question that actually relates to your
8 observation, which I was surprised about.
9 And I think I was looking for the statistic recently, and I couldn't find it, and I don't know if it
10 shows up in the report.
11 But one of the reasons why I think this whole discussion about CHIP and its relationship to
12 Medicaid and its relationship to the exchange coverage ends up getting quite confused is that we certainly
13 know that there are states that administer CHIP as a Medicaid expansion and states that administer CHIP as
14 a separate program.
15 But what we don't know, it turns out -- and I went to colleagues who study CHIP much more
16 closely than I do to try and find the answer, and they didn't know -- is the number of states in which CHIP,
17 as a separately administered program, is administered as a form of premium assistance rather than as a
18 state-administered insurance program because that adds another layer of complexity to CHIP.

1 It begins to make CHIP look a lot more like what's going on in the exchange system but a much
2 better product, okay, potentially, at least in terms of cost-sharing.
3 And it raises the further question of how, in those states, how we even think about CHIP.
4 Is CHIP, at that point, public insurance?
5 Well, we don't talk about qualified health plans as public insurance. We're talking about them as
6 private insurance that you get a public subsidy for.
7 And so remarks like this one in the evaluation is a problem because you could push the whole thing
8 a step further and say in states in which CHIP is a Medicaid expansion and what states do is buy managed
9 care products. Is that -- you know, isn't that perfectly analogous to the purchase of a qualified health plan?
10 And so our thinking about how we characterize what is going on in these various insurance
11 affordability programs, which I think is the right way to think about it -- it's what CMS characterizes them as
12 -- is much more along a more subtle continuum than we're giving it credit for.
13 And I think one observation we might want to make in our comments is that we're not -- it's very
14 important to bring out the variation in the arrangements because by simply describing CHIP as its own
15 public insurance plan we're not catching all the nuances and we're not seeing the connections where we
16 need to see them.
17 CHAIR ROWLAND: Thank you very much.
18 And we'll look forward to seeing a draft letter to the Secretary and to the Congress that incorporates

1 many of these comments for us to send during this fall so that it doesn't take the full six months that the
2 statute gives us to comment.
3 Thank you.
4 And now we will turn to behavioral health, and Amy Bernstein will meet with us at tab 3 of your
5 briefing books.
6 **### SESSION 2:**
7 **BEHAVIORAL HEALTH SERVICES IN THE MEDICAID PROGRAM: BACKGROUND AND**
8 **POLICY ISSUES**
9 * MS. BERNSTEIN: Okay. Thank you.
10 Moving on, the Commission has previously discussed the unique role that Medicaid serves in
11 providing care to people with disabilities, and we're now beginning our focus for real on the large number of
12 Medicaid enrollees who are receiving behavioral health treatment, many of whom have substantial
13 disabilities.
14 When I say "behavioral health," just for the record, I'm using the term of art that's used by many
15 Medicaid programs, which includes both mental health and substance abuse treatment, which can be similar
16 in many ways and different in many ways. We should also note at the beginning of the presentation that
17 mental health treatment encompasses a wide range of conditions and severity of illness, so that in some
18 states, depending on the state, you could have almost three separate delivery systems: one of them for

1 people with, let's call it, "mild" conditions that don't cause substantial disability; people with severe mental
2 illness who may have profound disabilities, everyone in between; and then people with substance abuse,
3 which is often administered through an entirely separate system. However, we're still going to call it all
4 behavioral health so bear with me.

5 In this presentation I'm going to give you some statistics on prevalence and treatment to show the
6 magnitude and importance of this issue to the Medicaid program. I'll give you a little bit of information on
7 coverage and benefits and the complexity of the delivery system, which I'm sure you are all familiar with,
8 and then give you some very broad policy areas for your consideration so that you can help us focus staff
9 work over the next cycle. So please be thinking about issues that are missing or things that you would like
10 to focus on or things that for some reason you would not like to focus on.

11 Behavioral health, again, encompassing both mental health and substance abuse, is very relevant to
12 the Medicaid program. The Medicaid program spends more on behavioral health treatment than any other
13 payer, including private insurance. In 2009, the year where the most recent sort of aggregate statistics on
14 substance abuse spending are available, it's estimated that about 12 percent of overall Medicaid spending is
15 for behavioral health treatment. Based on a survey I'm going to describe in a few minutes, about one-third
16 of Medicaid enrollees age 18 and over have behavioral health problems and about 10 percent have what
17 have been classified as severe mental illness.

18 Enrollees with behavioral health problems are more expensive and harder to treat on average than

1 those without behavioral health problems, and expenditures have been increasing and are of concern and of
2 great interest to states.
3 Using recently spun data from the National Survey on Drug Use and Health -- there's an "on," not
4 an "of"; I always get that wrong -- or NSDUH, which is the major source of federal information on mental
5 health and substance abuse prevalence in the United States -- I will in a second give you some actual
6 statistics, which are also at Tab 3 in your binder at the very end, a copious amount of tables for those of you
7 who like to read through tables. This is a large survey of randomly selected individuals age 12 and older,
8 and it includes people in non-institutional group quarters as well as the civilian non-institutionalized
9 population, and this is actually kind of unusual for a federal survey. Most of them only include
10 non-institutionalized people. This includes people in college dormitories, civilians on military bases, and
11 people in group quarters, which are not included in, let's say, the National Health Interview Survey.
12 When we did this analysis, we divided people into three groups, people 18 to 64 years, all people,
13 and we compared Medicaid, privately insured, and uninsured people. Of that population, the people with
14 reported mental illness or substance abuse, because those are the ones ostensibly in need of treatment, and
15 then people in that age group with serious mental illness, who are with greatest need of treatment. And
16 then there's one table that I'm not going to present here on children. It's harder to diagnose or assess
17 mental illness in children so that NSDUH does not do it. There are some data on children with major
18 depressive episode and other things. But I'm not going to present that here, and, thus, I will move on.

1 So based on this survey, almost one-third of Medicaid enrollees age 18 to 64 -- and I should also say
2 I neglected to say I did not include people 65 and over in this analysis because so many of them are duals
3 and they have separate behavioral health issues, and we will -- we can sort of talk about them in a sort of
4 separate conversation. But in any case, if we're just focusing on non-elderly adults, about a third of them
5 who said that they had Medicaid coverage -- and, again, this is self-reported data, so, you know, this is what
6 they said.
7 CHAIR ROWLAND: And it's data prior to the Medicaid expansion.
8 MS. BERNSTEIN: Yes, it is. This is 2011 to 2012 -- well, 2010 to 2012 combined data so that
9 we had enough people with serious mental illness in order to make estimates. A third of them had any
10 type of mental illness as assessed by the survey compared to 17 percent of the privately insured and 21
11 percent of uninsured persons. And, again, 10 percent had serious mental illness, which is higher than both
12 of those other two groups. About 8 percent of both the Medicaid non-elderly adults and uninsured adults
13 had reported drug abuse disorders, compared to 4 percent of the privately insured, and about the same
14 percentage of youth, as they are called, age 12 to 17, had a major depressive episode comparing the
15 Medicaid and the uninsured population, which was greater than the privately insured population.
16 As far as reported treatment, about one-quarter of the Medicaid adults received some mental health
17 treatment in the past year compared to 14 percent of the privately insured and 10 percent of the uninsured
18 adults, so Medicaid is more likely to provide treatment. About half of those who are assessed to have a

1 mental health or substance abuse problem did not receive treatment, so half did, half did not. About
2 three-quarters of those with what was estimated to be severe mental illness and were on Medicaid reported
3 receiving some mental health treatment -- again, that means one-quarter did not -- compared to two-thirds
4 of privately insured and about half of uninsured. And about 10 percent of them, of the Medicaid enrollees,
5 23 percent with a behavioral health disorder and 41 percent reported that they did not receive needed
6 mental health or substance abuse treatment.
7 So it's not that they did not receive any treatment. It's that they perceived that there was additional
8 treatment that they might need. So sort of keep that in mind. Unmet need, but not necessarily no
9 treatment.
10 So just to also point out that Medicaid enrollees, in particular, with behavioral health conditions also
11 have a substantial amount of co-morbid acute or chronic medical conditions. So they are harder to treat.
12 They are -- at times. One study that was commissioned by the National Mental Health Directors
13 Association, I think, predicted that people with mental illness on average die about 25 percent -- 25 years
14 earlier than the general population, and not all of this is due to suicide or accidents, but a lot of it is due to
15 neglected and preventable conditions. And, again, this makes them more difficult to treat in a lot of ways.
16 So moving on, what does Medicaid cover? The mandatory Medicaid services include --
17 CHAIR ROWLAND: Can I ask you one question?
18 MS. BERNSTEIN: Yes.

1 CHAIR ROWLAND: Were you able to do anything with regard on the substance abuse to people
2 who are HIV positive?
3 MS. BERNSTEIN: No. The sample did not, from that analysis. We could look at that if you
4 want, but that's sort of a separate analysis. There aren't enough of them, and I am not sure that the
5 NSDUH asked that question. I didn't look at it specifically. I can check if that's of interest. I mean,
6 there's -- I mean, we can talk later, but the fact is that mental illness and substance abuse are co-morbid
7 conditions in so many disabled groups that it's a question of how you sort of separate them out.
8 So, again, the mandatory Medicaid services include necessary physician and inpatient services except
9 for stays in institutions for mental disease, which is called the IMD exclusion, which I will touch upon later,
10 and also necessary outpatient services are covered. States may provide optional services for behavioral
11 health. All states currently provide at least some prescribed medicines, although not necessarily all
12 behavioral health medicines that are needed, and these other things that are listed here, targeted case
13 management, rehabilitation, and peer supports, are among the most common. And as you all know,
14 services can also be provided under waiver and demonstration authorities, although these are less common
15 for adults' serious mental illness than many other HCBS waivers that are provided.
16 Substance abuse treatment, differentiating just for a minute, is a little bit different. Compared to
17 services for mental health disorders, Medicaid covers far fewer substance abuse services. And many states
18 have limitations of the amount and types of substance abuse services covered or don't cover certain services

1 like outpatient detoxification at all, or some states limit substance abuse services only for certain
2 populations, such as people with serious mental illness or people who are pregnant or other groups that they
3 identify, and there may be stringent limits on the number of visits or where they can receive treatment.
4 The Medicaid behavioral health infrastructure is even more complicated than many other Medicaid
5 infrastructures. In addition to Medicaid, there are numerous other federal, state, and local organizations
6 that provide mental health services. I've just listed a few. The interactions with the Justice Department
7 or the criminal justice system and the housing system and the education system are among the most noted,
8 sometimes. The Substance Abuse and Mental Health Services Administration provides grants to provide
9 treatment and education and services to this population. And at times these services and infrastructures
10 have different eligibility rules, different regulations -- some of them will treat families and not -- you know,
11 some of them won't. Some of them have different income limits. And this makes the system difficult to
12 navigate for an already very vulnerable population, especially those with serious mental illness or major
13 substance abuse problems.
14 Even within the Medicaid program, again, as you all know, there are carve-ins and carve-outs.
15 There are, you know, reasons that states have done this, to control costs, to have more predictable costs, to
16 align with behavioral health networks that are already existing. On the other hand, there have been, you
17 know, disadvantages cited having to do with underfunding and non-integration with the medical care
18 system. So these are things that states are struggling with right now. Sixteen of the 38 states in the last

1 Kaiser study available on this always carve them out, and in five states, behavioral health was always carved
2 in, but this is changing rapidly and in recent years more states have been making efforts to integrate more
3 behavioral health and medical care through waivers and demonstrations and just in general. And, again,
4 this changes frequently.
5 So that's a very high level, very fast overview. Obviously this is an incredibly complex area. I
6 could, we could all go on and on about, you know, what is going on and what the issues are. But we
7 thought that what might be most helpful for you is to sort of tell us where you want us to go, and I will list
8 very quickly some major areas, but I am sure that there are others. And, again, we just need direction.
9 So the first one is a general access question. Are the people who need these services receiving
10 them? What can be done to improve this? Is there sufficient supply of providers? Many say probably
11 not, certainly in certain areas. And what steps have states taken to address existing access problems?
12 And how can we learn from that and spread this information?
13 Payment is obviously an issue, and, you know, we know that costs are increasing. Areas of specific
14 increase that have been noted by many are the large increase in opioid use over time and the expense.
15 Psychotropic drug use is increasing for all populations, but especially for the Medicaid population. Foster
16 children have been singled out as a problematic -- an area that requires study about how to deal with the
17 increase in that population. And, again, what promising initiatives have been implemented to try to
18 address these concerns?

1 Integration of medical and behavioral health services that I alluded to before are of interest to many.
2 Many states are doing various things to integrate care. I should say integrating medical and physical care is
3 also a continuum, so it could be sort of anything from universal screening for mental health or substance
4 abuse in the medical system, and then, you know, triaging to the appropriate specialty system to complete
5 integration of services under one payment, and everything in between. States have tried collocation of
6 services, other strategies, but integration of medical and behavioral health services is not sort of one simple
7 thing. It's a combination of different strategies that states are trying.
8 Again, we can, and will, of course, track what states are doing, but it would be perhaps useful to
9 know what the advantages and disadvantages are of these different models.
10 I alluded to the Institution for Mental Disease exclusion previously. This is an issue that comes up
11 a lot. For those of you who are not familiar with this, I will give you a three-sentence description of what
12 the IMD exclusion is, which is that Medicaid legislation specifically prohibits individuals between the ages of
13 21 and 64 from receiving federal matching or federal financial participation for Medicaid services while they
14 are a patient in an Institution for Mental Disease. So this is -- they not only can't receive payment for the
15 institutional care; they can't receive payment for any care from Medicaid while they are a patient in these
16 institutions. And an Institution for Mental Disease is not just a hospital. It's any institution that is
17 deemed to contain more than half of their patients with diagnoses of mental disease, which includes
18 substance abuse. So basically all substance abuse institutions that have more than 16 beds are considered

1 IMDs, and they cannot receive payment.

2 So this interacts with many different portions of the Medicaid system. One is long-term services

3 and supports. So, for example, if a nursing home has more than 50 percent patients with a diagnosis of

4 mental disease, they would be an IMD and can't receive payment. Anyhow, so one -- and there are actually

5 many other issues with long-term care that I won't go into now.

6 Substance abuse treatment, as I noted, is problematic in that all substance abuse facilities, residential

7 facilities, are considered IMDs if they have more than 16 beds. The mental health parity legislation that

8 requires that mental health and substance abuse be treated the same as all other medical treatment with

9 respect to co-payments and other payments is -- it does apply to new Medicaid plans. However, the IMD

10 exclusion still applies. So, for example, in California, if you were admitted -- if you were treated at a

11 residential care facility for substance abuse, you would have the same payments. Unfortunately, you can't

12 go to that facility. So the argument there is that they could get some other kind of treatment, but, again,

13 there are issues there.

14 And then the last issue that I'm identifying here -- and I'm sure there are others -- is how the IMD

15 exclusion interacts with the EPSDT program. EPSDT, as you all know, is supposed to provide all

16 medically necessary services to children under age 21, including all mental health and behavioral health

17 services. However, there are issues with the IMD exclusion, again, and other mental health treatment that

18 is basically being played out in the courts. And I will let Commissioner Rosenbaum explain it if you need

1 more detail on that.

2 As states expand their Medicaid programs, there is some literature that -- and some anticipation that

3 many of the new enrollees in the alternative benefit plans in the new adult group may have substance abuse

4 and mental health disorders. So if the system is already strained, will this strain it more? What is the

5 percentage -- or what are the needs of this new population? How will that affect what is already happening

6 in the existing system? And what are states doing to anticipate and to deal with this issue?

7 Oh. He told me not to do that, and I did it. I told you I was going to forget. He said, "Don't

8 do it."

9 All right. Sorry. He did, and I said, "I'm not going to remember." And I didn't.

10 Okay. So with that, and that, again, fast and very high level overview, we are eager to hear your

11 thoughts on where we should go in this important and increasingly important area.

12 CHAIR ROWLAND: I have a lot of hands, and I know we are going to start with David, because

13 he told me he wanted to start.

14 I just had one question first. On the substance abuse issue, isn't there also a prohibition in the

15 statute from providing Medicaid to someone whose sole diagnosis is substance abuse? I think that is also

16 important to note that they need a comorbidity to be covered by Medicaid. It was added to the Social

17 Security amendments.

18 David.

1 VICE CHAIR SUNDWALL: Amy, thank you. This is obviously an important issue for
2 everyone everywhere and not just Medicaid.
3 I was appreciative that you got some data on how big a problem this is; first of all, that it is not
4 overwhelming. It's big, but it's not -- it seems so daunting unless you get some data behind it.
5 I have some experience with a good friend in Morocco, of all places, which is our sister country for
6 our state. I've been there a number of times. The percentage of serious mental illness is consistent across
7 the globe in countries, so it's obviously a genetic component. That is a costly but a finite challenge.
8 Behavioral health is, of course, much bigger and more important than Medicaid patients for obvious
9 reasons, stress of not having a job, not having enough money, whatever education. So it's clear to me that
10 there are reasons why it would be a higher prevalence than in the general population.
11 But what I want to emphasize -- and I think the Commission can do a favor of -- we can do a
12 service. With your help, we really do identify those places where this integration is being done well. It's
13 cost effective.
14 I work in a primary care clinic, two half-days a week, sometimes three, and we have embedded in
15 our clinic, behavioral scientists, a medical social worker who does counseling and then another nurse
16 practitioner who can prescribe. And for those of us who are primary care physicians and see people who
17 are mentally ill, we get very challenged by the polypharmacy, and we need the expertise of people that can
18 prescribe that safely. And so to have them in primary care clinics is such a big plus, and I know we're not

1 unique.

2 Intermountain Healthcare has helped fund something with the State of Utah where we have this

3 benefit of having mental health workers on-site, but it really is a boon both for the patients and the

4 providers, and I'm confident it saves lots of money. So I would recommend that we try and identify these

5 sorts of demonstrations that ought to become common practice in Medicaid and covered.

6 Thank you.

7 CHAIR ROWLAND: I will just go through what I have, so anyone I am missing can raise their

8 hand. I have Andy, Judy, Sara, Trish, Donna, Denise, and Mark. Okay. So I'll start with Andy.

9 COMMISSIONER COHEN: Amy, thanks. It's such a big and complicated topic. I can't say

10 how pleased I am that we're back sort of grappling with it again, because I think this is really a huge issue for

11 the Medicaid program and for the beneficiaries, and I just want to kind of reiterate a little bit kind of how I

12 think about this issue and maybe some thoughts about approaching it.

13 There's a few places -- Medicaid was really built as a program. Sara, you will correct my bad history

14 if it is wrong, but it was meant to be like a low-cost payer of services in the delivery system generally that

15 already existed, but there are certain areas that we have talked about in our work where Medicaid has

16 become like the leading payer and therefore has some responsibility not only to think about like is it efficient

17 payment for a service that is sort of received out there in the world by people who have lots of payers, but

18 really is like highly responsible for the design of the very delivery system that serves everyone. And that's

1 true in maternity care to some extent and definitely in behavioral health.

2 So this is sort of not just thinking about payment, but it's really thinking about how does Medicaid

3 affect the whole delivery system and how can it sort of lead maybe into some improvements. And

4 improvements just in terms of thinking like what is the problem, what are the problems that we are thinking

5 about, behavioral health, I think you really have to lead with the outcomes for people with mental illness

6 and substance use are just horrendous and so disparate from the general population, early death and sort of

7 terrible disability and lost years of productive life.

8 So, to me, that is sort of like the central problem that we really need to think about as sort of how is

9 it possible for Medicaid to actually improve the quality of care and the outcomes for this population, so

10 many of whom are in this program.

11 So not that that is a super narrowing way of thinking about it, but, I mean, to me, this is not about --

12 to me, at least, you would be missing the boat if we sort of dived into the IMD exclusion, which I think of

13 sort of at this point with so many years of history as primarily like a state-federal money issue and maybe a

14 little bit less sort of a fundamental delivery system issue.

15 Similarly, while the issues of polypharmacy and prescribing and things like that are so important,

16 again, that's sort of like a very specific set of issues, where to me the larger set, there are some possible

17 interventions.

18 For one thing, I think that looking at this sort of topic just raises, again, a set of issues that comes up

1 again and again for us, which is that even in places where there are models that really are fairly well
2 evidence-based and established, for example, assuming you're talking about something like collaborative care
3 models and other models of integrating behavioral health into primary care practices, but there are many,
4 many other forms of integration.
5 There is no sort of good mechanism for Medicaid to pay for that. I know in New York State, there
6 was sort of some like, you know, contorted demo to try to really expand the use of collaborative care, but
7 it's time-limited money and a whole bunch of practices sort of really invested in an effort to develop primary
8 care -- to collaborative care. It does cost more up front, however. The funding may be going away, and
9 it is just sort of this question of how can Medicaid adapt a bit when there is a really strong evidence base for
10 certain kinds of innovation.
11 So, anyway, those are just some framing points, and I think I will leave it there, but thank you.
12 Actually, I'm sorry. One more thing, and I'll be really quick about it.
13 You talked in Slide 3 about trends, about how expenditures for the behavioral health population are
14 increasing, and I think one thing that I just wanted to clarify with you, because I think it is really important
15 for us in thinking about what the sort of problems are, is that increase in their overall health spending, or is
16 it in their behavioral health spending? My guess is that it's the former, but I think that that is a really
17 important point, whether we're talking about the costs of -- the total cost of a population or whether we are
18 talking about behavioral health costs in particular.

1 MS. BERNSTEIN: These are behavioral health costs in particular.

2 COMMISSIONER COHEN: Increasing at rates that are out of whack with other increase trends?

3 What do we know about that?

4 MS. BERNSTEIN: I don't have the numbers on the top of my head, but the $44 billion and the

5 increases up to that $44 billion is done with a methodology that is like the national health expenditures

6 accounts, except that it focuses on mental health and substance abuse expenditures.

7 So it's not people at all. There are no people involved. It's just expenditures, and the increases, I

8 believe, are higher, maybe not in every recent years, but certainly from the 2000s and 1990s.

9 CHAIR ROWLAND: Do you know what share of that is prescription drugs?

10 MS. BERNSTEIN: They do, but I don't have the number with me. I'm sorry.

11 COMMISSIONER COHEN: Thank you for that conversation. So then I would just say since

12 we have the luxury of not being budgeteers, to me that does not in and of itself sort of like identify a

13 problem that we sort of would need to address from a cost perspective. I think looking at the overall cost

14 of care for that population is a different issue.

15 Many people would argue -- I don't know if they are right or wrong, but would argue that if there

16 were more and more effective behavioral health services that they -- in general, their overall costs for health

17 care could be actually decreased or at least the growth stop.

18 So I just want us to be careful in terms of what conclusions we leap to from that statistic.

1 COMMISSIONER MOORE: Thank you, Amy. This is a daunting topic, and you've done a
2 really nice job of separating out some pieces, so that we can kind of get our heads around it a little bit.
3 I like what Andy said in terms of the overall context of this and the fact that Medicaid has
4 increasingly taken over funding for a lot of historic reasons that go back to changes in medical practice and
5 especially practice around behavioral health.
6 But that said, I think we find ourselves in a position of really needing to try to come to some priority
7 areas that we can focus in on and maybe make a dent or have some impact, and for me, those areas would
8 be around the impact and valuation of standards for this idea of integrating care, how is it going, around
9 access and payments, which were mentioned before.
10 There's a lot out there. I don't know what we know about it. There may very well be studies that
11 have done some comparison and contrast, but I think it would be valuable if we could learn more about that
12 and be helpful in terms of letting successful models rise to knowledge -- the general knowledge base.
13 Secondly, I think looking at age groups and prioritizing age groups for which we might spend some
14 time and attention around duals, which I know you didn't get into here, but the pharmacy issues, especially,
15 I think we can learn something from there. And I think that's an important group that we should be
16 considering.
17 And also, children and the difference between the group that we call "youth," but also the very small
18 children. I know a lot of state Medicaid programs have looked at pharmacy benefits from children under

1 five, children even as young as under two, regionally and across the country, and I think as a country, we
2 need to pay some attention to that and follow what they are learning.
3 Then finally, I think it would make sense -- and I don't know that others would agree with me, but I
4 think it would make sense, 49 years after the beginning of Medicaid, when the world has changed so
5 dramatically around behavioral health, to take a very kind of zero based look at the IMD exclusion. In
6 fact, most states are serving that population through waivers, through new DRA provisions in a whole
7 variety of ways, and I'd like to know what it might cost to have a different provision around IMDs and just
8 know more about it. I just think the time has come for some more thinking about that and not to just
9 continue it forever.
10 CHAIR ROWLAND: Sara?
11 COMMISSIONER ROSENBAUM: So I thought Judy's list was great.
12 The one thing that I would add -- I can add it, you can add it -- is the issue of health homes. We
13 have the sort of two strange -- two things that seem to be at odds with one another. One is attempting to
14 rethink what is a primary care setting for people with mental health and substance abuse disorders, where
15 we're trying to pull everything together for them, and the question is how does that fit into a world where
16 states are still using carve-outs.
17 It seems as if a decision has been made that we want to integrate, but in terms of the broader range
18 of services, maybe the jury is still out. And so I'd like to know more about how the health homes

1 movement juxtaposes with managed care movement and whether we are moving big financing around up
2 here in a way differently from how we are moving financing around the primary care level, or if the
3 carve-outs are for very specialized services and well-marked for the health care systems that need to call on
4 those specialty services, so that would be an area to spend some time on.
5 CHAIR ROWLAND: Trish.
6 COMMISSIONER RILEY: I'd like to trigger off where Andy was headed, I think, around costs,
7 because the paper in the slide talks a lot about pharmacy costs, and I think that's just way too narrow a
8 viewpoint, though there are particular off-label issues that I think need further exploration. And I would
9 agree, it has to be about the total health care cost, much like when we talk about our long-term care
10 population.
11 And I think it kind of triggers into the question of what works. Your paper talks about 41 percent
12 say they have an unmet need, and that really raises questions for me about what are they getting from the
13 very expensive services and very extensive services now available. What's the unmet need, and how much
14 -- that begs the -- I feel like Patty. In her absence, I will have a three-stage question.
15 But it raises a bigger question about how did we get here. What works? Where is the evidence?
16 We need to focus far more on that. And how did we get here? Many of the ways we created this system
17 was through Medicaid maximization of mental health state dollars, and whether that was necessarily driven
18 by evidence or by money, I think is a big question.

1 There are big issues about sister agencies here that I think we need to address, we've addressed a
2 little bit in our administrative chapter, and there is real conflict sometimes between approaches by sister
3 agencies, who controls the budget, what does this system look like, what are we getting for the money we
4 are spending today before we try to go after the 41 percent of unmet need. I mean, in many ways, we need
5 to zero-base the whole discussion, not just the IMD one.
6 And I think the sister agency issue may be highlighted by two points. One is those dually
7 diagnosed with substance abuse and mental health disorders, two conflicting service approaches, two
8 conflicting sister agencies sometimes.
9 And even in the health homes issue, it strikes me, are there any examples we could look at where
10 instead of saying we are going to move -- we are going to expect a primary care doc in a primary care
11 location to take on the mental health situation, have there been any experiments where we take the primary
12 care doc and put him or her in the mental health center and try to reconstruct a different model of health
13 homes. And I think that sort of whole set of areas would give us some depth to this discussion that is
14 already rich, rich, rich.
15 CHAIR ROWLAND: Perfect. Okay. Then I have Donna, Denise. Donna first and then
16 Mark.
17 COMMISSIONER CHECKETT: Well, Amy, this is so interesting.
18 The one fact that to me like shouted out this -- of your work here that I've seen before and that I

1 know within my own group, within the group I work with we've seen, people with a dual diagnosis dying 25
2 years earlier than people without. It's shocking.
3 And I know your research shows -- and I have seen elsewhere too -- is that not only do they die
4 young, but they cost more in the process, and I think it's really disturbing, and I think we really need to step
5 back and look at that, and I think your calling out in your report I think for the Commission is the
6 beginning of what I think can be a very fruitful analysis.
7 One of the things that strikes me is, in Medicaid, in terms of system delivery and care delivery, we
8 are moving toward integration, and yet we continue to have in so many states a behavioral health carve-out
9 if there is a managed care system. And I understand a lot of that was evolved when states were starting
10 managed care. There was a lot of suspicion and concern about what was going to happen to people with
11 behavioral health, especially people with serious mental illness, so I understand all that.
12 But a lot of times -- that's now 20 years -- that was 20 years ago, and I really think that we need to
13 start looking at where there are carve-outs, why are there carve-outs, do we see difference, because the
14 people who are dying 25 years young and costing more in the process, they are not dying because they had
15 behavioral health, and they are not dying because they had physical health. They are dying because they
16 had both, and that's my concern about states that are continuing to hold onto a carve-out model.
17 When you've got people who are our sickest being treated by one system and treated by another
18 system -- and they are not even sharing data -- I think it is incumbent upon us to really question how is that

1 good for anybody. And I am not even going to talk about costing more. I am just going to say how is
2 that good for anybody.
3 So I really think we need to look at it, and I'd like to look at it in terms of who is doing what, why.
4 I know one of the things I have heard states say, well, the traditional, like the TANF-CHIP managed care
5 companies, they just carve out behavioral health to another company, anyway, so why bother? And I
6 think, is that still true, and is that different as opposed to companies that have full plans and have full
7 integration? And so there's just a lot of ways to cut it.
8 The focus I think really has to -- we have to keep going back to that 25-years-early concern, and I
9 guess I will end there.
10 I think IMD -- I think we need to look at IMD, as well, because I'd also question why. I get what
11 Andy is saying: Yes, it's just been around a long time. But why? And again, I'm just going to keep
12 going back to 25 years earlier and costing more and saying why is any of the status quo going to be okay
13 with the Commission.
14 Thank you.
15 COMMISSIONER HENNING: I guess I need my mic.
16 I want to channel Sara in that I think primary care medical homes are really becoming more of an
17 emphasis, just like what David said about what they do in their clinic. And what we do in mine, my
18 federally qualified health center, is we have a psychologist available in women's health, four out of five days

1 a week, and on the fifth day, she is over in family practice, in a different building but definitely accessible.

2 We integrate mental health with physical health, and I think that's one of the reasons why you see

3 better outcomes with people that get treated for their mental health issues because it's kind of a

4 chicken-and-an-egg kind of thing, whether are you depressed because you've got diabetes and arthritis so

5 bad in your knees because of your obesity, or is your obesity and diabetes contributing to your depression.

6 So you pretty much need to treat both, which we do in our clinic, and it's wonderful.

7 I see them. I identify, and we have found so many more people with depression just by screening,

8 by using standardized screening tools, then sending them to the psychologist, and then she refers them back

9 to me if they need medication. So it works really well.

10 And just another point that I'm sure Norma would agree with me, that many, many states could

11 easily increase access to mental health care if they just reduced unnecessary restrictions on nurse practitioner

12 practice. There are a lot of unnecessary regulatory restrictions out there. If we could practice to the full

13 extent and scope of our abilities as providers, there would be a lot more of us out there helping to treat

14 patients that needed the care.

15 COMMISSIONER HOYT: Well, people have hit a couple of my hot buttons already, but I'd be

16 interested in what best practices do look like right now for just tracking, prescribing drugs for kids. I'm

17 kind of on the integration between the two, how people are doing that, so that both docs or psychiatrists

18 have some place to go to, how do they access what other drugs kids are on.

1 I also don't know if this fits in here, but autism is such a big deal. Should we probe autism a little
2 bit and see how that's trending now? I don't know what best practices look like there. Just how states are
3 dealing with what seemed to be an epidemic of autism for a while, it just seemed inexplicable, the prevalence
4 of it and utilization.
5 Last comment I had, this could be a whole can of worms, but I think it's pretty significant. Trish
6 or somebody already mentioned the different agencies that get involved here. Everybody knows there's a
7 whole bunch of different states that close their state mental hospital, and it seems like a huge proportion of
8 those people ended up in the jails and in the correctional system. I am just thinking we ought to try to
9 probe that a little bit, too. This is not just Medicaid, but there's a lot of Medicaid dollars that go through
10 the correction system, and I don't know what's going on right now inside the correctional system relative to
11 behavioral health, because it seems to be totally unmanaged.
12 CHAIR ROWLAND: Well, it is also related to the fact that with the new Medicaid eligibility
13 provisions, there's going to be much more of a flow between the correctional system and the Medicaid
14 program and how do we look at that.
15 COMMISSIONER CARTE: Amy, thank you for this wealth of information around this really
16 complex topic, but I think for me, what's exciting about it is the Commission, hopefully, will start to look at
17 these things and how do we now bring an end to the era of mental health care by exclusion, whether it's
18 exclusion from those patients who were dealt with by putting them on a bus to another state or whether it is

1 the exclusion of those children who churn between CHIP and Medicaid. And on one hand, you are being
2 asked to prior-authorize for more services for children in mental health, but then you find that they have
3 gone to a private coverage or CHIP coverage, and suddenly, they're discharged, and they don't need services
4 anymore, that kind of exclusion.
5 Even the exclusion of IMD was rooted back to the Civil War years when the care of the mentally ill
6 was really the provision of states having responsibility for their care, and that now comes to an end.
7 So I hope that the Commission will turn its attention to health homes, especially for the severely
8 mentally ill. There has to be a place where these people get care, the whole person care that they need, and
9 it won't matter if they are sitting in the private insurance bucket or the affordable sliding care scale or the
10 public insurance bucket. So it's pretty exciting, really.
11 CHAIR ROWLAND: Thank you. Norma.
12 DR. NAYLOR: Just thank you for the report.
13 Just to add to what Denise was saying, and that is that SAMHSA, which is a federal agency you
14 mentioned, did not acknowledge psychiatric mental health nurse practitioners, and it was just about two
15 months ago that they finally did. It was based on the American Academy of Nursing, the Psychiatric
16 Mental Health Expert Panel. We got together, and we started writing letters to SAMHSA saying, "You
17 need to acknowledge us as someone who is able to provide mental health care," because they did not.
18 The other is that in South Texas, because we have lack of psychiatrists, psychologists, mental health

1 professionals, we are utilizing psychiatric mental health nurse practitioners who now it's mandated that they
2 are able to cover across the whole life span. It's just not an age group. They have to be able -- all the
3 studies are directed to across the life span -- children, adults, senior citizens. Because of the lack of mental
4 health professionals, it is a tremendous problem with the uninsured and those in poverty.
5 CHAIR ROWLAND: Well, Amy, I think you can tell that this topic is one that the Commission is
6 very interested in pursuing with much greater detail and a much broader range of options. I am hearing a
7 lot about looking at integration, a lot about health homes and their role, scope of practice, and the role of
8 different levels of expenditure versus the behavioral expenditures versus total.
9 So I think it's an important one for us to pursue, but I also think that much of the data you've
10 presented is just not available, and that one of the first things we should try to do is to get out some form of
11 a DataNode or something that really puts some of these statistics out there for people to use. And I really
12 hope we can build on that for our March report, as well, and have a really strong behavioral health chapter
13 in the March report.
14 And because Patty is not here, I will have to add one piece Patty would want. As we look at this, it
15 is such a complex system today. How do we simplify it? How do we make it more user-friendly? Part
16 of that gets into the point, I think, that Trish raised, which is, administratively, some of these problems
17 come from the structure of how mental health benefits are handled at the state level and to really look more
18 at the different model states have used for where the Medicaid agency has authority, where it doesn't have

1 authority.

2 But I think this is a great contribution and a really good start, so thank you.

3 And at this point, if anyone joining us in the audience has a comment they'd like to offer, if you

4 could queue up at the microphone, identify yourself and your association.

5 **### PUBLIC COMMENT**

6 * MR. GORDON: I'm Stuart Gordon with the National Association of State Mental Health

7 Program Directors, Amy. We're excited, we're absolutely thrilled that you guys are undertaking this topic.

8 It is many faceted.

9 If I can, let me suggest one more area for you to look at. Peer support, given the shortage of

10 psychologists and psychiatrists, and in some states even social workers, to deal with the people, Medicaid

11 programs have approved reimbursement for peer support in 33 states. In case you're not clear on what

12 peer support is, it's enlisting those who have undergone treatment, who have had the conditions that are

13 being treated and helping to serve and support the individuals in the programs.

14 We urge you to look at this in the Medicaid context but also in the context of the exchanges.

15 NAIC is currently revising their Model Act on access, and we have sent them a letter suggesting that when

16 they're looking at network adequacy they also look at the availability of peer support.

17 So we think that's an important issue, and we hope you'll look at that as well. Thank you.

18 CHAIR ROWLAND: Well, thank you very much.

1 MS. MARESCA: I'm Andrea Maresca, Director of Federal Policy and Strategy at the National
2 Association of Medicaid Directors, and I'll echo my colleague Stuart's appreciation for the Commission
3 paying attention to this issue today and your commitment to take on these issues going forward. It's a
4 timely topic, and as Ms. Bernstein mentioned, there is a lot going on in this space, as you all well know.
5 Just last night, for those who haven't been paying attention to their e-mail, CMS issued guidance that
6 tackles substance use issues and how they plan to move forward with states through their innovation
7 accelerator program, which we're also very interested in. I just wanted to flag for all of you that it's
8 something we're certainly going to continue to work closely with them, and I'd say that well over half the
9 states are interested in exploring how they can transform their approach to behavioral health and their
10 delivery and payment models. So this certainly is an evolving area, and I think it's really hard to pinpoint
11 data and to say this is working, because so much is going on, and it's happening right before our very eyes.
12 So I guess sort of a word of caution about not -- about whatever you explore is simply a snapshot at this
13 point in time, and that there's so much change that's going to happen over the next many years.
14 I also appreciate and want to echo many of the Commissioners' comments around the IMD issue.
15 It's something that we as an association have heard a lot from our members about and believe it's
16 appropriate for the Commission to tackle this issue. It is a statutory barrier to transformation in many
17 states. Certainly there are many other dynamics that impact behavioral health transformation. Some of
18 those are resource related, some of those are political, some of those are political will. But the IMD issue

1 is something that this Commission can certainly weigh in on and have an impact on in federal policy. So
2 we would really appreciate your attention to that, and this is a real opportunity to dig into that particular
3 issue, so thank you.
4 CHAIR ROWLAND: Thank you. And I would say to both of our two speakers so far, if there
5 are models that you think we should look at or places that we could really pursue as examples of good
6 integration and of good models, we'd appreciate knowing that.
7 MS. HOWELL: Hi. I'm Embry Howell from the Urban Institute. I want to point you to some
8 data that ties together your two topics today.
9 We started out with a puzzling finding that removing maternity care, boys are more expensive than
10 girls under Medicaid using national claims data. And so we wanted to dig out the source of that difference.
11 We found it was concentrated in two populations -- here when I say "boys," I mean all the way
12 through adolescence -- SSI and foster care. Among those -- and when you remove those populations,
13 there's no gender difference between boys and girls. When you look at those two populations, the main
14 source of the gender difference is mental health and substance abuse, and we have a brief on our website
15 that parses out the cost by type of service. It's in ten states only, so ten states are ten states.
16 MS. BERONIO: Hi. I'm Kirstin Beronio. I work at HHS for the Assistant Secretary for
17 Planning and Evaluation. I direct our Behavioral Health Policy Division, and I just wanted to make you
18 aware of some resources that might be helpful to you, particularly since a number of people mentioned

1 health homes.

2 We are in the middle of a multi-year evaluation of the Medicaid health home benefit, so we'd be

3 happy -- we do have some first-year findings that are posed on our website, and we'd be happy to talk with

4 staff further about sort of what we've been finding there.

5 I also wanted to mention that SAMHSA has a large grant program called the Primary Behavioral

6 Health Integration Program where they are actually focused on bringing primary care into community

7 mental health centers, community behavioral health centers, and that is also something that goes on a lot in

8 the health home. A lot of the health homes are actually sited in community mental health centers.

9 I also wanted to mention on the IMD issue that the ACA actually authorized a demonstration

10 program to look at lifting the IMD exclusion in private psychiatric hospitals. So that demonstration

11 program is ongoing, and there is an evaluation ongoing for that as well.

12 And on the issue of delivery system reform and where Medicaid can really be a leader and has been a

13 leader, you know, Medicaid funds many types of services in the rehabilitative space that private sector

14 coverage does not offer. So supported employment, for example, is a type of intervention that has been

15 proven repeatedly to have really helpful effects in terms of employment outcomes for people with serious

16 mental illness. There's a variation on that, which we're very interested and have a study currently

17 examining, where you provide those kinds of supports to help people re-engage in education, because as we

18 know, some of these more serious mental health conditions often arise when people are in their late

1 adolescent/early adult years, and it really disrupts their educational outcomes. So we're looking at ways we
2 can better help people get back to school and really engage in rewarding employment, which we think really
3 does have a positive effect on other, you know, aspects of their condition.
4 So, anyway, happy to follow up if anyone is interested in learning about some more of our studies.
5 CHAIR ROWLAND: Thank you very much, and we sure will follow up.
6 MS. SCHIFF: I'm Maria Schiff, and I'm with Pew Charitable Trusts, and I am project director of a
7 study that is looking at state health care spending across various programs, including substance abuse and
8 mental health, but also correctional health, and so I wanted to underscore what one of the Commissioners
9 talked about in terms of looking at costs of behavioral health to the state. Medicaid is certainly a large
10 payer, but correctional health shouldn't be underestimated, and not only in terms of a single stay, but high
11 proportion of recidivism has been attributed to individuals with untreated substance abuse or mental illness.
12 And we're particularly looking at the opportunities in expanding states for continuity of care for the
13 first time for exiting prisoners who might for the first time have the opportunity, if they were stabilized, in
14 prison, on a particular medical, pharmaceutical regiment to be able to continue those meds on the outside.
15 And I'm sure there are plenty of researchers hoping to see a lowering of recidivism in the coming years as
16 more and more of this population gets released from prison and integrated into the community.
17 CHAIR ROWLAND: Thank you very much.
18 Any additional comments?

1 [No response.]

2 CHAIR ROWLAND: If not, we will stand adjourned until one o'clock, and thank you all for

3 being with us this morning, and thank you to the presenters and the Commission.

4 * [Whereupon, at 11:52 a.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]

5

1 AFTERNOON SESSION [1:08 p.m.]

2 ### *SESSION 3*

3 **STANDARDS FOR ACCESS TO CARE IN MEDICAID MANAGED CARE**

4 CHAIR ROWLAND: If we could please reconvene, we're pleased to start this session on
5 standards for access to care in Medicaid managed care and with our three participants joining us today. We
6 obviously as a Commission are very interested in making sure that the access to care for Medicaid and CHIP
7 beneficiaries is of high quality and is always available to them to meet their health care needs, and so we are
8 always pleased to have others provide us with some information that can help inform our deliberations.

9 So I'm pleased to welcome Meridith Seife, who is the Deputy Regional Inspector General for New
10 York at HHS Division, and who is going to present us with a summary of the Office of Inspector General's
11 recent report entitled "State Standards for Access to Care in Medicaid Managed Care" issued in September
12 of this year, and to have with us from CMS James Golden, the Director of the Division of Managed Care
13 Plans at CMS, and a recent transfer from the State of Minnesota. And also back with us again is Cheryl
14 Roberts, the Deputy Director for Programs in the Virginia Medicaid program, and it's always great to have
15 you with us as well.

16 So I'm going to ask you to just speak in the order that you're seated, with opening remarks first on
17 the Inspector General's report.

18 * MS. SEIFE: Good afternoon. Well, I'm pleased to be here today to share our research with the

1 Commission and to talk about our new study on state standards governing access to care.

2 As you know, this is a time of rapid expansion for our health care system. The Congressional

3 Budget Office predicts that there will be 18 million additional Medicaid enrollees by 2018 as a result of the

4 ACA. Most of these new enrollees are expected to be served by Medicaid managed care plans.

5 Given the magnitude of these changes, we wanted to get a sense of whether enrollees are

6 experiencing problems getting access to care and to review what mechanisms states are using to avoid and

7 address these problems.

8 State standards are an important mechanism that states use to ensure that plan enrollees have

9 adequate access to care. These standards establish minimum thresholds that must be met by all Medicaid

10 managed care plans in the state. They ensure that each plan's provider network is adequate and that the

11 services can be provided on a timely basis. Federal regulations require that states establish these access

12 standards, but states have considerable latitude in the standards they establish for their plans.

13 After surveying each of the 33 states with risk-based managed care plans, we first identified the most

14 common types of standards that were established within those states.

15 First, there were standards that require appointments be provided within a certain frame.

16 Second, there were standards that limit the distance or amount of time that enrollees should have to

17 travel to see a provider.

18 And, third, there were standards that require a minimum number of providers based on the total

1 number of enrollees.

2 Almost all 33 states had established at least two of these standards, and many relied on all three.

3 Although the types of standards were often similar, there were considerable differences among these

4 states. For example, one state requires one primary care provider for every 100 enrollees, while another

5 state requires one provider for every 2,500 enrollees.

6 Similarly, wait times for routine appointments with a primary care provider ranged from a low of 10

7 days to a high of 45 days.

8 We also identified a number of instances where there are gaps, meaning that the standards didn't

9 always cover key provider types or all portion of the state. For example, some states had no standards that

10 applied to specialists. Ten of the states with wait time standards had established certain standards that

11 applied to primary care providers but not specialists. Similarly, other states only had standards that applied

12 within urban areas of the state. These gaps in the standards could potentially lead to some states being

13 unable to gauge access to specific types of providers or in specific areas of the state.

14 At the other end of the spectrum, we found that some states had additional standards for certain

15 provider types that were key to the Medicaid program, such as one pediatrician for every 200 child enrollees

16 or one obstetrician for every 300 pregnant enrollees. In other words, we found that state standards vary

17 widely and are often not specific to providers who are important to the Medicaid population or they did not

18 apply to all areas of the state.

1 We also evaluated the methods that states used to ensure compliance with standards. We found
2 that states employ a range of different strategies to assess compliance; however, these strategies rarely
3 directly tested whether the standards were being met.
4 For example, one state requires that plans only provide an annual attestation that they were meeting
5 the standards. At the other extreme, a number of states conducted extensive tests of their standards, and
6 that included secret shopper calls to providers. Such tests allow the states to determine the accuracy of
7 provider information, which is essential for measuring compliance with these standards.
8 As I'm sure many of you know, there's also an additional mechanism for ensuring that plans comply
9 with access standards. Federal regulations require that states with managed care plans provide for an
10 external quality review of their plans, and these reviews are supposed to determine compliance with access
11 standards at least once every three years. Most commonly, these reviews are conducted with entities
12 known as external quality research organizations, or EQROs.
13 We also found a lot of variability in the types of reviews conducted by these EQROs. Some
14 looked primarily at broad indicators of access, such as enrollee satisfaction surveys or a review of the plan's
15 policies and procedures.
16 One EQRO official noted that these methods can provide an overall sense of how a plan is
17 performing, but they do not directly measure compliance with the standards.
18 EQROs less commonly use direct tests to determine plan compliance. A few states' EQROs

1 conducted routine secret shopper calls to measure how many providers were actually participating in the
2 plans and the timeliness of appointments. EQRO officials noted that such tests are particularly effective
3 for measuring compliance.

4 And when we reviewed states' history of identifying problems with access, we found that most states
5 failed to identify a single violation over a five-year period. Perhaps not surprisingly, states that found the
6 most violations were the states that ensured compliance by conducting direct tests, such as calls to
7 providers. In fact, just three states identified over three-quarters of all violations. All three of those states
8 had developed rigorous oversight mechanisms for measuring access that included regular and ongoing
9 compliance tests and secret shopper calls to providers.

10 Finally, we found that CMS provides limited oversight when it comes to state standards for access to
11 care. CMS officials reported that they do not play a role in how states develop their standards, nor do they
12 play a role in assessing the adequacy of states' methods for monitoring compliance with these standards.

13 Although CMS does play a role in developing the protocols that states and EQROs use for their
14 external quality reviews, these protocols do not currently require the use of direct testing, including calls to
15 providers to determine compliance with standards.

16 Based on our findings, we made a number of recommendations to improve CMS and state
17 oversight. Specifically we recommended that CMS strengthen its oversight of state standards. We also
18 recommended that they improve their methods of assessing compliance with the standards, including

1 requiring the use of direct tests.

2 And, finally, we recommended that CMS provide technical assistance and share effective practices

3 across the states.

4 So, to sum up, we found that in order to ensure adequate access, plans have to be held to effective

5 standards that meet the needs of their enrollees. And there has to be effective oversight mechanisms to

6 allow states to determine when those standards are being met.

7 It's a simple message, but it's a crucial one as we demand ever more of our Medicare managed care

8 plans.

9 Thank you, and I look forward to your questions.

10 CHAIR ROWLAND: Thank you.

11 Now we'll hear from CMS, James Golden.

12 * MR. GOLDEN: Good afternoon. I want to thank the Commission for the opportunity to join

13 you today and to talk about network adequacy standards and their role in assuring timely, high-quality, and

14 integrated care for Medicaid managed care enrollees.

15 As has already been said, as a result of the ACA, many states are seeing their Medicaid enrollment

16 increasing, either through expansion or through increasing enrollment of already eligible individuals. Many

17 states have some or all of their Medicaid populations in Medicaid managed care and, in fact, managed care is

18 the predominant delivery system that is used today.

1 It is critical that managed care organizations, states, and CMS collectively use the full range of tools
2 and mechanisms available to ensure that enrollees are able to obtain timely, high-quality care, and network
3 adequacy standards and access standards are one of those tools.
4 CMS appreciates the OIG's work in this area and takes seriously our role in ensuring that states are
5 providing appropriate oversight to managed care organizations.
6 The OIG's Standards for Access to Care Report made a number of recommendations, and CMS
7 generally concurs with those recommendations. So, specifically, the OIG recommended that CMS
8 strengthen its oversight of state access standards and ensure that states develop standards for key providers,
9 taking into account their geography. CMS definitely concurs that oversight of state network access
10 standards for managed care organizations is important, and it's important if we're going to have effective
11 delivery systems to make sure that enrollees are getting appropriate care.
12 We are currently considering at CMS what our options are for setting forth our expectations for
13 network access standards and expect to address this issue through additional guidance that is being
14 developed.
15 CMS has received a variety of input from states and state Medicaid directors on this issue, and we
16 are actively considering their input as we are updating and thinking about revisions to our managed care
17 rules.
18 Second, the OIG recommended that CMS strengthen its oversight of states' methods to assess plan

1 compliance and ensure that states conduct direct tests of access standards. CMS agrees that states need
2 documentation of their ongoing oversight of health plan compliance and the provider access standards.
3 CMS is actively planning to collaborate with states and managed care organizations to identify best practices,
4 not only for assuring -- well, we are working with them -- not only to assure access to timely care -- I think
5 what I meant to say is not only to assure that there are network access standards, but that those standards
6 are being me by the managed care organizations, but more importantly that they're really delivering on the
7 purpose of those standards, which is really timely care.
8 The other thing with regard to that recommendation, direct testing and secret shoppers is one aspect
9 of a compliance strategy. But we would expect that states and managed care organizations will need and
10 want to assure access through many tools, such as enrollee surveys, provider surveys, complaint systems,
11 and delivery system reform, including payment reform for the providers in their networks.
12 Third, the OIG recommended that CMS work with states to improve their efforts to identify and
13 address violations of access standards. CMS should use the information it has started to collect to track
14 violations at the health plan level and ensure that states are addressing those appropriately.
15 CMS agrees that state oversight and remediation of identified violations are key to the operation of
16 an effective Medicaid managed care program that exists to meet the enrollee needs. The existing
17 regulations provide an array of remedies for states to use, and we believe that the flexibility should remain
18 with the states to determine which compliance actions are most appropriate for the relationship with their

1 contractors.

2 CMS will continue to track compliance efforts through our EQRO, the external quality reviews, the
3 reports, through our contract reviews to determine if our expectations for oversight and compliance are
4 being met and being utilized; and to the degree we find out about problems from other mechanisms, we will
5 continue to report those and work with the state through the regional offices both to identify and address
6 the issues as we become aware of them.

7 Finally, the OIG recommended that CMS provide technical assistance and share effective practices
8 for setting and overseeing health plan compliance and provider access standards. CMS has been providing
9 technical assistance to states that seek such information on standards through our existing contracted
10 resources. As our resources allow, we will continue such activities. And as I had stated previously, we are
11 actively working with state Medicaid directors and managed care organizations both to identify and
12 distribute best practices both for states and managed care organizations working with their providers.

13 In closing, I'd like to reiterate that we appreciate this work and agree that appropriate network and
14 access standards are important. However, they are not an end unto themselves. They are just one tool in
15 ensuring that Medicaid managed care enrollees are getting the right care at the right time at the right place.

16 CMS, states, and managed care organizations must consider a broader set of tools. That includes
17 such things as regular open communication between MCOs -- managed care organizations -- and state
18 staffs; routine evaluation of utilization trends for such things as well child visits, emergency department

1 usage, and out-of-network providers.

2 Managed care organizations and states also need to have mechanisms that both capture and respond

3 to trends in enrollee grievances and complaints to identify when problems exist and what is the cause of

4 them.

5 They also need similar types of systems for provider complaints that are having problems with

6 referrals and the like.

7 And, finally, we would suggest that we all take a look at both member and provider satisfaction

8 surveys as this can also give a great deal of information as to the perceived impact.

9 With that, thank you very much.

10 CHAIR ROWLAND: Cheryl.

11 * MS. ROBERTS: I'm probably going to be the middle of both groups. My name is Cheryl

12 Roberts, and I'm the Deputy for Programs and Health Services for the Commonwealth of Virginia.

13 We are actually in the middle of all the groups, I assume, Meridith. We have about 700,000

14 enrollees in our traditional managed care, and FAMIS, which is our CHIP program. We use seven

15 managed care organizations. We use NCQA. That's one of our guidelines. That will be important

16 when we talk about HEDIS and some of the things that we get from it. And most importantly, I want to

17 talk a little bit about the plans we're using, because that makes a difference when we talk about access.

18 We have the two of the top three national plans: Anthem, the WellPoint plan, which is also our

1 number one plan for commercial, our number one plan in Medicare for the state, our state employee plan,
2 which means that as a result of it is, because they have an all-products contract, we wind up getting all those
3 providers in our network. It increased our Medicaid access dramatically.
4 We have Kaiser in our network, which is the number one, as you know, in the country for quality.
5 We have also Aetna, which is also very big.
6 But the big change that we have in Virginia, which I also say gives us a lot of access, which is partly
7 why we think we're doing well, four of our major health systems are also health care plans. And as a result
8 of that, we wind up getting the physicians, the specialists, the ancillaries, everything -- in fact, we make a
9 joke about it. If you go to Norfolk, it says, "Welcome to Sentara." Sentara is one of the health plans,
10 health systems. They have everything from a PACE site to a nursing home.
11 So with that, we have rich networks. However, I will say that when we did get the report, I ran to
12 my contractor to make sure that the contract did say the standards and ran to my compliance team to make
13 sure that we were meeting that. So I do think that reports like that, the OIG reports, are good for states to
14 get. Oversight is good. It's not that we're always happy to see the audits, but the audits do make us ask
15 the question, which is where are we standing and where is our strength and where is our weaknesses and
16 what kind of assessments we can do. So I understand that.
17 In the same way, I am sympathetic to you, CMS, because for you to have 56 localities, 33 states with
18 managed care, with the networks, with the expansion, trying to develop standards that will make all of us

1 happy will be difficult, but good luck.

2 Okay. So let me at least talk about it from a state perspective, what we look at. When we look at

3 network access, we don't quite look at it the same way the OIG does. And I'm talking about the states that

4 I tend to look like. I tend to look more like Arizona and Tennessee, if you had asked where we are. In

5 general, when we look at network access, we look at it as network management. We're probably more

6 similar the way a plan looks at it.

7 So, therefore, we're not just looking at how many numbers we have. We're looking at where do

8 people get care. We're using geoaccess and also using Google tools to find out where that is, because it's

9 not just we have two providers. The two providers have to -- we have to understand what that means. It

10 could mean that that provider is a huge practice. It could mean that that provider is a single solo

11 practitioner. So we tend to look at the market dynamics.

12 So what Virginia does, which I think is unique, is that we're very deep into the market, meaning that

13 we actually meet with the health systems ourselves, the major providers, the associations, to get a sense of

14 what is going on and how the systems are working, and who they're contracting with and who they're not.

15 One of the things you look at is geography, like she mentioned, is because we had one plan who said

16 I can come into the region because I have two providers.

17 And I said, yes, but there's a mountain between where the people are and the providers. So,

18 therefore, that's not going to work.

1 So we try to have that kind of dialogue.

2 So when we look at those things and see things like telemedicine enter the place, clinics now where

3 you can actually get -- because I get my flu shots from a Walgreens.

4 You're looking at access as being broader than just counting the numbers, and I do want to ask that

5 question as we go forward.

6 So as we look at when you say standards, I'm going to suggest as one of my suggestions that you use

7 the data and that you start thinking about geoaccess.

8 I am using that. That's now an old term. My staff told me no, Cheryl, we're doing Google things.

9 But whatever we're doing, we need to move on and start to say that is it.

10 Some of the things that are standards here were put in, in 1995, to do for the PCCM program.

11 Perhaps, we need to move off of those.

12 I mean, I'll say that. Okay.

13 In terms of compliance, I would like to say -- because we did not have any sanctions, and the reason

14 we didn't, Meridith, is not because we don't believe in CAHPS; we act on it.

15 The moment I see there's a problem or a complaint, we intervene. That's our philosophy. Okay.

16 So the plan is not let off the hook.

17 It's just the fact of the matter is if we hear, for example, that a plan is having problems with the

18 health system in negotiations, we're there. We tell the system we want them involved. We want the plan

1 involved. So we actually intervene.

2 If we get a complaint from a person, we're actually on the phone. So we take those seriously.

3 However, this is one of the things we also do that's not necessarily reflected in the contract. And

4 what I realize is that we do things in the plan that this year I realized should be in the contract. This has

5 become part of our practice but not necessarily documented.

6 For example, we do monthly compliance checks. We do the map checks. We do look at

7 certifying for quality.

8 For example, one of the things we do is also look at our outcomes. One of the things we're proud

9 of is 90 percent of our children saw a PCP last year. We consider that very good.

10 So we brought in foster care kids this year. We were able to see that all the kids had gotten to see a

11 PCP and were being tracked. We consider that good.

12 So while that's not necessarily looking at your hardcore standards, that's what we look at in terms of

13 outcomes.

14 We, too, have our EQRO looking and doing on-sites and readiness reviews.

15 And we also look at any type of things that we think are an anomaly because that's what we're

16 looking for. Are we seeing a change, especially when we bring in a new population?

17 One of the things we're finding is that states bring in populations. We brought in the duals this

18 year. We brought in foster care. We brought in the aged/blind/disabled who have waiver services.

1 Then we did another check with our network because then we had to bring a whole other set of
2 providers in and a different type of providers that we were not normally used to.
3 So, at that point, that's a different kind of review, and again, it has to show up.
4 In fairness, I'm going to say my last comment which is, what do we suggest?
5 This is a Virginia suggestion. I'm not representing NAMD for this one.
6 All right, what we suggest:
7 One, I do agree because we're doing an EQRO RFP right now. Whatever you want us to do,
8 CMS, you need to tell us. We all will do it.
9 It's 75-25. We like that contract. That's the one to actually use. If you want us to do secret
10 shoppers, that's the opportunity to say what you would like us to do with that contract.
11 Two, I do believe that we need to look at different types of standards. I think there's lots to learn
12 from the managed care business, that it shouldn't be coming from us.
13 So, therefore, I would recommend that CMS and states hire people who have network management
14 and market analysis skills. I think that's a skill set that is going to be more important, as well as the data
15 analysis, and we need to hire that within the state because CMS needs that, too, so that when we do have
16 those issues of saying how you're complying that we're doing whatever the best technology is and not just
17 doing hand counts.
18 I think that we need to recognize that each state is a different market. And you're right; you're

1 going to have to look at markets.

2 For example, there are places where there is nobody. Okay.

3 So it doesn't matter if we sanction the plan, there is nobody.

4 And what I found happened is -- for example, it happened with us in Southside where an OB/GYN

5 practice closed down -- our plans had to move the pregnant women and actually house them closer in order

6 for them to be able to get closer in.

7 I can sanction them, but it really doesn't help.

8 So I really think that we have to ask the question of, what is a reasonable expectation of existence?

9 So I do believe we need to get access and understand that.

10 The last one I'm going to suggest is that we do need more managed care training. Obviously, I'm

11 getting to be middle-aged in more ways than one, and the answer is for my newcomers in managed care that

12 they could use the training.

13 Last year, Milbank trained 10 states, sent half of us to Arizona, half of us to Tennessee. And about

14 10 years ago, CACS trained us.

15 We could use that. We could use a best practice training if someone would actually do that work.

16 And then last, but not least, is in every state that I know that has managed care there's a person like

17 me who's very, very impassioned about providing access. You talk to Louisiana; you talk to Ruth

18 Kennedy.

1 The one thing is -- and I understand what it looks like on paper, but I can say I don't know any of us
2 that don't feel that the strength is in the network and we have to provide care to the people. We're
3 committed to it.
4 So that's what I'll leave for the Commission.
5 CHAIR ROWLAND: Well, thank you all very much.
6 And this has started a great discussion, and now I'll turn to the Commission members to pose their
7 questions to you.
8 And I will give Trish the first question if she -- you're good? Okay.
9 Sara then.
10 COMMISSIONER ROSENBAUM: Thank you. That was great.
11 It's very interesting; back now almost 20 years ago, we did a study of all the Medicaid managed care
12 contracts to look at the access standards, and NASHP, of course, did a similar study, not of the contracts
13 but of the practices adopted by agencies.
14 And I would say that the struggles around access today are exactly the struggles around access, you
15 know, decades ago.
16 A couple of questions. One, I am totally blown away, Meridith. I, of course, read the study as
17 soon as it came out. It was very well done.
18 I never heard of 1 to 100. My whole life has been access. Okay?

1 I mean, that's all I think about. You know, when I'm thinking about work, this is what I think
2 about.
3 And so I am trying to get my mind around what a state might have had on its mind.
4 It seems to me that one of the places people need help is if you look at -- there are some providers
5 that are totally Medicaid dedicated providers. That's really what they see. A health center in the middle
6 of downtown East Los Angeles -- you know, if you see any insured people, the people probably are going to
7 be on Medicaid.
8 But in so many communities, you have a mixed panel of patients.
9 So I'm wondering whether, for example, we ought to be thinking about -- especially in the managed
10 care world -- your panel of patients across all books of business.
11 We looked for that 20 years ago and noted, I think, at that time that Arizona was quite good actually
12 in stepping back and saying it really doesn't help us to know if you've got 1 to 200 or 1 to 300. We want to
13 know whether your practice management size is sensible.
14 And so my first observation is that CMS and states and the IG think about this, especially with the
15 new market where you've got people who, part of the year, are going to be on Medicaid and, part of the
16 year, are going to be on exchange subsidy coverage. We've got to start thinking all-payer standards here.
17 Number two, I think an underlying issue which doesn't really get talked about very much is that
18 Medicaid beneficiaries are disproportionately concentrated in areas designated as HPSAs or MUAs.

1 And so the problem is that measures that might work for Northern Virginia or Washington, D.C. --
2 the west side of the city, you know, the Northwest quadrant -- in terms of our expectations and our supply
3 are just very different from what happens when you're dealing with an MUA/HPSA population.
4 So one question also is thinking about, for example, how HRSA thinks about this in relation to CMS
5 and what kind of dialogue CMS and HRSA have had back and forth around what would be sensible ways
6 for thinking about developing access since I assume the same considerations underlie developing a health
7 center would go into thinking about sufficiency.
8 And so the question is, can we sort of get beyond the world where we're thinking about Medicaid
9 patients in isolation here, where we look at programs that have a long experience with access, that have had
10 to have divergent standards because local conditions are different?
11 And in the post-ACA world, I think, you know, thinking multi-payer is going to be very important.
12 CHAIR ROWLAND: Mark, then Donna.
13 COMMISSIONER HOYT: I am from Arizona. I had already written down the same question
14 Sara just asked about total book of business.
15 Another question I had was I know this happens at time, but if it's not required, why not -- whatever
16 standards the state decides to follow for network adequacy and those kinds of things, is it written into the
17 scoring tools so the RFPs they use to select MCOs to do business with so that they follow those protocols?
18 Do they -- I mean it's, I guess, up to the state how many they want to sample, but do they have

1 letters of intent from doctors?

2 Do they have actual contracts?

3 How do you verify that to sort of check and see that it's real?

4 Do they assign some kind of scoring criteria to it as part of their definition of what best means, you

5 know, if they're trying to find the best MCOs?

6 Is there a readiness review, I guess, procedure that's followed where they're not given any members

7 until they pass muster on these access measures?

8 MS. SEIFE: We actually didn't specifically look at how they were reviewing it before the contract

9 was signed, but I think you raise a really great point, which is how do you ensure whatever those standards

10 are, that what the plan is presenting to the state as how many providers are actually working there kind of

11 resembles reality.

12 And that's one of the reasons I think we kind of keep mentioning and bringing up the importance of

13 some kind of testing or some kind of review, to ensure that that provider information is an accurate

14 representation of reality.

15 MR. GOLDEN: Well, I have to say I've only been at CMS since September. So I still have a lot

16 of carryover from Minnesota.

17 And I can't speak to what all states might do as part of their RFP process, but certainly as part of

18 Minnesota's RFP process we certainly did two aspects usually around network adequacy and the scoring.

1 One was, of course, a pass-fail, which was do you have network adequacy, make sure that you're
2 demonstrating the network adequacy as part of the RFP process which also was going to be required as part
3 of the contracting process.
4 But then we also worked with our counties. So we procured at a county level.
5 And the counties also had a component in the scoring of the RFP, and portions of that were clearly
6 related to enrollees that were in that county, both their experience with the providers in that region as well
7 as access in areas where we were concerned with.
8 So, for example, dental was an area that we were always looking at and trying to get feedback on.
9 Was there variation in the plans, both in the access available and then the ability to get to those types of
10 appointments?
11 So I certainly know that some states are using it in their RFP scoring process.
12 MS. ROBERTS: I want to address Sara's, too.
13 Sara, you're correct; there is a concern about certain providers getting swamped between the
14 marketplace and Medicaid and how does that work.
15 It's also important, like you said, to realize where people get care.
16 Necessarily, what we have found, for example, using Charlottesville for example, is people will leave
17 Orange to get care in Charlottesville. So it's really not -- that's why when you're looking at the access
18 you're looking at where people get care naturally.

1 Okay. So that's one issue.

2 On your side, you asked a question. Yes, when we do an RFP or we bring in a new population or

3 go to a new geographic area, we ask for all the letters of intent, but we also ask for a big percentage of them

4 to be signed before we go live, or we won't go live.

5 Now since our plans are NCQA plans, the credentialing process takes 60 to 90 days. So we take

6 that in account, meaning that we give them six months to go live so that we can get all those providers in.

7 And we do a mix.

8 So, for the states that have that kind of a push, we have to keep that in consideration. But we will

9 not go live unless the vast majority of that is confirmed because that's the key in the process.

10 And then in terms of readiness review, all states have, I think, a readiness review check. It may not

11 be actually in the contract. That goes back to probably requiring that. But, usually, that is part of the

12 process of doing the project plan and the implementation.

13 CHAIR ROWLAND: Can we go back to Sara's point and each of you address the issue of the

14 all-payer aspect versus the Medicaid-only?

15 MR. GOLDEN: Well, I think a couple of things in thinking about Sara's comments.

16 I do think it's critical to take a look at how is Medicaid doing in relation to the other payers, and so I

17 think there are a variety of tools to be able to do. Right?

18 So one can certainly look at CAHPS data, particularly in states where you might have payers -- you

1 might have managed care organizations that are serving multiple populations, both the commercial
2 population and the private pay as well.
3 I think that -- so there are CAHPS.
4 There's some HEDIS data that one can look at.
5 You know, I think in working -- when states are working with their managed care organizations,
6 what are the commonalities that are across those systems that are there?
7 What are they doing across their lines of business around delivery system reform?
8 And thinking about how do they work with providers to treat their entire book of business in
9 payment reform is another approach that states and organizations need to be looking at.
10 And then I think it is important to take a look at what is -- as we think about people transitioning
11 between Medicaid and QHPs and tax credits, what are states doing in total, not only at their Medicaid
12 agency but at their commissioner of insurance, to really think about what are some of the requirements that
13 we want to have common across that transition?
14 What is the information enrollees need to really be able to plan forward in their life?
15 It's really comparability across not only what are the standards but also what is the information
16 available and how easy is it for people to consume that information.
17 COMMISSIONER ROSENBAUM: Yeah, another source, I think.
18 I mean, on this point -- and I forget. Maybe it was Cheryl; you mentioned it.

1 This is where the managed care industry itself is so invaluable.

2 I did some work not too long ago, looking at growth of what you could call multi-market plans that

3 are capable of crossing over from the Medicaid market to the exchange market. And there's been

4 tremendous growth.

5 And where the growth is happening, by and large, is happening in two ways. One is classic

6 Medicaid managed care plans that are growing into the exchange market. The others are, of course, large

7 commercial insurers with a history of commercial activity, who are acquiring Medicaid products. And,

8 quite frankly, there was no contest between the two.

9 The Medicaid plans were having a much easier time with it because they started with a network that

10 was perfectly adjusted to the Medicaid market and then they were growing capacity.

11 But the companies that were trying to do it from the other direction could not -- they simply -- they

12 were all sort of exploring the issue of how do you come up with payment and other management

13 mechanisms to get to an all-products clause.

14 And I think that everybody realized that they were ending up with situations where you would have

15 a network that was only a network that was available on one side of your product.

16 And so I think between the companies that are struggling with this how do we grow a network, and

17 the states like Virginia that have thought about what do you do to encourage a network to take all payers,

18 and where everybody is sort of in the same boat with the measures. I mean, I think that's really the key in

1 all of this.

2 MS. SEIFE: Yeah, I think those are such important points.

3 And as you just start seeing such growth in managed care and competition with the exchange

4 programs, it's really important, I think, for states to get a handle on it.

5 You know, we found that in some cases providers were seeing -- individual providers were seeing as

6 many as -- taking as many as 20 different Medicaid plans, and that's just on the Medicaid side.

7 And one of the things that actually surprised me a little bit, or that I certainly found interesting, is

8 that a lot of states weren't reporting to us that they were doing a lot of utilization reviews and looking at

9 their data and actually seeing how many doctors didn't provide any care to any Medicaid patients, how many

10 did and they saw 5 patients, 10 patients, 100 patients.

11 You know, maybe they were doing that and just not reporting it to us, but I think that activities like

12 that are probably increasingly important.

13 CHAIR ROWLAND: Donna.

14 COMMISSIONER CHECKETT: Well, thank you so much for coming today, and your thoughts

15 are on a very important issue.

16 I have, I guess like Sara, spent a lot of my career thinking about access. It started originally just

17 thinking about how to get people access to Medicaid. And then we had great things like expansion for

18 pregnant women and changing FPL limits, et cetera.

1 And long ago and far away, I was a state Medicaid director in a state that had serious access
2 problems for our Medicaid population. We had about 900,000 people on the program.
3 And the main complaint I would hear from the rare times I heard from members -- if you're a state
4 Medicaid director -- you know this, Jim and others -- you hear all the time from providers, hardly ever hear
5 from members.
6 And, when I did, their issue was shockingly never about reimbursement rates. It was always --
7 that's a little joke.
8 It was always about being able to see doctors and to get care for their kids or get care for themselves
9 or get care for a loved one.
10 And one of the major reasons I started managed care was because I saw it as a system that was going
11 to improve access, and in my state it has in many ways.
12 But, Cheryl, you said it so well. If there isn't a doctor in Missouri's Bootheel, there just isn't a
13 doctor.
14 And my concern with the OIG report -- it's only -- and I think it's what the Commission members
15 have been saying. We have to look at the larger context.
16 I'll bet, Meridith, you could do a very similar report for Medicaid fee-for-service and have the same
17 results.
18 You know, we have 50 percent -- my understanding. I heard this just earlier this week; 50 percent

1 of current Medicaid beneficiaries are in full risk managed care; so, full risk.

2 It's larger if you count the other care management programs.

3 So that means 50 percent are truly on their own.

4 I fully understand. And I spent earlier in my career, since I left the state, in managed care.

5 I fully understand these problems and challenges and deficiencies, but I still believe that at least

6 giving people a phone number to call on their managed care plan -- they can call, and they can get help.

7 In my state -- I don't know how it is now, but we had 900,000 beneficiaries, and we had 11 people

8 who answered our member services call.

9 And I think that fact -- and I doubt it's much better now, and I think it's very common in many

10 states.

11 It addresses also what I heard both Jim and Cheryl say. We have just a significant issue of capacity

12 in our states. Not just are there enough staff, which is the first thing you ask, but just in an incredibly

13 sophisticated and competitive and rapidly changing market, do we have staff who can even do the types of

14 analysis, Meridith, that you mentioned and I think, Cheryl, that you alluded to?

15 You know, you need more training.

16 I think it's just so complicated.

17 So I very much appreciate and value the purpose and what the OIG study is pointing out for us to

18 contemplate.

1 I just really think that we all have to look at a much bigger context. To me, I worry about
2 everybody on Medicaid and being able to see doctors.
3 So I would just conclude there, but I really appreciate it. I think it's a very important start of what I
4 hope will be a robust discussion.
5 CHAIR ROWLAND: [Off microphone.] [Inaudible] something else.
6 COMMISSIONER CHECKETT: Providers. Providers.
7 COMMISSIONER EDELSTEIN: Meridith, you mentioned in passing the issue around
8 specialists, which is especially acute for children with special health care needs and families dealing with that,
9 and, Jim, you mentioned the dentists. So those are -- dentists somehow fall neither in the primary care nor
10 specialist arena, but they sit out there.
11 I was wondering if each of you from your perspectives could comment on access issues, particularly
12 around access to pediatric specialists and to dentists.
13 MS. SEIFE: Well, we actually have a study that's coming out specifically on access to dental care in
14 Medicaid, not around managed care, but just more generally about states' experiences as well as some of the
15 methods that they are using to increase access around dental care.
16 I mean, I think you are absolutely right. There are clearly some areas where there's just such a
17 demonstrated need, and I think dental care pediatric specialists are certainly one.
18 At least certainly on the dental side, we are asking states about what strategies they are using, and

1 they are definitely using some interesting strategies to improve access.

2 MR. GOLDEN: I think both of those are very challenging issues that states are facing.

3 I think states have been looking at a variety of strategies to try to address them. On the dental

4 provider, you have a number of states that are looking at midlevel providers that are trying to see where they

5 might be able to fill in on some of those gaps and how that might fit into the system and how they can work

6 with dentists in that.

7 There's a large interest in some of the alternative deliveries; teledentistry, as an example, where that

8 might be appropriate in thinking about, again, how to work with either dentists or midlevel providers that

9 are kind of new. I think those are challenges that states are going to have to deal with.

10 I think with regard to some of the challenges for pediatrics and children with special health needs, I

11 think it gets to some of the stuff that both Donna and Cheryl were saying.

12 One of the challenges I think that states face is when there aren't providers in certain areas, there

13 just aren't providers, and I think it really heightens the need to look at other mechanisms that are generally

14 within Medicaid to try to address that, thinking about some of the nonemergency transportation, thinking

15 about some of how -- the importance of care coordination and case management to try to help families

16 coordinate those, particularly when there might be significant travel involves and getting all of that

17 coordinated up. But I do think that those are a lot of challenges that states are facing right now.

18 MS. ROBERTS: One question is easier for me than the other, so I'll go the easy one.

1 For dental, we carved it out from the MCOs, and we went with DentaQuest, but before we did that,
2 we actually built a coalition of dentists -- we call it the DAC -- and the dentists built the program. We did
3 the other.
4 We had a hard time getting access on dental care along, so we figured that if we got the dentists
5 involved, so the dentists are actually almost a board for us, and as a result of it, we were able to increase our
6 access dramatically, obviously, and we've won awards for that. So I'm very proud of that program. It's
7 called "Smiles for Children."
8 But it's very intense, so I will say that. In order to do that, you have to have a -- you really do have
9 to have a full focus on the dental issue.
10 And also, we pay for -- we don't pay for adult dental. We just do emergency dental for adults.
11 We'll be covering dental care for pregnant women beginning in March, but the whole dental access issue, it
12 was intense to do, actually almost as hard as bringing up a health plan, because the dentist has such unique
13 issues and did not really want to take Medicaid enrollees, not because of the price, because actually -- we
14 actually put out a survey. We asked the question whether or not -- if we gave you a 30 percent increase,
15 whether we gave you a 50 percent increase. They said no because of the no-shows. The no-shows in
16 dental become a killer here because of the way the dental practice works.
17 For children with special health care needs, what we tend to do is we're lucky that our tertiaries, as I
18 mentioned, are health systems who are also health plans, that that helps a great deal in terms of that, in

1 terms -- also the medical schools in terms of bringing that in.

2 However, in the areas that we have access issues, we have found that, one, we have had to do

3 non-par network agreements. That's what the plans had to do. One of the advantages of managed care is

4 they can do non-par agreements. That's another thing that doesn't show up in the network, and that if

5 they have to do that, they can. They can leave the state. We see that a lot, both in Northern Virginia,

6 going across into D.C. and Georgetown, and we also see it in our Tennessee lines, where we see especially

7 for children with special health care needs, they're actually leaving the state in order to be treated.

8 So I think that the issue becomes -- but that's a bigger issue, I think, in terms of trying to figure out a

9 way to increase the workforce for that, for those areas. We have areas that -- now we see it in our med

10 schools, that people are not entering, because that's something that's a bigger issue.

11 We worked on the expansion twice before. Two times, we started the expansion and stopped.

12 We won't talk about what happened to poor Virginia and what happened in the last round, and one of the

13 things we were talking about were capacity issues here, meaning that could we afford to bring in another

14 100,000, 200,000 people in, and what we would have to do in terms of extenders, and they treat -- changing

15 some of our regulations to allow nurse practitioners and other extenders to have the same kind of work that

16 they do with physicians in order to get that capacity up. So I think that one is the harder one.

17 VICE CHAIR SUNDWALL: Thank you. This is really important to us. It is clearly in the title

18 of our Commission. Access is front and center.

1 I am also reminded, though, why we need to monitor this is because, as Chris and others have
2 mentioned before, coverage does not access make, necessarily.
3 I remember here in Washington, D.C., when I lived in this vicinity for a number of years, they had
4 Medicaid presumptive enrollment for all pregnant women. There was no coverage problem, and yet infant
5 mortality was still embarrassingly high. So coverage is not always the issue, but access is.
6 In our charter, in our statutory obligation, we're also supposed to come up with some kind of an
7 early warning system, and I think -- if I were still a Hill staffer, I think they put that in their understanding
8 that they were going to really challenge the market on health care. They were going to expand Medicaid.
9 They were going to have exchanges. But with all that change, they wanted to know what are the problems
10 with access to care.
11 I was pleased to see all this activity going on, but I didn't hear you say -- or maybe I misunderstood,
12 Meridith, but it seemed to me like with all the variation among the states, they still hadn't identified any real
13 deficiencies. They were doing things differently, but they weren't really coming up with these potential
14 warning systems or threats. Am I misunderstanding what you're doing? Or you're just doing a lot of
15 measurement. They're doing a lot of various kinds of measurement, but they haven't come up with gaps or
16 problems?
17 MS. SEIFE: The states specifically are not coming up with gaps?
18 VICE CHAIR SUNDWALL: Whatever tool you're using.

1 MS. SEIFE: So, I mean, I would definitely say that states certainly are looking at a lot of different
2 aspects of access.
3 VICE CHAIR SUNDWALL: And doing it differently.
4 MS. SEIFE: And doing it very, very differently across the board.
5 We definitely do have concerns that a lot of times their warning system that they're using is they
6 might take a map of where beneficiaries live and sort of look at where the providers are supposed to be. If
7 you don't actually know if those providers who are supposed to be there are really there providing access to
8 care, there is a disconnect that could be lost, and that early warning system doesn't exist. That was
9 certainly a concern for us and making sure that there are really effective ways that states are using and
10 employing to actually measure access, and so that they know when there is going to be a serious warning
11 sign, because it's incredibly important now more than ever, as you're about to see such increases in the
12 number of people being covered.
13 Does that answer your question?
14 VICE CHAIR SUNDWALL: So your survey identified deficiencies in this, in how they are going
15 about measuring it, but you don't know how in these various surveys they are doing, they have identified
16 gaps in access to care. It sounds to me like you have identified deficiencies in the survey instruments but
17 not necessarily found how they are in fact creating an early warning system for problems with access.
18 MS. SEIFE: Well, we did ask states to report to us when they are finding problems with access

1 and how many sort of specific violations that they had identified, and we asked them to describe what those
2 problems were in each of those states. And as I noted, there were relatively few in a lot of states over that
3 time.
4 MR. GOLDEN: I wanted to address the question on early warning systems, because I think it's
5 something that Cheryl said, and I think it's something that we hear when we talk with states.
6 I think it's helpful to divide the problem into two pieces. So if you think about access problems as
7 an acute problem of something has changed and something has gone wrong, I think states are probably
8 doing a reasonable job in that area, because it tends to come through call centers, it tends to come through
9 member help areas, where you start to see problems. There wasn't a problem; suddenly, there's a problem.
10 Your call center tends to start to light up. You may not initially know what the problem is, but you have a
11 pretty good sense that something is going on in this one region, and it tends to be localized. In that sense,
12 I think you definitely have warning systems that states are attuned to.
13 There might be variation, but I do think that that is -- that things that states are used to, particularly
14 those that have good communications with their managed care organizations.
15 I think that the other concern is where there might be a chronic problem, right, where it's been bad,
16 it's bad for Medicaid, it's bad for the commercial population, there aren't many providers. I think in there,
17 it tends to come in two places.
18 One is, one of the concerns that we would often hear is around transportation cost. There is a

1 requirement to get people to the providers. The transportation cost is costing as much as the medical cost.
2 It doesn't seem to make sense, the way that it is -- the dollars are flowing for really serving people. I think
3 that tends to be a warning system that is out there.
4 I do worry, though, that if you just have a systemic problem and people have just grown accustomed
5 to this is how life is, there may not be good warning systems for that situation, other than when you get
6 people together in the room. They know it in this region of the state, where they're all having the same
7 problem getting providers, getting providers to see any of their populations, but there aren't always good
8 answers to that.
9 COMMISSIONER CHAMBERS: Okay. Thank you very much. Great report and great
10 discussion today.
11 My personal perspective has changed so much over the last dozen years, having a dozen years ago
12 sat in, James, essentially your role at CMS as sort of the federal regulator, as being the group director in
13 CMS of the last time the Medicaid regulations on managed care were issued, and we're waiting the new ones.
14 But my perspective at that time changed very dramatically, as when you're on the other end of the spectrum,
15 in which now I have been over the last dozen years, CEO of plans in California of about a half a million
16 members in which you see what it's like trying to assure access.
17 It was just very rewarding to hear a term such as "reasonable expectations" and "open
18 communication with regulators," particularly at the state level. We have that in California, as the

1 Department of Managed Health Care and the Medicaid agencies have very open communications about
2 compliance, because they understand with the state so geographically diverse, in five of the six counties that
3 my plan is in, in Southern California, very wide swatches of geographic access issues where there just are no
4 specialists, as we have discussed before.
5 But as a managed care plan, you always are trying to make sure that there is access, because the
6 members will get access one way or another. So, if they don't have timely access to specialists, they will
7 eventually end up in an emergency room in a hospital, and they will get access to the specialty care through
8 the hospital, which is not the appropriate place to do it. So we are constantly working in meeting the
9 regulatory access standards, but how we can use early warning systems.
10 Like we used the call center, as we were getting calls where there is access, and we can track them
11 down to certain geographic areas where the members are having issues. We take that grievance and
12 appeals, looking at those. Taking it to the Quality Improvement Committee within the plan in which they
13 then work with our provider contracting is to address where we may be seeing shortages of specialists,
14 particularly, but it's a very dynamic process.
15 At the state level, California requires assignment of no more than 2,000 members to a primary care
16 physician. The shortcomings of that are that the primary care physician may have contracts with multiple
17 plans in which they have 2,000 members in multiple plans, and so while you're being compliant, you don't
18 know if that's an issue.

1 So it's just good to hear it's not a simple thing; it's the right care at the right place at the right time.
2 And managed care plans have the real agendas to make sure that we are being compliant. So regulatory
3 access standards are one way of measuring that in compliance.
4 And I know Donna would share this as her background in her plan, a very large national plan, is the
5 industry looks forward to working with regulators and making this work, because it's in all our interests.
6 And just one real quick final comment is often times access is directly tied to reimbursement. We
7 have Medicaid, Medicare. We're in the exchange in California, and when you go to a provider, particularly
8 specialists, there's different reimbursement levels for that same -- the provider will say, "Sure, I'll take
9 Medicare, but I won't take Medicaid." In California, Medicaid is about two-thirds of Medicare in primary
10 and specialty services, so it is very difficult oftentimes just to engage physicians, particularly where there are
11 shortages.
12 So I think we have to be realistic that, particularly in the Medicaid program and states that have very
13 low reimbursement levels, where capitation payments are tied to fee-for-service reimbursement, is where
14 there is going to be reality is that plans are going to be held to very strict standards, is that that will probably
15 translate into the need for additional reimbursements, and we just have to understand the financial
16 implications of having a very strict, tight enforcement mechanism, and not calling for no regulation. But I
17 think we have to be realistic that oftentimes you can only buy your way into access in some places,
18 particularly Medicaid.

1 So more statements than questions, and you can respond or not, but I just wanted to make those
2 comments, so thank you.
3 MS. SEIFE: No, I think that that's an incredibly important point, and we've certainly spoken to
4 enough state Medicaid directors and providers, as well, that we certainly appreciate those comments.
5 One of the states that I think we highlight in the report would do a lot of analysis that was very
6 helpful to the plans, I think, one, just for the state to get a handle on what access looks like, but I imagine
7 would also be good tools with the actual -- for the actual plans to use.
8 They would actually go in and say in this three-county area or this section, there either are no
9 providers of this particular type or there are four providers and none of them are participating, have you
10 reached out to them yet. You would see this sort of back-and-forth communication between the state and
11 the plan, and I think in a lot of cases, you may want those sorts of -- I think those cooperative relationships
12 can be very effective in addressing access concerns.
13 COMMISSIONER CHAMBERS: Can I just tell you one quick example? One of the geographic
14 areas where there is only several hospitals, so the one hospital terminated the contract and demanded a
15 significant rate increase, and it threw us out of compliance on the 30-minute, you know, the 30-mile --
16 30-minute rule. And the regulatory agency, actually, when we presented to them is very unrealistic
17 financial demands on the part of a provider, is they actually gave us a waiver of the access standards,
18 realizing that ultimately it was going to fall back to the state as meeting those unrealistic demands was going

1 to increase state Medicaid expenditures, and so we've continued to work to try to get that contract in place.
2 But that's the cooperative nature of realizing that there is a cost and limits to what can be spent in doing
3 that, and I'm sure Cheryl goes through that at the state level all the time in working with plans, so thank you.
4 COMMISSIONER CARTE: I just wanted to ask if you have any other information about how we
5 step away from these antiquated access standards of reporting every three years to something, more real
6 time. And, Mr. Golden, you and Richard both just hinted at that, but I'd like to hear more details about
7 the how. Richard referred to it as when the call center lights light up, but what are the triggers, and have
8 you seen states where systems and -- Mr. Golden, even the Insured Kids Now network that CMS helped to
9 look at dental access, how do we bring these things up to speed and make them more real time, or do you
10 know places where that's happening?
11 MR. GOLDEN: Well, yeah, I think that -- well, the antiquated network standards, I guess I think
12 of it as network standards really in many ways perhaps serve as a floor or at least as a measuring point, right?
13 So whether it's time and distance or number of providers per enrollee or some other -- waiting time for an
14 appointment, that's there.
15 I think one of the things that states and CMS and even managed care organizations need to think
16 about is how do we update what the standards are now. So if you think about changing technologies that
17 are there, so, for example, how does increasing use of telehealth, e-visits, start to factor in, particularly as it
18 might relate to time and distance types of standards? You know, in areas -- one of the challenges that

1 many states have is the distribution of behavioral health providers. But that is also an area where I think
2 many states are trying to do a lot more around telehealth. So I think one of the questions is, what is the
3 appropriate way to incorporate those into network standards?
4 I'm not sure that I know the right answer. I'm not sure that even states at this point know the right
5 answer. And I think that's part of why one of the things we're really trying to engage in is a conversation
6 both with the states and with managed care organizations to try to get to what are best practices and how do
7 we get those disseminated more quickly. And what are bad practices? You know, what -- and maybe it's
8 not that they're bad practices, but they don't work. How do we start to get that information out there?
9 I think another concern that I'm thinking about and interested in getting more feedback on is, as we
10 start to think about long-term services and supports, maybe it's a situation where people aren't going to the
11 providers but the providers are coming into the home. What are the proper kinds of network adequacy
12 standards and provider numbers to deal with those populations? How do we assure appropriate access for
13 the types of services that those populations need? Because those populations are the populations that are
14 moving into managed care now. You know, and advocacy groups and people that are concerned about
15 those populations have a lot of concerns about how do we have proper measurement.
16 And so I think network standards need to evolve as technology changes, as we think about the way
17 care is delivered. And I think -- I don't have the answers. I don't know that -- the answers aren't going to
18 come from CMS down. But they're really going to come from looking at what is being tried, what's

1 working, and how do we make sure that people have that information.

2 MS. SEIFE: Yeah, I think that's -- just to echo what you're saying, I think states are really trying a

3 lot of different measures. It is hard to craft really good access standards that are going to make significant

4 improvements.

5 I would want to just highlight one thing that we do mention in the report. There actually is a state

6 -- at least one state that has made their certain core HEDIS measures part of their access standards, which I

7 thought was interesting. It requires a floor, and if you don't meet that floor, you have to have a certain

8 improvement every year. Other states are either using HEDIS measures to reward plans that are doing

9 well on them or to penalize plans that are not.

10 There does seem to be a lot of activity in states or at least thinking about that as one possibility. I'd

11 just add that to the discussion.

12 MS. ROBERTS: We are one of those states, in case you figured. That's why when I went to my

13 staff, immediately they started reading me my HEDIS scores to say what the access was. So we tend to do

14 that, too. We're very big about that we also have performance on quality and access is -- one of the access

15 standards is in that in terms of how to incentivize plans.

16 I think that -- and, actually, Richard, I'm glad you spoke up, in terms of talking about the plan's

17 involvement. There's lots to learn about some of the things that we've learned over the last 15 years as

18 plans have evolved. A lot of plans have left the market and, unfortunately, should have. That was the

1 right answer for them. But now that we have this market of plans that we're seeing in these different
2 twists, they should be part of the conversation. I think that's what I would recommend to CMS. CMS
3 traditionally has not included the plans in the discussion. We've always treated them hands off as
4 contractors in some ways, and I understand that, because in some ways you have some issues. You've got
5 procurement issues you have to make sure -- but to not have them at the table, they bring a wealth of
6 information. I try and talk to my national plans. They tell me what other states are doing. For example,
7 when I got a political inquiry from a legislator, I go to my national plans and says, "How did you address it
8 in other states?" So that can be very good to have.
9 COMMISSIONER HENNING: So now that we're talking about access, what can CMS do on a
10 regulatory level to make it so that nurse practitioners, nurse midwives, nurse anesthetists can actually
11 practice to the full extent of their training and education? And, in particular, you know, the second part of
12 that question is what can they do to help address the inequities as it pertains to hospital privileging?
13 Because that's a big issue for us. If you're a nurse midwife and you can't access the hospital and 95 percent
14 or more of births are done in a hospital, and you have to have an OB/GYN sign your privileges in order to
15 practice, and that guy gets in a car accident, you're out of business the next day.
16 So I guess that's my question. What can CMS do for us in those two areas, letting us, you know --
17 from a national level, instead of having to chip away at it from state by states, practice to our full extent of
18 our training and abilities, and then, secondly, work on hospital privileging from a national level?

1 MR. GOLDEN: I don't know that I have a good answer to your question. I'm not sure exactly
2 what CMS can do. You know, having come from a state, I think that any scope of practice issue and these
3 types of issues are among the most challenging within the state, to be honest.
4 So I'm not entirely sure what can be done. I think one of the things that probably is useful is to
5 look at states that have had some success in addressing these issues and try to look at what the impact has
6 been on such things as access. So has it made a difference? I do think that there is, in working with
7 states and thinking about things that states might want to consider, thinking about things that have worked
8 in other places within the country, identifying things like this to the degree that they are improving access, to
9 the degree that they're helping to get care, sharing that with the states. But in the end, these types of issues
10 really are usually at a state level.
11 COMMISSIONER HENNING: But isn't it CMS that's actually saying that, you know, they're
12 paying hospitals to provide access to Medicaid and Medicare --
13 COMMISSIONER MARTÍNEZ ROGERS: I'm a nurse also, a psychiatric mental health clinical
14 nurse specialist. It's a state issue, and the only way that we're going to handle it is through our
15 organizations, professional organizations to deal with the states. But it's a state issue. I don't see how
16 CMS -- personally, I don't see how CMS can do it.
17 CHAIR ROWLAND: And James thanks you, Norma, for taking him off the hook here.
18 [Laughter.]

1 CHAIR ROWLAND: He tried to say it was a state issue, but now we've made it -- Sara.

2 COMMISSIONER ROSENBAUM: I am trying to connect the dots for Denise. I'm sitting here

3 thinking about ways in which it comes back. I mean, and obviously in payment policy, the agency can be

4 very, very clear, which generally CMS is, about the availability of payment up to the full scope of practice.

5 But you can lead the proverbial horse to water, but you can't get him to drink anything.

6 You know, there's this interesting convergence now of multiple agencies, CCIIO, interestingly,

7 Labor and Treasury because of reference pricing, Medicare because of Medicare Advantage, CMCS -- I

8 mean, you're all circling the same things. Some of you express it as network issues. Some of you express

9 it as access issues. And the Medicaid access questions historically have been defined beyond networks, but,

10 you know, when you scratch it, it really is a network adequacy issues.

11 And so I'm wondering, now that basically you have multiple federal agencies all focused on the same

12 question, whether there's not a way in sort of the collective federal activities to signal a multipayer direction.

13 Because if the regulators from across the federal agencies were involved, it would send, I think, a clear

14 message to state Medicaid programs, state CHIP programs, state insurance regulators that, you know, we

15 recognize this now as a result of the Affordable Care Act, you know, is a national issue.

16 And so in the space of a week, you get Labor and Treasury with their reference pricing Q&As, you

17 get CCIIO struggling with trying to set -- you know, trying to think through network adequacy standards,

18 CMCS on the same page, everybody looking at Medicare Advantage to see what it says, and so I think it's

1 just so broad that I, you know, again would say that you don't want to see Medicaid sort of struggling with
2 this alone. And the coverage -- there's a lot of Medicaid is struggling with this, and really the fact is
3 everybody's struggling with it.
4 The other thought I had just -- I want to be sure we get it into the record somewhere today -- is that
5 there are two other access dimensions that we really haven't talked about at all. One is language, and the
6 other is disability access. There are, you know, a constant flow of DOJ complaints involving literally
7 physical access to hospital and physician offices, drug stores, dental offices, I mean, you name it, just literally
8 not being able to get into an office. And so I think that as we start to think about the dimensions of the
9 problem, it's more than just having enough capacity in the system. It's making the system accessible.
10 CHAIR ROWLAND: With that comment, I think we've learned a lot from this panel. We
11 always have tried to focus on where more training could help at the state level, and, Cheryl, you made such a
12 wonderful point at our retreat several years ago about as these models change, you need different staffing
13 capacity, and we really are trying to look at what the ideal administrative structure would be for states to be
14 able to really staff up in this changing environment. And I think that will be part of our looking at the
15 administrative work.
16 I think you made some great points about monitoring access to care for Medicaid, but we're also
17 very interested in knowing how that compares to -- and the all-payer question raises that -- access to care in
18 private insurance, because many of the places where you've pointed out there are no doctors for Medicaid,

1 there's no doctors for anyone, and I think that's an important comparison point that we want to keep in.

2 And I know that you talked about call centers and secret shoppers, and I have to admit that I'm a

3 real fan of secret shoppers since my first Medicaid venture ever was to be a secret shopper for the old PHP

4 plans in California under the person who was then Governor for whom this building is now named, and had

5 to call all the managed care plans in the L.A. area, and then find out from their provider lists how many of

6 those providers had even heard of the plan. So I do believe in that, although I think Anne just pointed out

7 that if we have too many secret shoppers, no one will be able to get through the lines for an appointment.

8 [Laughter.]

9 CHAIR ROWLAND: So I think we ought to take some caution in that.

10 But thank you very much for giving us a very informative session and really helping us as we struggle

11 with what are the right access measures, what are the right oversights, and as David points out, we do have

12 this early warning system chart, but we're not quite sure who we're supposed to even be warning. So that's

13 another piece of our puzzle.

14 So we'll take a quick break and then come back, but thank you to the panel for a great discussion.

15 * [Recess.]

16 CHAIR ROWLAND: Well, we have now just finished talking about the access component of our

17 statutory mandate, and now we are going to turn to the payment component and the way payment affects

18 access and our framework for looking at those issues.

1 So I don't know. Moira or -- Jim is going to start. Okay.

2 ### *SESSION 4*:

3 **FRAMEWORK FOR EVALUATING MEDICAID PROVIDER PAYMENT POLICY**

4 * MR. TEISL: Yes, and thank you very much.

5 So I want to start with just a couple of figures with which you are generally familiar, but they are

6 worth repeating every time we get into these conversations about Medicaid payment.

7 Obviously, the Medicaid program is a major payer of health care services in the U.S. It accounted

8 for 15 percent of total health care spending in 2012, and that is projected to rise to nearly 18 percent over

9 the next decade, due in large part, of course, to increases in enrollment.

10 In FY13, Medicaid expenditures totaled $460 billion, 58 percent of which were federal dollars.

11 Further, MACPAC's statutory authorizing language directs the Commission to review Medicaid and

12 CHIP payment policies, including assessing the relationship of payment to access and quality of care for

13 Medicaid and CHIP beneficiaries. So we begin with our old friend, Section 1902(a)(30)(A) of the Social

14 Security Act.

15 [Laughter.]

16 MR. TEISL: This is the foundational statutory provision that governs payment for all

17 Medicaid-covered services, and the statute identifies five fundamental aims for Medicaid payment policy.

18 That's to assure that payments promote efficiency, quality, and economy; to avoid payment for unnecessary

1 care; and to promote access. And as we just discussed in the last session, that's "access within geographic
2 areas equal to that available to the general population."
3 Given the program's role as a major payer for health care services, both federal and state
4 policymakers are trying to maximize the efficiency of Medicaid spending. As we know, payment policy can
5 be a powerful lever to contain costs and potentially, at the same time, to improve measures of access and
6 quality. However, there is not much in the way of federal regulation addressing the payment principles
7 articulated in 1902(a)(30)(A), and while state Medicaid programs are increasingly adopting more
8 sophisticated purchasing strategies, at the same time most spending continues to incentivize volume more
9 than value.
10 So we have been asking questions regarding Medicaid payment and the principles articulated in the
11 statute since the Commission's inception. We also noted in our very first report that there were no sources
12 of systematic and comprehensive Medicaid payment information available, which obviously creates a major
13 challenge for conducting Medicaid payment analyses.
14 We since have followed up that initial report with a number of specific examples. We have made
15 recommendations in this area regarding improvements in payment-related information.
16 We've also done a lot of work to help build our knowledge base in the area of Medicaid payment
17 policy. I won't go through everything we have done in the four-plus years, but I will highlight a couple of
18 things.

1 We have published annual state-level service spending data, including supplemental payments to the
2 extent we have been able to, as well as utilization and health status by state in our MACStats in each Report
3 to the Congress.
4 We have collected and published information on state-specific payment methodologies for, to date,
5 physicians, inpatient hospital, nursing facility payments, and state payment policies regarding Medicare
6 cost-sharing payments.
7 We have interviewed states following implementation of the primary care physician rate increase,
8 enacted through the ACA, to better understand the issues surrounding implementation of the provision and
9 its effect on access, and you will hear much more about that shortly from Ben.
10 So we've done all this work, but to date, we haven't really been explicit about how we think about
11 Medicaid payment policy more generally. We think at this point, we have sort of established enough of a
12 track record in this arena to begin to move beyond just saying we don't have the data and we need more
13 information to actually applying what we do know in some sort of a more systematic fashion.
14 So a framework would allow us and others to evaluate and compare Medicaid payments in a more
15 consistent manner, even where underlying payment amounts and methodologies aren't necessarily the same.
16 It would help us consider whether a particular provider payment methodology is consistent with the
17 fundamental aims, articulated in the statute, or more or less likely to promote those aims compared to
18 potential alternatives.

1 It could also allow state and federal policymakers to weigh the effect of payment policies, not just on
2 bottom-line spending, but also on these fundamental aims.
3 So I am going to go through each of the principles relatively quickly, and then Moira is going to talk
4 about how we would actually apply a framework going forward.
5 So, economy, measures of economy are largely comparisons of the level of payment -- so they start
6 with that payment amount -- to something like provider costs or what other payers pay for the same or a
7 comparable service.
8 As you will recall, the earliest statutory payment requirements tied Medicaid payment to Medicare.
9 Once that link was broken, we were sort of left with the upper payment limit, which set this regulatory
10 ceiling on aggregate payments to particular types of providers.
11 The statutory payment provisions that exist today generally still tie payment to either Medicare or
12 provider costs. Examples include the ACA's primary care payment increase, the prospective payment
13 system for FQHCs and RHCs, as well as payment requirements around hospice.
14 I list -- and we are going to sort of do this on each slide. We list some data sources as well as some
15 of the associated limitations. This is review for you at this point, but we wanted to sort of step through it
16 as we started to talk about the application for a framework.
17 Other possibilities that aren't listed here include some state-specific data sources regarding economy.
18 California, for example, posts hospital financial data. Some provider associations in certain states maintain

1 data sources, and some of them make those available.

2 The emergence of all payer claims databases in some states, we think holds some promise for

3 comparable economic data, although right now our experience is that their utility for Medicaid analyses is

4 somewhat limited.

5 And speaking of limitations, I will highlight just a few. You are very familiar with the fact,

6 obviously, that provider-level supplemental payment data is hard to come by, which, of course, greatly limits

7 our ability to account for the total amount of payments that providers received.

8 The Commission has made a recommendation on this subject. We are hopeful that going forward,

9 data availability in that area will improve.

10 Second, of course -- and we have talked about this before -- there is a ton of variation in how states

11 pay providers and what is included within that payment. Just to highlight an example that we have been

12 trying to puzzle through recently is variation and the extent to which payment for hospital-employed

13 physician services is included in the inpatient payment rate versus not and billed separately.

14 Again, we have been working to document these state-level policy details across states, and that's

15 really starting to help our understanding of the variation when we consider differences in payment.

16 So very early in its existence, the Commission developed a framework for assessing access in

17 Medicaid, which is displayed here, and we believe this access framework could fit neatly within a broader

18 framework for assessing Medicaid payment policy. As you recall, the framework's focused on both the

1 availability of needed services and the extent to which enrollees use those services, and of course, it requires
2 that those measures be evaluated considering the unique and diverse characteristics of the Medicaid and
3 CHIP populations.
4 At the time when we introduced the access framework, the Commission also noted that evaluation
5 of access has to consider the appropriateness of services and settings, which is, of course, consistent with
6 the statutory requirement for safeguarding against unnecessary utilization, as well as the efficiency, economy,
7 and quality of care -- reinforcing the sort of interrelationship of all these principles.
8 National data sources regarding access can be hard to come by, although claims data provide a
9 decent sense of at least utilization, and tomorrow, Katie Weider and April Grady will talk about an analysis
10 where we used utilization as an indicator of access.
11 Measures of provider availability are more limited, I think, at the federal level. They are often held
12 at the state level. There are some national surveys. They don't always give us the ability to conduct
13 state-level analyses, and particularly at the sort of Medicaid subgroup level. Another challenge, of course,
14 is the availability of access indicators for the general population in the geographic area, which again is the
15 actual statutory basis for comparison.
16 With respect to quality, of course, Medicaid payment is intended to provide not just access to care,
17 but access to quality care, and definitions and measures of quality emphasize different aspects and different
18 contexts. Generally, quality care is considered to be safe, effective, patient-centered, timely, equitable, and

1 reliable.

2 Quality measurement can rely on a variety of data sources, including administrative data like
3 eligibility, claims and encounter data, clinical data from medical records and patient-reported outcomes, yet
4 quality measurement in Medicaid remains challenged by a number of factors, including, of course, the same
5 challenges I just mentioned for the other principles, but also for the fact that that measures for common
6 health conditions within the Medicaid population aren't always available. And you will hear more
7 tomorrow from Rob. Actually, you heard some today, and you will hear more tomorrow regarding quality
8 measurement in Medicaid and CHIP.

9 Finally, efficiency. We have been thinking about efficiency as sort of this overarching principle
10 akin to value. A 2010 report was commissioned by the Assistant Secretary for Planning and Evaluation,
11 ASPE, at the Department of Health and Human Services, and they define state Medicaid efficiency as -- and
12 I am just going to quote it -- "that which produces better outcomes for a given level of spending relative to
13 other states, or similar outcomes for lower costs." And they picked this definition based on Medicaid's
14 role as primarily a health care payer. It accounts for each of the required statutory principles, and we sort
15 of think that all the various goals of Medicaid payment articulated in the statute can kind of be rolled up to
16 this overall measure of efficiency.

17 Obviously, the measures and the limitations overlap in efficiency from each of the other principles.
18 Here, we really highlight the overlap between measures of economy and measures of efficiency, because we

1 have to start with sort of those measures of payment amount relative to things like cost and what other
2 payers pay, and then the effect of those payment amounts on things like access and quality.
3 So Moira is going to now talk about how we would apply a payment framework for Medicaid.
4 * MS. FORBES: Thanks.
5 So the idea that we're proposing or asking for your feedback on here is the idea that going forward,
6 we'll seek to assess payment policies more systematically using these principles as a framework, and to
7 present information to you not on maybe one aspect of it, but across all of these.
8 And when we say payment policies, we are speaking broadly to include both the sort of state-specific
9 fee-for-service payment policies for certain provider types or service types, capitated or global payments that
10 have a comprehensive set of services for a population of enrollees for a period of time, and payment
11 reforms that are intended to realign financial incentives to achieve improvements in access and quality and
12 value.
13 As Jim mentioned, we have a lot of projects going on that are either specifically focused on payment
14 or related to payment, and staff actually got together about a month ago to sort of look at this portfolio of
15 projects and think about how do we make sure not just that our research goals for each individual project is
16 achieved during this sort of report cycle, but how do we make sure that all of this work systematically
17 relates, so that the Commission overall is saying something meaningful about Medicaid payment policy.
18 And what we kept coming back to was 1902(a)(30)(A) and a mechanism to relate our work back to that.

1 So I will talk a little more about two projects we have going on and how we think this might work.

2 We have done a lot of work on inpatient payment. We compiled the state-specific landscape of

3 fee-for-service inpatient payment policies. There's that giant matrix on the website.

4 We did the project last year that Jim referenced on supplemental payments and trying to really

5 understand the net effect of provider taxes and supplemental payments on net inpatient payments.

6 The work we're doing now is to compile an index of hospital payments across states that allows us

7 to actually compare them. It's to get payments into a format that allows us to look across states,

8 controlling for demographics, controlling for case mix, and allow us to actually look at the relative economy

9 of inpatient payments across states. And once we've done that, then we have the information -- we have

10 some of the information that we would need to start to evaluate relative effectiveness across states.

11 So that's one place where relating this back up to this framework, it will help us understand how and

12 why payments differ among states, and our ability to account for these differences when looking at specific

13 payment policies, which in inpatient range from DRG to cost-based to per diem, and think about how

14 consistent each of those is with the statutory principles.

15 Another project we have is focusing more on payment reform. We are looking at safety net

16 accountable care organization in Medicaid -- the safety net ACOs. Again, consistent with the proposed

17 framework, we are trying to understand whether the design elements of those ACOs are better aligned with

18 achieving improvements in access and in quality and value, compared to the traditional fee-for-service

1 payment incentives for safety net providers serving Medicaid beneficiaries.

2 Our initial work is qualitative, but we are hoping perhaps in the later phase to get some quantitative

3 information from the ACOs and from the states that will allow us to actually learn something, to assess their

4 effectiveness.

5 So our hope is that over time, as we relate all of these various payment projects, using this

6 framework, it will help the Commission determine what -- be able to say something about what Medicaid

7 payment policies best address efficiency and economy and promote access to quality services and

8 appropriate utilization. I mean, that's sort of our ultimate goal for the work of the Commission.

9 What did I do? Okay.

10 Besides our technological challenges, our other big challenge in doing this --

11 [Laughter.]

12 MS. FORBES: I'll give that to Jim.

13 Again, we believe we can consistently use the statutory principles as a framework. That much, we'll

14 say we can do.

15 What we do not think we can do is -- we think it's unlikely that we will have sufficient quantitative

16 information to ever make a very clear-cut assessment of the effects of a given payment policy, particularly at

17 the state level. It would be great if we could say, 'State paid according to Method A, and now they've done

18 Method B, and we have the data to say access is better, quality is better, cost is down, so Method B is a

1 winner." I mean, that's sort of the perfect world, and then the Commission could say something about
2 Method B. But to do that across all the states with all the data limitations we have, that's obviously
3 challenging.
4 So we'll continue to do what we do now, which is look for quantitative information when we can,
5 and use qualitative information when we need to.
6 We do think that it is reasonable that through all this work we have going on that we can estimate
7 the direction and magnitude of the effects of changes in payment policy on economy, quality, and access.
8 The Commission can determine the appropriate metrics and data points to measure the effects of specific
9 payment policies, and we can identify where better data or more appropriate metrics are needed.
10 Again, with the supplemental payments project, the Commission made a recommendation on
11 collecting provider-level data so that we could do policy analysis, and I think that is a valuable contribution
12 for the Commission to make.
13 So before we hand this back to you: the Commission has done a lot of work since 2010 on filling in
14 a lot of the information gaps on Medicaid payment policy. We know a lot more, and I think the policy
15 community has a lot more information based on a lot of projects that we've done.
16 There are still a lot of things that we don't know. There's some things we'll probably never know
17 about the amounts or the methods or the outcomes of state-specific payment policies, but we still think that
18 it's helpful to have an approach to very systematically think through payment issues according to those

1 principal policy goals outlined in the Social Security Act and determine whether particular policies are likely
2 to advance our policy goals and result in improved efficiency and value for the program.
3 So the questions we have for you are, first of all, have we explained this well enough, and do you
4 think this is a useful way for the Commission and for others to think about how to evaluate Medicaid
5 payment policy going forward?
6 When we are thinking specifically about access, quality, and economy in particular, or efficiency, are
7 there other data sources? Are there other things we should be looking at? Are there different ways we
8 should be thinking about it in order to do the assessments that would be helpful for you to make an overall
9 assessment of value?
10 And going forward, as we are thinking about what we should be looking at in the future, are there
11 other areas within Medicaid payment policy where doing more assessment or collecting more information
12 would be helpful in forming future policy discussions?
13 VICE CHAIR SUNDWALL: Well, thank you. Again, this is another really important
14 responsibility of the Commission.
15 A few observations. It is a little frustrating when you say we don't know enough yet; we can't really
16 make specific recommendations. We have a pretty significant budget, and it seems like on these projects,
17 you are going to be paralyzed by perfection. Aren't there some ways we can make some conclusions across
18 states that would be useful to the Commission and for us to make reports?

1 Anyway, I guess I am just -- I appreciate your integrity in saying we don't have enough information
2 to be concrete, but I do think we have a responsibility to come up with some things.
3 Regarding databases, I didn't hear mentioned those states that have an all-payer claims database.
4 That should be useful in this. I know some states -- we have a very good one that is rather robust.
5 So how do you respond to my sense that you are being too timid or too cautious, too academic in
6 your analysis?
7 MR. TEISL: Well, I will start with the all-payer claims database, just really quickly.
8 We did mention we do look at them, and we are hopeful about their utility going forward. Our
9 experience to date -- and correct me if I am wrong -- is that they have limited utility for Medicaid analyses,
10 but we think that that will continue to improve.
11 With respect to the larger question, to sort of reiterate what I think Moira was saying, we do have
12 data limitations, and we have spent a lot of time over the last few years highlighting those data limitations.
13 I think we are going to continue doing so in the interest of identifying places where more information would
14 be of more value.
15 At the same time, we are beginning to sort of collect a lot of information through reviews of state
16 policy materials, through a variety of different interviews, site visits we've been doing, to begin to get a good
17 idea of the direction and relative magnitude of consistency, I guess, with these statutory principles.
18 So I guess I'd say, sort of to the contrary, we want to step beyond just saying we don't have enough

1 information to say. We want to sort of gather the quantitative information when we can, but then
2 supplement that with sufficient qualitative information, so that we can actually get to policy
3 recommendations.
4 VICE CHAIR SUNDWALL: One little comment. I will help demystify the variation among
5 payment. When you're responsible for a Medicaid program like I was, your decisions are based a lot on
6 what you got from the legislature that year. It's money-driven. It's not some malevolent effort to not pay
7 some higher than others. You live with what you get, and of course, it varies over time.
8 CHAIR ROWLAND: Burt.
9 COMMISSIONER EDELSTEIN: Jim, in light of the complexity of all of this and your effort to
10 gain some piece of it that perhaps the Commission can deal with up front and thereby begin building a
11 portfolio of response around the relationship between especially payment and access, as Donna mentioned
12 earlier, the only thing that providers call about is payment, and the supposition is more is better.
13 But we really, I think, can focus closely in any of the provider groups, not as much on payment
14 method as payment amount, and take a look at what policymakers really need to know, which is the
15 sensitivity analysis. If one increases payment, how much bang for the buck do you get?
16 So, for example, in the analyses that I've conducted, we took a look at payment rates that range from
17 a 60 percent discount to a 15 percent premium based on commercial rates, and we find that the spread in
18 ultimate utilization is only about 5 percent. So from a policymaker's perspective, why put a tremendous

1 amount of more money into provider payment if the bang for the buck is so modest?

2 So I think one piece where at least for some types of providers, where there is enough experience,

3 enough volume to look at one payment methodology that gets you to a payment amount, and look at those

4 places where payment amounts have changed, so you have a pre and a post, we might be able to, as a

5 Commission, focus on something that we can say early on about the relationship between payment and

6 access, while you continue to build all of the resources that you have been working on.

7 Does that make sense? Might that be a valuable way for the Commission to go forward with a

8 short-term but productive reflection on the relationship between payment and access? I guess I'm asking

9 that of the Commission as well as staff.

10 VICE CHAIR SUNDWALL: The study, that is very intriguing to me, but other primary care

11 specialties, has there been a study of those various payment ranges related to access?

12 COMMISSIONER ROSENBAUM: I think certain specialties or certain areas had work done in

13 them, so I think there is some evidence around OB/GYN, what a fee increase does by way of access or

14 maybe dental, but it's not --

15 COMMISSIONER EDELSTEIN: And the pediatricians, I believe, have taken a good look at this.

16 CHAIR ROWLAND: Well, we are going to have a session following this on the primary care

17 bump, which exactly speaks to that issue.

18 There have also been a number of surveys previously of physicians where they indicate that it isn't

1 just payment. It's a lot of other issues, as well, and I think we had previous sessions that highlighted that.
2 So I think it's always important to point out the range of factors that influence access, and that payment is
3 one of them, but prompt payment sometimes is more important than high payment, too, which is another
4 issue.
5 VICE CHAIR SUNDWALL: True.
6 COMMISSIONER ROSENBAUM: I actually was sort of thinking something along Burt's lines.
7 I just assume that it's such a dramatically different thing, depending on what we are talking about
8 here. There are certain parts of the health delivery system that are accustomed to giving a deep discount,
9 and their participation, at least for certain things, is pretty much assured, regardless.
10 For example, hospitals are accustomed to deep discounts in Medicaid because they make it back in
11 other ways, and if they're non-profit, they use some of their tax obligations to write down the loss.
12 I think the question is sort of what buckets of care we build around the measures would be number
13 one. I can't even begin to get my head around our taking your very excellent criteria and trying to map all
14 of health care delivery. It reminds me of that wonderful commercial, a guy who comes and wants to rent a
15 movie. He's staying in a motel, and he asks the woman behind the desk if she has any movies to rent, and
16 she says, "I have every movie ever made for all time."
17 [Laughter.]
18 COMMISSIONER ROSENBAUM: So I think what we might want to do is choose some real

1 bellwether types of services in different settings, different patient populations.

2 The other thing I would point to, while I realize what a sensitive subject it is -- and, of course, it's

3 back at the Supreme Court. It's David's example exactly of a Medicaid agency trying to get money from its

4 legislature, the legislature saying, "We're not giving you money," and that case is now back at the Supreme

5 Court, the Armstrong case under an equal access claim.

6 But I do think that it is worth looking at particularly what the Court of Appeals for the Ninth

7 Circuit, which has been the court way out there on this question. They have been coming at this issue for

8 about 15 years, and they have laid out methodologies. They have laid out sort of their vision, and their

9 vision is much a process vision. They want to see that a state went through the kinds of exercises we're

10 talking about, and when they don't see that, they then struck down a payment reform.

11 So the question is whether we look at criteria and we look at some of the process steps used, which

12 in some ways is reflected in the 2011 CMS regulation that disappeared, but I think we are on the right track

13 trying to find, trying to get somewhere, but I think we might want to be quite selective and may need a

14 discussion about what we look at.

15 COMMISSIONER COHEN: Thank you, guys, so much for tackling this intellectual heavy lifting

16 of trying to give us some principles and a framework. It's really great.

17 I just wanted to ask you a little bit about the thing that I am not quite getting or that -- yeah. I see

18 very well how the framework that you have done, which I think is great, works for fee-for-service payments.

1 I'm having a little more trouble thinking about it in the context of either value-based payments, bundled
2 payments, other kinds of payments, and I guess I would make maybe a couple of comments.
3 One is for efficiency and economy. I am not really sure how they are different, but they are. We
4 will assume for a moment that they are different. You have done what you can do, which is to sort of look
5 for indications from the statute and elsewhere, like what that means, but what it's led you back to is either --
6 for both of them, I think, and correct me if I am wrong -- either provider costs or comparisons to what
7 other payers pay for a similar thing. That is a very sort of status quo sort of oriented way of looking at
8 things, and it may be all we can get from the statute, but it does sort of worry me that that leads you to a
9 very fee-for-service, what's the cost of the service, and if other people around you pay roughly in the same
10 arena, then you check that box and you're good.
11 So I'm kind of concerned that we don't have sort of some other way of trying to think about
12 efficiency and economy, and thinking about it in terms maybe not just of a service -- and maybe this is
13 implicit, and you can do this in your framework, but thinking about it as a course of treatment, like in a
14 bundling kind of a way or something else. It is the one area where the framework isn't quite coming
15 together, because if you're not thinking about fee-for-service, then you're trying to think about things that
16 are either payments oriented towards pushing behavior incentives in a direction and/or ones that sort of
17 look at efficiency and economy maybe over a course of treatment or based on an outcome. And it might
18 end up looking inconsistent with efficiency and economy with the sort of criteria that we have right now.

1 It really is a question. I mean, I don't understand it entirely. So I guess the question part of that
2 is, Can you talk about how the framework would apply to non-fee-for-service payments a little bit more?
3 MS. FORBES: I'm sorry. Oh, to non-fee-for-service.
4 COMMISSIONER COHEN: Yes.
5 MS. FORBES: Which is actually easier for me to think about, since that's more my background.
6 I mean, I think about we'd have to look at three things. One is what is the change in payment
7 intended to do. When we implement a payment reform and it's bundling things or it's providing a
8 comprehensive set of services to a population, everything about that, the design of that, how you select your
9 providers or your vendors, how you set your underlying rates, what you put in a contract, all of that should
10 be aligned with your defined goals for improvements in access and quality and value, so we can look at all of
11 those things.
12 We can look at how well that is operationalized. That's a lot of what some of our site visit projects
13 have been around, is so you have an idea about how you are going to do that, and when you actually go out
14 and do it, when the rubber hits the road, where do you find that when you're actually getting down to paying
15 providers to do something different, how does that work?
16 And then sort of the third piece is what are the data and what are the metrics that we can use to
17 measure that. Are they available? Are they realistic? Are we actually going to be able to collect them?
18 When we collect them, are they reliable?

1 And so I think the Commission's work in looking at these kinds of payment reforms would be to
2 ask all of those kinds of questions and to make assessments about all of those aspects of it, the design of it,
3 the operation of it, and the outcomes of it, and to try to bring back something to you that says it appears the
4 goals are appropriate, the way it's being implemented appears reasonable to achieve those goals, and we do
5 or do not have evidence to show that it is reaching those goals--and to try to speak specifically about access
6 and quality and value, but to think about the whole system, because when we were talking about that kind of
7 reform, it's not just did this person get paid to deliver this thing, which is very straightforward, but the goals
8 are much bigger. And so I think the way we think about it would be more comprehensive.
9 COMMISSIONER COHEN: But does that require -- so you are just saying you would define
10 efficiency and economy a little bit differently in that context, and I am just wondering in terms of the criteria
11 that you just sort of had listed in your slides and that you had talked about. You would use different
12 criteria because it's a different approach or --
13 MS. FORBES: I think we would use more aggregate measures.
14 MR. TEISL: Yeah. I think we're thinking about measures of economy as that payment amount,
15 right, and looking at that payment amount relative to something like provider's cost or what other payers are
16 paying for the same or similar service. That tells you something, but it doesn't tell you that much.
17 What we want to get to is an assessment of ultimately efficiency, that bang-for-the-buck question:
18 What are we getting for the dollars that we are spending? And that's true in both fee-for-service or a

1 non-fee-for-service environment.

2 Ultimately, we would like to be able to look at that, that bundled or aggregated or accountable or

3 whatever type of payment we're considering, relative to what we might be spending outside of that reform,

4 but also look at those levels of payments and what we're getting for them in terms of both quality and

5 access.

6 COMMISSIONER CHECKETT: Well, Andy teed up my concerns, and I'm glad she did, because

7 I read this a number of times, and I kept feeling like I'm missing something. I'm not getting why we're

8 doing this.

9 I think my concern on it is that things are moving so rapidly in the area of payment reform. We

10 have the SIM grants. We have a lot of states -- or not a lot -- some states incorporating requirements for

11 value-based purchasing into their managed care contracts, even if it's just a percentage. We've got the

12 DSRIP. I guess it's Delivery System Reform Programs. I know there's a big one in New York going on.

13 We have ACOs. We have pay-for-quality initiatives.

14 I don't know when you put all those things together that it's actually a large portion of the spend. I

15 suspect it isn't, but it's a large portion of payment discussion these days, and I think it's an important

16 discussion.

17 In my mind -- and I am biased, and I'm not afraid to say it -- I don't need to ask if fee-for-service is

18 efficient or economical. I mean, I already know it's neither. So my concern on this is I just want to make

1 sure that we look at areas -- and I think, Moira, you were hitting on this -- where at the end of the day, the
2 work is going to be meaningful and useful and impactful, that it isn't just, "Well, we looked at something,
3 and we found that it wasn't very efficient." Well, all right, you know, and I'm not being flip about it,
4 because there is really a lot happening in this whole area of payment reform.
5 So if we're going to go and look at a construct like this, I just really hope that we are focused on
6 areas that are very timely and that are innovative and that I think are starting to change the way the nation
7 purchases health care.
8 So that's my concern. I think it sounds like you guys are thinking of that in that time frame or that
9 type of construct, so thank you.
10 EXECUTIVE DIRECTOR SCHWARTZ: I just want to mention at this point, really the genesis
11 behind this work, although it's these guys' work, not my work, is because there are all these exciting things
12 going on, and we have projects to gather information on all of those and a real desire to be able to say
13 something more than, "Isn't that interesting?" because, yes, you have to describe it first before you
14 understand it, but then also to be able to say -- and by following these over some period of time to get the
15 information from the states about what actually happened, so that we would be able to say it was an
16 interesting concept, but in reality, it failed to deliver on these two aspects, or it was bad on these, but it was
17 awesome on this other one.
18 And for these different variations, that's exactly the point to be able for you to say -- you know, to

1 sort of check off and benchmark them against those things, rather than just to be in a position of constantly
2 describing new things and always waiting for the data for a proof of concept.
3 COMMISSIONER CHECKETT: Anne, thank you for clarifying that because then I am very
4 comfortable with the construct, which made sense to me. I just was having trouble figuring out where it fit
5 in what is a very, very dynamic time in terms of payment, so thank you so much.
6 CHAIR ROWLAND: But isn't part of the intent of this framework to be able to compare the
7 status quo, too? These are the kind of criteria that we would use. So you need some framework so that
8 you're not just examining everything in isolation.
9 COMMISSIONER CHECKETT: I thank you. I appreciate that very much.
10 CHAIR ROWLAND: Okay. Herman.
11 COMMISSIONER GRAY: I'm just glad that the Commission is going to study something that's
12 completely noncontroversial like provider payments.
13 [Laughter.]
14 COMMISSIONER GRAY: I guess I would echo Donna and Andy at the risk of piling on. Not
15 only are there significant payment arrangement changes going on in the environment, but there's also lots of
16 other confounding factors, so physicians are lining up knocking on doors, trying to get hired, and does
17 physician behavior change from a payment perspective, if they are employed and get a paycheck as opposed
18 to sort of eat what you kill -- kind of philosophy and how do you measure that and analyze and understand

1 it. I don't know what the answer to that question is. There's lots of, in many markets, hospital
2 consolidations going on and a desire to just get bigger and bigger and bigger, anticipating a population
3 health, value-based sort of payment methodology coming down the road. And so whether it benefits them
4 in the short term, they're still doing it because they see that as their long-term sort of strategic approach to
5 survival.
6 And so I, too, want to make sure that the questions that we ask, ultimately, we get something that is
7 actually knowable at the end of the day, and that's not a criticism at all. I think it is really going to be a very
8 interesting and exciting journey to get there, but I think the complexity of this, you probably understand
9 pretty well, but it's really pretty significant.
10 CHAIR ROWLAND: As you might recall, the Congress once asked us what our principles were
11 for evaluating various policies that we look at, and so I think it is incumbent upon the Commission to say
12 these are the lenses through which we are looking at different options in different policies out there, and
13 while we can tweak and refine this and maybe merge it even more to look more dynamically at what the
14 impact on access is, I think we do need a comparative framework, whether it's looking at differences
15 between two states and what they are accomplishing or between two different provider payment models or
16 whatever. So I think this is a great start.
17 David.
18 VICE CHAIR SUNDWALL: You probably are following this carefully, but the CMMI, Center for

1 Medicare and Medicaid Innovation, has funded a lot of these projects to look at different payment policies.
2 Maybe some of the SIM grants to the state Medicaid innovations -- is it time yet for us maybe as a
3 Commission to get an update from them on where they are, or have they gained enough information? I
4 know they infused a whole lot of money, $10 billion over so many years. The test is very kind of -- in part,
5 to test these payment things, would it be worth it yet to have them come tell us where they are in evaluating
6 their funded demonstrations?
7 EXECUTIVE DIRECTOR SCHWARTZ: We could certainly find out who might be the
8 appropriate person to give such an update for you.
9 I would say that in practically every one of these state innovations that we are looking at, many of
10 them are SIM states, so the SIM funding is of a component of something that they are trying to do, whether
11 that's a bundled payment or a multi-payer sort of thing. So we can be also more explicit about that as we
12 bring back some of those updates on what is going on in particular states.
13 CHAIR ROWLAND: And DSRIP too.
14 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. And DSRIP is a project that we are looking at,
15 as well.
16 CHAIR ROWLAND: Well, thank you both.
17 And just to continue looking at payment policy, as we all are very aware, the physician primary care
18 payment increase that was slated to be in effect for 2013 and 2014 is about to at least end with the federal

1 reimbursement, and we've been interested in knowing what the impact of that is, and probably we'll hear
2 that there's no absolute answer. We don't have an equation that we can plug to say this much of an
3 increase in physician payment yields this much of an increase in access, but Ben's going to try and tell us
4 what we know.

5 ### *SESSION 5*:

6 **AN UPDATE ON THE MEDICAID PRIMARY CARE PAYMENT INCREASE**

7 * MR. FINDER: I think we have some information, as Moira characterized it. So with the
8 framework fresh in your minds, let's begin to evaluate the primary care payment increase.

9 I'll start by reviewing our previous work, which was covered a little bit in the discussion before and
10 the discussion on access earlier today. After that I'll present findings from our more recent work, which is
11 some semi-structured interviews in about eight states, and I'll describe our methodology around that in just
12 a minute. And our hope is that this session will update you on the primary care increase and that it will
13 spark some conversation about the provision. To that end, we've included some policy questions for you
14 to discuss that will help start that conversation.

15 Before I get into our previous work, I wanted to give you just a crash course on the primary care
16 payment increase, sometimes called the PCP bump -- you may have heard it referred to as that -- or
17 Medicaid/Medicare parity.

18 You'll recall that it's a provision of the Affordable Care Act that requires states to increase the rates

1 of certain services for certain physicians. The increased rates would be paid for services between January
2 1, 2013, and December 31, 2014. The federal government will fully fund the difference between the states'
3 prevailing rates on July 1, 2009, and the Medicare rates in 2013 and 2014.
4 So just to be clear, that's if a state paid, let's say, 80 percent of the Medicare rate in 2009, they get
5 their usual match for that 80 percent of Medicare, and then the federal government will fully fund the 20
6 percent up to the Medicare level.
7 With that under our belt, we'll recall that we last discussed this in our June 2013 report to the
8 Congress. There was a chapter in that report that reviewed research that demonstrated the association
9 between lower payment rates in Medicaid relative to other payers and lower physician participation. I
10 think we covered that a little bit in the previous session. And as Diane mentioned, there are other factors
11 that affect provider participation in Medicaid, too, factors like patient non-compliance, which someone
12 mentioned in the access discussion earlier today; delayed payment or timely payments; and paperwork
13 requirements.
14 The chapter also presented findings from semi-structured interviews with officials in seven states.
15 Those interviews were conducted in October of 2012 to January of 2013. And when we say officials, we
16 mean Medicaid officials, which include people like the Medicaid director, their policy staff, and their
17 technical staff; officials from Medicaid MCOs, which tend to be operations staff and some of the policy
18 staff there as well; and provider organizations like medical societies, primary care associations, and chapters,

1 local and state chapters of provider groups like the American Academy of Pediatrics.

2 So at the time of those interviews, states expressed concern to us that the late publication of the

3 final rule gave them little time to be ready to implement the payment increase by January 1, 2013, and they

4 raised a couple of concerns, operational concerns, about their preparation for the payment increase, and that

5 was identifying providers, making modifications to claims processing systems; and at that time states and

6 MCOs were really wrestling with how to implement the payment increase in a managed care setting.

7 One of the chief issues under that header is there are many ways that MCOs pay some of their

8 physicians. Some MCOs use a subcapitation system or per member per month. There are alternatives to

9 the fee schedule-based payment mechanism that's used in fee-for-service. So that creates difficulty for the

10 states and MCOs in figuring out what the baseline rate was or a comparable rate to what the fee schedule

11 would have been under managed care and to figure out what to increase the rates to.

12 The chapter also highlighted the importance of a comprehensive evaluation of the effect of the

13 primary care payment increase, ideally using national claims data and adjusting for other factors. But we

14 noted that these data wouldn't be available until well after the provision expires at the end of this year.

15 In light of those data concerns, we suggested that surveys and key informant interviews might

16 provide another strategy to get more timely information about the primary care payment increase. So this

17 summer, we set about conducting semi-structured interviews in eight states. We conducted 29 interviews

18 with officials in Alabama, Kentucky, Michigan, Missouri, New Mexico, Rhode Island, Virginia, and

1 Washington. These states were chosen with a number of criteria as mentioned in the paper in your
2 binders, but primarily to represent different perspectives from within the country and within different
3 Medicaid programs. Two of the states we had interviewed in our last round of interviews. That included
4 Alabama and Rhode Island.
5 And today I'll discuss the findings from the more recent interviews with you. They generally fall
6 into four areas.
7 The first area is provider outreach and enrollment. We found that states reported initial challenges
8 in identifying eligible providers have largely been resolved. Providers were required to self-attest to their
9 eligibility. They can attest based on two ways, either through board certification, the second pathway is a
10 claims threshold. So if you're a primary care provider practicing without board certification or without
11 certification in one of the boards that was specified in the regulation, but 60 percent of your claims in the
12 previous year fell under the claims that were enumerated in the regulation, you can become eligible for the
13 primary care payment increase.
14 We found in our interviews that this pathway was less often chosen. Providers tended to self-attest
15 based on board certification. Really to a majority, basically between 78 and over 90 percent, depending on
16 the state, said that they attested based on board certification.
17 So in designing that self-attestation process, one of the major challenges was determining eligibility,
18 and states reported that they lacked clarity from CMS on the parameters for determining eligibility.

1 For example, one state told us that they had rural health clinics that were not FQHCs or FQHC
2 look-alikes in which their providers were paid on the fee schedule. There was a lot of back and forth with
3 CMS over whether providers under this system would be paid the primary care payment increase or not.
4 We also asked states about their outreach efforts to providers, and not surprisingly, states reported
5 that their efforts were generally limited to the providers who were already participating in Medicaid, and I
6 say "not surprising" because they were able to contact the people for whom they had information for.
7 Those are the people that participate in their programs and that are being paid on a regular basis.
8 But in most of the states that we spoke with, the provider organizations told us, and states also
9 confirmed, that they partnered together to communicate the information and education about the payment
10 increase to the broader provider community.
11 States said unanimously -- sorry. States unanimously reported that few of the participating
12 providers were new to Medicaid. So largely the people that got in or self-attested were people that were
13 already in their networks. And states and provider organizations mostly used the typical communication
14 methods -- these are things like e-mail blasts, provider bulletins, regular mail -- to communicate the
15 education and information about the primary care payment increase.
16 There were two states that had sort of innovative methods that we felt were worth highlighting for
17 you. One state mentioned that they purchased an ad in a professional journal to provide that information
18 to providers to get in on the payment increase. And another state described town hall-style meetings

1 where the Medicaid director went around the state and talked to providers about participating and what it
2 would take and how they could get in.
3 Most states reported that they -- making the first increased payment in May 2013 or later. In one
4 case, a state wasn't able to begin making the payments until October of 2013. And some of the
5 interviewees we talked with expressed concern that these delays may have cast doubt on whether providers
6 would ever receive the increase and shortened the time frame in which providers would receive or
7 experience the increase overall.
8 Secondly, in four of the states that we interviewed, they reported that the payment increase was
9 implemented at different times in the managed care organizations, the Medicaid managed care organizations,
10 than it was in the fee-for-service system.
11 You'll recall that in our previous round of interviews, states were concerned about the challenges of
12 implementing within managed care, and it seems like those concerns were largely realized. In this round of
13 interviews, states confirmed that those challenges contributed to delays in implementing the provision.
14 And in some states, providers expressed confusion or frustration about the separate timelines for
15 implementation.
16 This next slide gets to the issue that Moira highlighted over did the payment achieve its intention or
17 what it was intended to do. In general, the payment increase had at best a modest effect on provider
18 participation, according to states and MCOs. Three of the states reported a modest increase, and three of

1 the states said that anecdotally they believed it helped, but they didn't have the data to support that.

2 Two of the states said that it didn't have any effect. These states reported to us, though, that

3 provider participation in their networks was already high. In one case, one state noted that state

4 regulations require providers participating in an insurer's commercial market to also participate in their

5 Medicaid managed care markets.

6 Six of the eight states told us that it did not have an effect on the use of primary care services. On

7 the other hand, in the two states that did report it had an effect, they said that it had between a 1 and 7

8 percent on an increase in the use of primary care services between 2012 and 2013. I'd note we interpret

9 this with some caution because it hasn't been adjusted for other factors that were going on in the states.

10 It's worth noting that one of the states was a state that opted into the Medicaid expansion and the other

11 state did not opt into the Medicaid expansion.

12 We also asked states and provider organizations about patient load. We thought another way of

13 looking at this might be to see whether providers increased the number of Medicaid physicians -- or

14 Medicaid enrollees, sorry, they were already seeing. Unfortunately, neither states nor provider

15 organizations had any data to share with us on this topic.

16 We have seen some other research on this area. For example, the Ohio State Medical Association

17 found that providers did increase the patient load. We also interpreted these results with some caution

18 because their response rate to their survey was 8 percent. And we're always looking for other studies in

1 this area, too.

2 We tried to ask states and medical societies about the impact on providers, how much they received

3 on average as a result of the increase. States didn't have a systematic way when we asked them this to

4 communicate to us or to tell us how much providers received on average. So we tried to look at this two

5 other ways. We looked at overall spending on the federal level on the payment increase. So from January

6 1, 2013, through the halfway point of this year, three-quarters of the time frame in which providers were

7 eligible to receive increased payments, the federal government spent $5.6 billion on the payment increase.

8 I'll note that that's expected to grow as states process more claims payments and draw down more federal

9 funds.

10 We also looked at the increase on specific codes. There's some information in your binders about

11 this as well. We compared rates for all of the affected codes from 2009, 2012, 2013, and 2014. And we're

12 still working through the data, but we've highlighted six particular codes for our Commissioners. These

13 are codes that are commonly provided in Medicaid. Three of them are office visit codes, one is a vaccine

14 administration, and one is an emergency room code.

15 The increase varied by states, which we knew, and it's a common refrain in Medicaid; and it varied

16 by code also. For vaccine administration, we found that increases ranged between 37 percent and 52

17 percent, and office visit codes, they vary across the board. So when we looked at the increase, it was as

18 little as 23 percent in some cases to over 80 percent in three states. For example, in one state the rate of

1 physician office visit went from $11.98 to $48.72 between 2009 and 2013.

2 The last area that I want to talk about are states' evaluation efforts and the future of the payment

3 increase, and I'm going to take this in a little bit of a reverse order.

4 It has been reported that six states plan to continue to pay Medicare rates for primary care services

5 at the state's usual match in 2015. An additional eight states plan to continue to pay at higher rates,

6 although not necessarily at Medicare level, according to a recent Kaiser survey. The six states that plan to

7 pay at their -- pay the Medicare rate at their usual match were Alabama, Colorado, Iowa, Maryland,

8 Mississippi, and New Mexico. We interviewed two of these states, and they confirmed that to us. And

9 the other eight states were Connecticut, Delaware, Hawaii, Maine, Michigan, Nebraska, Nevada, and South

10 Carolina.

11 And what I mean by they'll pay at higher rates, although not necessarily Medicare level, one of the

12 states we talked with said that they planned to split the difference with their providers. So, in other words,

13 they're not going to go all the way back down to where they were in 2009 but halfway between the Medicare

14 rate and where they were then.

15 So back to evaluation efforts, nearly all the respondents reported that they didn't have plans to

16 evaluate the primary care payment increase, and nor had states been asked to provide data to CMS. One

17 state said that they -- one of the local universities does a workforce survey and they planned to use some of

18 that data to do an evaluation, but that was the only state that mentioned to us that they planned to evaluate

1 the effect of the primary care payment increase.

2 States wanted to -- most of them mentioned that there was a staff capacity barrier, that they didn't

3 have the time to dedicate towards evaluating this, especially in light of the fact that it was set to expire.

4 And there are some federal efforts underway. For example, ASPE plans to -- ASPE has a contract out

5 with RAND in which they plan to explore claims data next year. Unfortunately, the results won't be

6 available until late next year.

7 There's also some new research, and this is different -- we weren't able to incorporate it in the paper.

8 It's something that we've just heard about recently. There's some new research from the University of

9 Pennsylvania and Urban. We're very grateful to them for lending us their slide and giving us the

10 permission to show it to you today. It's in the process of publication, so before I get to it, it's important to

11 note that we're including it given its timeliness. The provision is set to expire in December, so it's

12 important we continue to think about this, consider it as we're thinking about the evaluation of the primary

13 care payment increase in general. But it's also important to consider where it is in their process, too.

14 So Urban and the University of Pennsylvania did some secret shopper surveys in which they tried to

15 get a new appointment with Medicaid managed care and private insurance. They sent secret shoppers out

16 or calling providers over the phone to try to get a new patient appointment, and they told the providers they

17 either had Medicaid managed care or private insurance. They did this in 2012 and 2014, so they

18 established a baseline, and they have some updates to it. And they tried to compare the likelihood of

1 getting a new patient appointment with the magnitude of increase in the fee-for-service payment rate.
2 Broadly they found that the likelihood of getting a new appointment increased by about 8 percent between
3 2012 and 2014.
4 They also looked at the association between the magnitude and likelihood, and this is where we'll
5 look at the graph. If you look at the states on the right, those are states where the increase in the provider
6 payment rates or the fee-for-service rates were higher. States on the left had a provider rate prior to the
7 bump that was closer to the Medicare level. And --
8 COMMISSIONER ROSENBAUM: Sorry. Did they call the same [off microphone]?
9 MR. FINDER: They did, yeah.
10 COMMISSIONER ROSENBAUM: So it was matching them against what [off microphone].
11 MR. FINDER: Most of their sample was the same. There were some new, and some fell out due
12 to attrition. But broadly most of them were the same.
13 So what they found was that there's an association between the increase of the payment rates and
14 the likelihood of accepting new patients in Medicaid.
15 There are some limitations to this, so they're looking at the fee-for-service increase, but they sent out
16 the secret shoppers saying that they had Medicaid managed care. But despite these limitations, we believe
17 it's worth bringing to your attention as you consider the effect of the primary care payment increase.
18 CHAIR ROWLAND: Is this about to be published or released? What's --

1 EXECUTIVE DIRECTOR SCHWARTZ: They presented it to a group of people on Tuesday,
2 and then they asked permission -- they've submitted it to the New England Journal, and they actually asked
3 permission from the New England Journal for us to show it here without --
4 CHAIR ROWLAND: Without jeopardizing --
5 EXECUTIVE DIRECTOR SCHWARTZ: -- jeopardizing their publication.
6 CHAIR ROWLAND: -- the publication.
7 EXECUTIVE DIRECTOR SCHWARTZ: So I don't know what the turnaround time is at New
8 England Journal, but it probably will be out soon. So I don't know what reviewers will say about it, but --
9 CHAIR ROWLAND: Although I would say then for those -- it should not be cited, or it should
10 be preliminary and not cited.
11 MR. FINDER: Yeah, I'm -- the audience probably can't see because there's a row of
12 Commissioners. But at the very bottom of the slide, it says, "Not for quotation or distribution."
13 VICE CHAIR SUNDWALL: [off microphone].
14 MR. FINDER: It's not in your packets, yes. That's right.
15 VICE CHAIR SUNDWALL: [off microphone].
16 [Laughter.]
17 CHAIR ROWLAND: We've learned that people can take pictures of slides with phones.
18 MR. FINDER: So I hope that these findings provide you with a little fodder to deliberate on how

1 to proceed with our analysis on the primary care payment increase.

2 At this point, many organizations are calling on the Congress to extend the payment increase.

3 There's two bills in the House and one bill in the Senate that would extend the payment increase.

4 The paper outlines some options for how we could proceed with this analysis. For example, the

5 Commission could choose to publish an analysis that reports these recent findings along with a synthesis of

6 others and discusses the policy issues. Or the Commission could choose to make a formal

7 recommendation to the Congress on the future of the payment increase.

8 In thinking about those options, we have outlined some of these policy questions for you. Some

9 of these were borrowed directly from the payment framework questions, you'll probably notice. The first

10 question is: What conclusions can be drawn about the impact of the provision? So there are some

11 findings from our work and others' from which to draw some of these conclusions.

12 For example, we know that the response has been mixed. Some states were cautiously optimistic

13 about the provision's impact. On the other hand, other states reported they experienced no changes in

14 provider enrollment and that access to primary care wasn't a concern.

15 Secondly, how well does increasing primary care rates for certain services relate to promoting

16 primary care? We know that Medicaid rates historically have been low relative to other payers and that this

17 has been associated with lower provider participation. On the other hand, it's not the only factor. These

18 are things that we discussed earlier. Delayed payment, paperwork requirements, for the bump, did the

1 payment increase provide enough incentive to offset these operational challenges?

2 Thirdly, how can the outcomes related to the primary care payment increase be measured?

3 And, lastly, does the primary care -- does the provision itself warrant extension? Providers have

4 been paid more, reducing one of the commonly cited barriers to Medicaid participation. On the other

5 hand, there are other questions about whether operational issues overwhelm the payment increase.

6 Moreover, if it does warrant an extension, there are other policy questions to consider. How would

7 an extension be implemented in managed care? Who should be eligible for increased payments? And,

8 more broadly, are there other things that we should think about and other changes that we would make to

9 how it was implemented?

10 So that's the findings that we have for you today, and I look forward to your conversation.

11 VICE CHAIR SUNDWALL: Well, thank you. This is of great interest to me as a primary care

12 physician, and I always applauded the intent of the Congress in increasing this. What I'm surprised at is

13 apparently they never had a requirement in the law that they evaluate this policy. If CMS didn't have such

14 expectations on the states, then I imagine -- I'm just kind of nonplussed. I would have thought there

15 would have been a built-in mechanism, because I admit that we're kind of going on faith now, but it would

16 make a difference to access, and because there was no requirement on states to evaluate it, we now don't

17 have any evidence as a Commission to say, yes, go forward with this, it makes sense, because how are we

18 going to make that recommendation if we're an evidence-based Commission? So we can't do it because it's

1 the right thing to do. We're supposed to have evidence that it would make a difference in access.

2 MR. FINDER: The regulations don't require that states conduct an evaluation. They do lay out

3 the case -- or the regulations require that CMS require states to provide some data to them. When we

4 talked to states, we asked them, have you heard from CMS about providing this data? And they hadn't at

5 this point.

6 It is clear, though, that CMS supports ASPE in their efforts to better evaluate the effect of the

7 payment increase.

8 COMMISSIONER CHAMBERS: Thanks, Ben. For someone who has lived through this

9 implementation over the last two years, it has been almost a nightmare, quite frankly. And when you look

10 at the long-term policy questions, I think about -- you know, the second one, well, the one the slide -- how

11 well does increasing primary care rates for certain services relate promoting access to primary care. We

12 found a number -- not adding a lot of physicians, there was a lot of uncertainty for primary care physicians

13 that weren't participating, well, this is only for two years, so why do I want to go through all this? And

14 then when they found out it was going to be -- particularly in California, there's a lot of -- we do a lot of

15 capitation, either directly to primary care physicians or to IPAs that capitate primary care physicians. So

16 everyone was trying to protect the existing contract. So you don't want to put a new rate in for a limited

17 period of time, so it's like here's your rate, and then we're going to give you this additional to make up the

18 difference, and administratively it's been a nightmare, quite frankly.

1 Then the state, the way they have gotten approval from CMS, and it took them like a year to get
2 approval of the state plan amendment, how it was going to be paid, and so, you know, we're still making
3 payments for 2013. So I think we have to be careful, as I say, the take-up rate wasn't high, but I think if a
4 state -- or this was extended permanently, would primary care physicians approach it differently? And I
5 think the administrative difficulties of doing it would change going forward because, as I assume, if the
6 increase was permanent, you know, the reimbursement to providers, particularly capitation payments, would
7 be increased and there wouldn't be this big hassle of trying to figure out whether you got paid or not and
8 you got paid the additional amount. So it just -- it could be -- if it was put into place permanently, it may
9 overcome a lot of the barriers that we had in, one, recruiting new physicians, and, two, getting current
10 physicians satisfied that it really is not -- they're not sure if they've gotten any additional money or what.
11 So just a couple comments from on the ground.
12 CHAIR ROWLAND: You know, I think that's an important comment. That whole framework
13 was so temporary that it really didn't provide for full implementation, the concept. And, two, in the budget
14 report that the Medicaid directors did with us, they noted in another 14 states -- a third of the states said
15 they probably wouldn't continue the bump; a third said they would do it if the federal government
16 continued to pay them the differential; and a third that then reported on said they were going to do it even
17 though it was back at the existing match rate or at a level close to it.
18 So I think there was some recognition among many of the states that this was at least worth

1 continuing, but it was a funding issue in some of the other ones.

2 COMMISSIONER CHAMBERS: Could I just -- a real quick follow-up to your comment, Diane.

3 When you said the six states plan to continue to pay the higher rates at their usual match rate, did they have,

4 you know, at Medicare, close to Medicare before the rates? So, I mean, it's pretty easy to say, yeah, we're

5 going to continue doing it because it really didn't cost us that much, as opposed to states like I was saying

6 earlier today, California's rate prior to the bump was about two-thirds of Medicare, which meant that

7 primary care physicians were getting like a 50 percent increase, which that cost the state a whole lot more to

8 consider whether to continue it or not. So I'm just curious. Did it have an influence on the states that

9 said they were going to continue at the lower match, it really wasn't much different if they rolled it back

10 because they were pretty close?

11 MR. FINDER: So it ranges. Alabama I think was in the high 70s or low 80 percent prior to the

12 payment increase, and they're one of the examples. So it ranges, is the answer. It varies.

13 I should note also that when we did talk to states about whether or not they were going to increase,

14 two of the states mentioned that they had legislation in their state legislature to increase it that ultimately

15 didn't make it out of committees or didn't make it out of the legislature. So there were two other states

16 where they wanted to, but weren't able to because they didn't have the budget authority.

17 CHAIR ROWLAND: Ben, a question. When we released this, was there any issue of

18 confidentiality with naming the states that participate? Or were they all willing to be named in the

1 documents?

2 MR. FINDER: So we told them that the specific things that they told us would be kept

3 confidential, but in aggregate we would mention their participation. Things like their fee schedule rates are

4 public information, and I think we don't have a problem releasing that information publicly. But there are

5 -- I guess the answer is there are some parts of it that are -- we should keep confidential and some parts that

6 we don't.

7 CHAIR ROWLAND: Okay.

8 COMMISSIONER CARTE: I would be interested to see -- I've never seen any figures as, you

9 know, budgetary impact, overall how much does it cost the state Medicaid program as a percentage of its

10 overall Medicaid budget to do this. I think that that would be helpful information for the Commission to

11 see.

12 And, secondly, I'm curious to know if any of the states that you interviewed about specifics had

13 anything -- thoughts about how they would rather see this primary care money used towards effectiveness

14 or efficiency or other performance things such as quality measures, such as care coordination, supportive

15 structure, because, you know, when you talk to primary care physicians, they'll tell you how challenged they

16 feel, especially for pediatric areas, to -- if they find certain issues, where do they send those children?

17 Which goes back to our access issue.

18 VICE CHAIR SUNDWALL: Sharon, I can't resist countering that a little bit. As a primary care

1 physician, I can't tell you how I resent yet another quality measure request or another survey or another -- I
2 would rather have the money, if I were in private practice, but we just feel beleaguered. There's the
3 HITECH requirements for meaningful use. There's the array of NCQA. There's the -- now every health
4 plan has their own request for you to document what you're doing, and then you get letters telling you
5 you're not doing it right. And it's just one -- I want to say, "You come take care of the patients then.
6 Quit telling me how to do it and asking me how I'm doing it."
7 CHAIR ROWLAND: His end is --
8 COMMISSIONER CARTE: I understand.
9 [Laughter.]
10 COMMISSIONER HENNING: And I would be remiss if I did not mention that those of us that
11 provide primary care to women, like OB/GYNs and nurse midwives, as well as nurse practitioners, do not
12 get a primary care bump, period, because it wasn't written into the legislation. It was written into the
13 House legislation, and apparently by the time it went to the Senate, their legislation either didn't have it in it,
14 or it got dropped at the last minute. Whichever the case was, you know, we were left out of the legislation.
15 There are a lot of nurse practitioners that work in states that are fairly rural that actually have their
16 own businesses, that this could be a very large help to them. There's those of us that work in states that
17 are restrictive that we wish weren't quite so restrictive and, you know, may possibly help us eventually. So,
18 you know, it's something to think about, especially primary care for women. I mean, OB/GYN care, we

1 take care of vaccines, we do HPV vaccines, we do flu vaccines, we do weight management, we do annual
2 GYNs, we do Pap smears. These are all primary care functions, and we're just not in this legislation.
3 CHAIR ROWLAND: You know, I clearly think where we are is that we're using the primary care
4 payment bump because it's there as a vehicle to examine what we can from it. But what we're really trying
5 to assess as a Commission is how do we promote broader access to primary care. What are all the tools
6 that could be used, including changes in scope of practice, including broader use of managed care, including
7 different payment policies? And maybe that's really the framework that we want to go at. This is one
8 shred of information, but it's not the sole way to promote better access to care. And we've all noted that
9 specialists can be an even bigger problem in the Medicaid program than primary care doctors, so maybe it's,
10 you know, second tier is, you know, and what happens when they need a specialist.
11 COMMISSIONER COHEN: I might also say that I think this example, you know, is instructive
12 for two other things, although I think the evidence is a little murky about it. One is, you know, thinking
13 about the value of very temporary policies and payments bumps and just thinking about the sort of juice for
14 the squeeze, you know, kind of, you know, ratio of, you know, how hard is implementation versus a really
15 well-meaning effort to put, you know, some presumably available budget money, you know, to good use,
16 but you really have to think about implementation. So I do think that that is another sort of area that we
17 can think about from this example, is just sort of what's the value of a short -- you know, of a really short
18 implementation, no matter how well intended.

1 And I think the other one -- and I think it's kind of interesting. I mean, people have different
2 theories about how much payment motivates change in behavior among providers and how quickly or how
3 slowly, and I think that this is sort of, you know, interesting and instructive. Probably much of the money
4 went to fairly small practices without much of like a policy infrastructure or, you know, other things. And
5 yet, you know, there's some evidence that there was some movement, some change, even in a short period,
6 but not very much. So -- but that's another thing that I think it kind of just enhances our information
7 about like does payment change people's behavior and how quickly and what kinds of practices and I just
8 thought I'd throw that out.
9 COMMISSIONER CHECKETT: Actually, just a question for Anne or Diane. Is Congress
10 seriously considering an extension to this?
11 CHAIR ROWLAND: Well, the President actually proposed it in his last budget, and we don't
12 know whether it will be proposed in the next budget. And some have talked about trying to do it during
13 the lame duck session, but I think it has less chance than CHIP.
14 EXECUTIVE DIRECTOR SCHWARTZ: I think Congress is getting a lot of questions on it and
15 would be interested in what the Commission has to say. You saw the letter that I passed around from
16 ACOG. The physician groups are certainly very interested in that. You know, I don't know where they
17 are in the queue of things that Congress might want to do with the next Medicaid dollar.
18 CHAIR ROWLAND: Oh, the interesting part, of course, is that because everybody had to do it,

1 the infrastructure now to do it and continue it has been set up so --

2 COMMISSIONER COHEN: And you can -- I mean, now you're looking at the opposite of it.

3 You're looking at the unraveling, even if it was expected. Again like at policy levels of always expect it, but

4 now, you know, without it, providers are going to experience a payment cut, and how does that change

5 behavior.

6 CHAIR ROWLAND: I do think that the findings in this chapter are worth getting out sooner

7 rather than later as I would say this would make a nice issue brief of kind of where are we in raising the

8 questions about undo -- you know, if you undo it, are you really -- you are going to have a cut, sort of the

9 implications of not moving forward. But I think that would be a very helpful policy brief to have out to

10 just say this is the mixed response, which is why I asked about identifying the states that we talked to be sure

11 that, you know, the states don't mind being identified if they do, but most of the data that you've put out on

12 the states is publicly available.

13 COMMISSIONER MOORE: If we do some sort of an issue brief, maybe another issue to raise is

14 the lack of a clear evaluation plan and the thought that if it is to be continued, that that be a part of any

15 future discussions, whatever.

16 CHAIR ROWLAND: Thank you, Ben, and now I'm going to do a sort of switch, and I'm going to

17 call on Rob Nelb to come up and talk to us about the HHS Reports on Adult and Child Quality in Medicaid

18 and CHIP, which were intended to be discussed tomorrow, but we'll have a few less Commission members,

1 and we are running a little ahead of schedule today. That sort of ties with our morning discussion.

2 EXECUTIVE DIRECTOR SCHWARTZ: And Rob can relax tonight.

3 CHAIR ROWLAND: Yeah, Rob will have double duty today and needs to go in tomorrow.

4 VICE CHAIR SUNDWALL: What tab is this?

5 CHAIR ROWLAND: This is now Tab 9.

6 ### *SESSION 8*:

7 **REVIEW OF HHS REPORTS ON ADULT AND CHILD QUALITY IN MEDICAID AND**

8 **CHIP**

9 * MR. NELB: Great. Yeah, it's your lucky day. You get to have two of me, and I know you were

10 hoping to get out soon, but I'll try to entertain you for the last hour.

11 [Inaudible comment/laughter.]

12 MR. NELB: Fair enough. So this afternoon I'll be reviewing two recent HHS reports to the

13 Congress on adult and child health care quality in Medicaid and CHIP. Even though we've rejiggered the

14 schedule, I think it's actually – a good time to put it because quality, of course, is something that relates to

15 both the access and payment issues that we heard before, and, you know, even if people have different

16 views about quality measures, as we heard from Dr. Sundwall, I think we can all agree that understanding

17 quality and ways to improve it relates to a lot of our different efforts.

18 So there are two specific reports I'll be talking to you about. The first is a report on quality of care

1 for adults that HHS released in June of this year as required by the Affordable Care Act. And the second
2 report is a report on quality of health care for children that was released by HHS in July of this year. It's
3 the second of such reports required under CHIPRA. Because both reports are so similar, I'll be presenting
4 them both together today. And just like the CHIPRA evaluation that I presented this morning, because
5 these are reports to the Congress, the Commission has a unique opportunity to comment. And so I'll be
6 specifically asking for your feedback today about potential areas for comments that the Commission may
7 want to make.
8 Since it's been a little while since the Commission was briefed on the CMS core quality measures, I
9 thought I'd begin today's presentation with a bit of overview for you, of reviewing these measures and how
10 they fit into the larger context of Medicaid and CHIP quality improvement efforts.
11 With that background, then, I'll dive in to actually describe the contents of these reports, which
12 really are kind of a status update about where HHS is in implementing many of those different quality
13 efforts.
14 And then, finally, I'll identify some potential areas for comments that the Commission may want to
15 consider in any future written response to HHS and the Congress. Again, just like my presentation earlier
16 today, the memo that you have is really a draft for discussion, and I'll be listening to your feedback to
17 incorporate it in any future written response.
18 Okay. So let's begin at the 10,000-foot level. What is quality? And how do Medicaid and CHIP

1 fit in?

2 As I'm sure you're all well aware, definitions of health care quality vary widely. As we heard earlier

3 today, in 2001 the Institute of Medicine defined quality as "care that is safe, effective, patient-centered,

4 timely, equitable, and reliable."

5 Since then, HHS in these reports and in some others has adopted a slightly broader definition of

6 quality that involves a goal of achieving care at the right time in the right setting, which is a view that

7 incorporates prevention and care outside of the traditional clinical setting.

8 In addition, these reports that I'll be talking about today go even a step further and actually include

9 some discussion about the duration and stability of coverage as another component of quality. So that's

10 why they'll be part of the discussion as well.

11 So as you're well aware, Medicaid and CHIP agencies are really the primary drivers of quality on the

12 ground in Medicaid and CHIP, and the states advance quality primarily through their role as purchasers of

13 health care. So states are the ones that set definitions of benefits in many cases, and they also design

14 payment policy strategies such as various incentive arrangements for quality. And in many states, as we

15 heard, that administer managed care programs, there's another element of quality that's sort of built into

16 their day-to-day functions.

17 CMS in its federal role primarily supports the states' quality efforts through a variety of means,

18 including technical assistance, grants and demonstrations that provide additional funding, federal policy

1 guidance about requirements and options, and, finally, quality measurement standards.

2 So, again, the reports I'll be talking about today focus on what CMS' role has been in terms of

3 quality, but I just thought I'd begin by highlighting the fact that, again, the states and other players have an

4 important role to play as well.

5 All right. So let's talk a little more about quality measures, which is one of the key focuses of the

6 reports. So quality measurement is integral to both state and CMS quality improvement efforts. In order

7 to improve, you need to know how you're doing. But as I'm sure you're aware, the types of quality

8 measures used vary.

9 On the one hand, there are process measures, measures of whether a particular type of service or

10 care was received -- for example, office visits or screenings. And they're probably the most commonly

11 used, in part because they're the easiest to measure.

12 However, more and more payers have been moving towards outcome measures, measures of health

13 status, to get a better sense of care. So if a process measure might be diabetic screenings, an outcome

14 measure might be something like control of diabetes or, better yet, the prevention of diabetic complications.

15 Another way to look --

16 CHAIR ROWLAND: Rob, let me just interrupt for one second.

17 MR. NELB: Sure.

18 CHAIR ROWLAND: The slides since I moved this from yesterday to today -- sorry, from

1 tomorrow to today, are now in the back of the room if anyone wants the hard copy of the slides.

2 MR. NELB: Great. And hopefully the Commissioners found it at the end of your -- in your

3 materials.

4 Yeah, I just lastly wanted to mention patient-centered measures, sort of another way to look at

5 quality from the patient perspective. An example would be some patient satisfaction measures, CAHPS, or

6 some sort of patient activation measures of how well patients know how to manage their care.

7 If that wasn't complicated enough, the world of quality measures gets even more complicated when

8 you look at the number of quality measures across payers, and sort of slight variations in different

9 definitions of quality measures. In fact, in a recent HHS report, they estimated that as many as 4,000 --

10 over 4,000 different quality measures are currently in use by public and private payers, many of which, again,

11 are measuring the same thing, just in slightly different ways.

12 VICE CHAIR SUNDWALL: [off microphone].

13 [Laughter.]

14 MR. NELB: And so the CMS core quality measure program sort of enters into this context as sort

15 of one of many efforts to focus states and others on a common set of measures to try to capture quality of

16 care that can be used by states but also by managed care plans and providers to understand how quality is

17 doing.

18 CHIPRA was the first to require a core set of quality measures for children, and those measures

1 were developed in 2009, and voluntary state reporting of the measures began in 2010. The Affordable
2 Care Act then followed by requiring CMS to develop a similar core set of quality measures for adults.
3 Those measures were developed in 2010, and voluntary reporting of those measures is underway this year.
4 Again, these two core quality measures are the main focus of the report, but there are many other
5 HHS measurement alignment efforts underway through the National Quality Strategy and a variety of other
6 multipayer partnerships.
7 Okay. So now that you have a little context, what do the reports say? Again, the main focus of
8 the report is a status update about where CMS is in implementing the core quality measures and also a listing
9 of where it is some other quality improvement strategies underway.
10 Overall the reports describe a lot that's happening. About 50 different quality improvement
11 initiatives are described, and there's more detail in the appendix to the memo. In the interest of time, I'll
12 just mention that, again, many of the quality efforts overlap between children and adults, so obviously
13 efforts on pregnant women, children are sort of overlapping. And although most of the efforts described
14 are sort of CMS focused, there are a few that are sort of multipayer or across CMS or across HHS that are
15 notable as well.
16 More of the report talks about those core quality measures, so I'll spend a little time explaining the
17 status of those.
18 The children's core measures are a little further along, again, because they started earlier. As of the

1 latest report, all states are reporting some of the core quality measures, and half of the states are reporting at
2 least 14 of the 26 measures last year.
3 It's worth noting that CMS actually has started calculating two of the core measures for states using
4 information from EPSDT reports, and so that's why all states are reporting, because CMS was able to give
5 them the data for that. But that being said, for those states that are reporting kind of more than the
6 minimum, CMS has now started using some of that data and putting it together to show trends across states
7 and variation over time.
8 The adult core quality measure program is still a bit newer, and we'll find out more as early as next
9 month, actually, on the results to date. As of the time of the report, at least 26 states reported that they
10 were planning to report this year, and half of those state plan to report at least 18 of the 26 measures.
11 While the main focus of the reports is on quality as it is traditionally defined, as I mentioned, there is
12 a brief mention in the report around some coverage issues, particularly on the duration and stability of
13 coverage, mostly talking about CMS efforts around the Affordable Care Act and also the Connecting Kids
14 to Coverage Challenge and various grants for children.
15 It's worth noting that in the child health care quality report, it makes mention of two
16 recommendations that HHS had previously included in the 2015 President's budget. The first is a one-year
17 extension of the CHIPRA performance bonus fund, which expired last year. Performance bonuses you're
18 aware provide additional funding to states that implement enrollment simplification practices.

1 The second recommendation was permanent extension of the Express Lane Eligibility option,
2 which is a state plan option to use data from other agencies to help simplify enrollment in Medicaid and
3 CHIP. This provision expires next year, and the Commission had previously recommended a permanent
4 extension of ELE.
5 Because the Commission has talked about some of these coverage issues earlier today and in other
6 contexts, I thought I'd spend the rest of my time focusing more on those quality areas as traditionally
7 defined, but happy to answer any questions on these. Yes?
8 COMMISSIONER ROSENBAUM: Actually, I think I'll hold.
9 MR. NELB: Okay. We're almost there. Two slides. Great.
10 So, again, now that I've reviewed the findings, it's your opportunity to comment and provide
11 feedback on areas you might want to include in a future letter. Just like the earlier report I presented,
12 because this is a report to Congress, MACPAC is technically required to review and comment within six
13 months, which for these reports is coming up rather soon.
14 I want to point out that three years ago, in 2011, the Commission did comment on HHS' first child
15 health care quality report where it expressed some general support for CMS' quality improvement efforts
16 and made a few technical comments around specific measures. And so now, three years later, the
17 Commission could choose to restate its prior comments, or it could make some more pointed comments
18 about the direction, scope, and pace of progress that CMS had made to date.

1 To kick off the discussion, I wanted to outline five potential areas for comments, and more
2 information about these is in your materials. The first is about gaps in reporting of the core measures.
3 So as I mentioned, reporting has improved, but in part because the measures are voluntary, data hasn't been
4 collected from all states. And so the Commission may want to comment on potential ways to improve
5 reporting of those measures, to the extent that they find it useful.
6 The second area to comment might be on the overlap between core measures and T-MSIS, the
7 Transformed Medicaid Statistical Information System, which is in the process, as you know, of collecting
8 better claims and encounter data, which could eventually be used to calculate some of these core measures
9 for states using that data.
10 The Commission has talked about T-MSIS before and at this point perhaps might want to comment
11 on any ways to sort of accelerate the progress and the ability to actually start using this data for quality
12 purposes.
13 A third potential area of comment might be about the use of core measures in managed care
14 oversight and provider quality initiatives. So far quality measure reporting has just sort of been at the state
15 level, and there are questions about whether -- now that the measures have been developed, whether they
16 can actually start being used in various payment policies, not just reporting but some sort of pay for
17 performance or other strategies.
18 Fourth, the Commission may want to comment about the lack of core measures for individuals with

1 disabilities. As you may recall, back in 2012 the Commission made a recommendation for more quality
2 measurement for individuals with disabilities, which is a topic that these reports are largely silent on.
3 And, finally, the Commission may want to comment on funding for the adult and child core quality
4 measures programs. So both CHIPRA and the ACA, when they created these measurement requirements,
5 included some additional funding to be used for the development of those measures and also grants to
6 states to implement quality improvement activities and develop the reporting capacity. In general,
7 CHIPRA allocated about $45 million a year for the child core quality efforts, and the ACA allocated about
8 $60 million for those efforts. And new appropriations for both of these programs end this year.
9 So hopefully that's enough to get you started for some discussion today. I'm here to answer any
10 questions, but I'll mostly be here as a listener to get your comments included in any future response.
11 CHAIR ROWLAND: Well, thank you, Rob, for your flexibility to wind up our day for us. I
12 have Sara, I have Andy, and I think all of us would agree that our comments on the first report probably still
13 stand as comments on this report, especially for the need for improved data, the need to look at people with
14 disabilities and develop those standards and how important these qualities are.
15 COMMISSIONER ROSENBAUM: Well, maybe it's the time of day and I'm just -- there's been
16 such a succession of things to think about that now they're sort of mushing together in my brain, but I'm
17 wondering if there's actually any synergy between the last presentation and this presentation, that is, whether
18 we might draw some connection between a continuation of an investment in increased payment for primary

1 care as an incentive for states developing a more robust reporting system. I assume that a lot of the quality
2 measures -- I am so not the person to, you know, think about -- I mean, I just don't delve deeply into quality
3 measures. But I assume a lot of the measures have to do with the effective primary care, access to primary
4 care, outcomes from primary care, and whether we might not tie the two activities together for Congress
5 and say, you know, it's a good thing for states to be paying attention to sort of this unified set of measures
6 and, in addition to incentivizing their collection and analytic work, whether somehow we connect the
7 primary care payment increase to this, so that we're getting some measure of effect, realizing that it's not an
8 access measure, but it is. There are access measures in there.
9 COMMISSIONER MOORE: I said ask Sharon what she thinks. I think you know this better
10 than the rest of us.
11 COMMISSIONER CHECKETT: She was talking to her neighbor.
12 [Laughter.]
13 COMMISSIONER CARTE: All right. Well, I was just saying to Richard that, I mean, this is
14 really what I think needs to happen, is that primary care -- and also it speaks to your question, David, about,
15 you know, I think primary care physicians do feel very besieged by all these measures of quality, and maybe
16 where some of that primary care bump money needs to go is really into the supportive framework for
17 quality care like the care coordination and like showing you your measures, both at your practice level and at
18 the individual level. And that's something that, you know, I learned with our pediatric quality grant, is that

1 states will have to look at issues of quality from the plan level, which we've currently been capturing with the
2 CAHPS surveys and these quality measures, but you also need to know by practice level and look at regional
3 variation.

4 VICE CHAIR SUNDWALL: Anything the Commission could do to lend some support for
5 administrative simplification of this -- you know, we're not against being monitored or measured. We
6 welcome information that will help us practice medicine better. But that figure is startling, there are 4,000
7 quality measures, and you're right, we feel beleaguered. But I would be willing to take what time it takes to
8 give the information if, in fact, it helps me practice better, if it's simplified, if it's coordinated.

9 So I think we're on to something here about, you know, primary care and quality to the extent it
10 improves access, but the Commission maybe can shed some light on this because we can't -- by the way, the
11 same thing is happening in public health. There's a myriad of measures, and the ASTHO, Association of
12 State and Territorial Health Offices, is trying to bring some semblance of understandability to these multiple
13 efforts to monitor what's happening in public health.

14 COMMISSIONER CARTE: And, further, you know, the networks and the MCOs have to have a
15 role in that supportive structure as well.

16 COMMISSIONER COHEN: Thank you, Robert. You are our hero for volunteering to go
17 earlier than you had to.

18 I just would say that whatever --

1 CHAIR ROWLAND: [Speaking off microphone.] -- tomorrow.

2 COMMISSIONER COHEN: Right.

3 Whatever other substantive comments we have, I think it's extremely important for us to be in, my
4 opinion, a big-time cheerleader for focus on quality. All of our conversations today sort of led to the what
5 are we paying for, what's the value, what's the quality like. That is the "it" that we are really all chasing and
6 trying to design a program around, getting the most of that, and I think it's not sexy. It's not always the
7 issue that rises to the top of political discussions. The amounts of money that it takes to really focus on it
8 really aren't that high, but they permeate throughout the system, and there are frustrations associated. It
9 actually takes more effort to simplify things than it does just to add on.

10 So I am a big fan of, as an advisory committee, just reiterating how incredibly important the
11 endeavor is, and I would even vote for some comments around we understand that it takes resources and
12 effort to make a quality-like measurement system, a really smart and streamlined one, and would support
13 some wording around support for such funding.

14 CHAIR ROWLAND: I think if I want to channel Patty a little bit, one comment might also be,
15 well, don't require any measures that you are not going to evaluate, so that really to focus on what are the
16 key measures that are the indicators and not the 100 other ones that somebody thinks are interesting, but
17 they are not necessarily going to point to, to where the issues or the problems are.

18 Other comments?

1 [No response.]

2 CHAIR ROWLAND: Well, clearly, this way in which you have developed of laying out a summary
3 of the report and then some possible comments, I think is a really great format and has made it a lot easier
4 than previous times to try and at least understand what's in some of the secretarial reports, and I think it
5 provides a nice format for going forward with the letter. So thank you, and thank you for the flexibility of
6 coming up today and helping us wrap up this day.

7 Now, if there are any comments from the public that they would like to offer us, we will entertain
8 your comments before we adjourn.

9 **### PUBLIC COMMENT**

10 * DR. McMENAMIN: Hi. I am Dr. Peter McMenamin, Senior Policy Fellow at the American
11 Nurses Association. I am the Health Economist for the Association, and a long time ago, I was the Chief
12 of Ambulatory Care Reimbursement Research at the Happy Children Fun Academy, here at -- remember
13 HCFA?

14 [Laughter.]

15 DR. McMENAMIN: So I've done a lot of work on both Medicare and Medicaid issues,
16 particularly with respect to physician participation.

17 If you don't mind, I have comments on each of the three sections that were on the agenda for this
18 afternoon. With respect to network adequacy, we get a lot of comments from CMS about, "Well, you

1 know, we can't do anything that's in the law or the regulations," and it occurs to me that part of the troubled
2 history of involving APRNs in Medicaid and Medicare is that there are specific mentions of those
3 specialties. There are four advanced practice registered nurses, nurse practitioners, nurse midwives,
4 certified register nurse, and that's just -- and clinical nurse specialist. All four are recognized in Medicare.
5 Midwives and nurse practitioners are recommended -- or included in Section 1905, so they're mentioned as
6 part of the benefit package for Medicaid. Section 1906 allows the states to add additional professions,
7 clinicians to the list of Medicaid participants, and many states have included CRNAs and clinical nurse
8 specialists, although not all of them.
9 So they're in the law. They're part of the benefit package, and arguably, if they're in the benefit
10 package, Medicaid managed care organizations must provide access to such services.
11 In fact, in -- you are going to love this. In Section 1932(a)(5)(B)(iv), it does allow Medicaid
12 managed care organizations to not provide certain services, but if they do not provide all of the services,
13 they are obliged to both tell the beneficiaries that they are not going to provide it directly and to inform
14 those beneficiaries on how they can access the services to which they are entitled.
15 So if you don't have a midwife in your network, you have to tell the bennies how they are going to
16 receive midwife services if that's what the beneficiary does desire. It seems like there's no way around it.
17 Network adequacy has to be -- you have to cover all of the services separately enumerated in the benefit
18 package. So I say for Medicaid, that's nurse practitioners and midwives.

1 They do say in 1932(b)(7) that if you have too many, you can't exclude individuals in certain
2 occupations, but zero is not too many. It is never too many.
3 Unfortunately, in the case of private health insurance and many Medicaid plans, they do not
4 credential the advanced practice registered nurses into their networks; that is, they do not allow them. I
5 have seen letters from ANA members complaining about not being credentialed into networks. I have
6 seen a letter from the Colorado Medicaid managed care organization explaining that they do not contract
7 with APRNs in urban parts of Colorado. That seems to be a violation of 1902, which is to statewide in
8 this provision, and 1905(a)(17) and (a)(21), which are the provisions that say midwives and nurse
9 practitioners are part of the benefit package.
10 As far as I know, CMS does not respond to those issues. They've certainly not responded to
11 members who have written, saying how do you allow this, and I would recommend that the Commission
12 remind CMS to try to do something, because it is important. And APRN is an important part of the health
13 care community.
14 Specifically for Medicare in 2011, 100,585 APRNs billing under their own MPIs, provided $2.4
15 billion in services to 10.4 million Medicare bennies. That was 30 percent of the Medicare fee-for-service
16 population. A year later, it was 11.4 million bennies, and that's a third of the Medicare fee-for-service
17 beneficiary population.
18 And in Tennessee, for some reason, it was more than 58 percent of the beneficiary population will

1 receive one or more services from an APRN.

2 We have no official estimate of the number of APRNs in the country, although it's probably in

3 excess of 300,000 now, and at the time of the Affordable Care Act being passed in March of 2010, there

4 were 152,000 individual APRNs who had a national practitioner identifier, and for each of the four roles,

5 they existed in each of the 50 states and the District. So there are lots of advanced practice nurses who are

6 available.

7 CHAIR ROWLAND: Peter, I am noting that there is quite a line behind you, so if you could

8 please expedite your remarks.

9 DR. McMENAMIN: Okay.

10 CHAIR ROWLAND: Then we're always willing to take written comments, as well.

11 DR. McMENAMIN: Okay.

12 And they did make a modest suggestion for the exchanges that they should have a threshold for

13 credentialing advanced practice registered nurses of 10 percent of the count of APRNs in a particular state,

14 which data are available from CMS.

15 On the second topic, you should check with CMS, because there were many studies of physician

16 participation in both Medicare and Medicaid in the '80s, and the elasticity advancements was remarkably

17 similar, approximately .7, 10 percent increase in fees and allowed charges, led to a 7 percent increase in

18 Medicaid participation, Medicare participation, Medicare assignment.

1 And briefly, on the Medicaid primary care incentive payment, we mentioned APRNs were not
2 included. That's partially because it was part of the Health Care and Education Reconciliation Act, the
3 Patient Protection and Affordable Care Act. If you're doing an evaluation, you should check not only on
4 whether more physicians participated, but whether more physicians hired more nurse practitioners, because
5 a lot of nurse practitioners whose services are built into physician services do not appear. But it would be
6 an easy way to increase the production of primary care services and just hire more midwives, nurse
7 practitioners.
8 My understanding is approximately 12- to 20,000 APRNs -- well, actually nurse practitioners had
9 their services built into that too. So they just don't show up in the counts, but they are an important part
10 of why primary care access to primary care has increased.
11 CHAIR ROWLAND: Thank you.
12 MS. WIEAND: Hi. I'm Betsy Wieand. I'm with the American Congress of Obstetricians and
13 Gynecologists. Thanks for the opportunity to comment for the record.
14 I have two separate comments. One pertains to this morning's session on behavioral health, and
15 the other pertains to the primary care access program in Medicaid.
16 The first with behavioral health is we would just appreciate and recommend that you think about the
17 complexities of pregnant and parenting women who have substance use disorders when you make
18 recommendations. While it is important to address the IMD exclusion, it is not a magic bullet for pregnant

1 and parenting women. A lot of women are the primary caretaker and cannot go into inpatient rehab for
2 substance use disorder treatment, so ensuring access to outpatient treatment is essential when making
3 recommendations about benefit designs and access to care to address on that need.
4 And then in terms of the primary care access program, as provided in your materials, ACOG
5 strongly believes that Section 1202 of the Affordable Care Act should be extended and expanded. I want
6 to thank Commissioner Henning for highlighting the fact that women's health was left out of the program.
7 We would ask that the Commission recommend to Congress that the program be extended and expanded.
8 As noted in the materials, women make up the majority of participants in the Medicaid program at
9 more than 68 percent. Prior to health care reform implementation, 12 percent of women, ages 18 to 64,
10 relied on Medicaid for their health care coverage.
11 Many states already do recognize the central role OB/GYNs play in delivering primary care to
12 female beneficiaries, and 35 states recognize OB/GYNs as primary care providers in managed care or
13 primary care case management.
14 OB/GYNs deliver primary care and preventive care services, as to CNMs and MPs. Preventive
15 counseling and health education are essential and integral parts of the practice of obstetrics and gynecology,
16 and OB/GYN is often the only doctor a woman sees on a regular basis, with potentially as many as 7
17 million coming to Medicaid by the end of 2014. Ensuring that physicians can afford to see these patients
18 is essential.

1 Though Medicaid payments reduce a physician's willingness to accept Medicaid patients, only 44
2 percent of OB/GYNs accept new Medicaid patents.
3 Again, ACOG asks that the Commissioners take into account women's health needs in accessing
4 care and Medicaid when making a recommendation to Congress about extending and expanding the
5 Medicaid primary care access program.
6 Thank you.
7 CHAIR ROWLAND: And thank you for the letter that you submitted that's part of the
8 Commission's materials.
9 MS. LOVEJOY: Hi. Thank you very much for letting us speak. I am Shannon Lovejoy with
10 the Children's Hospital Association, and we really appreciate that the Commission has used today to look at
11 so many issues related to children's health and children's hospitals.
12 I did want to kind of echo some of Betsy's comments related to the Medicaid primary care payment
13 increase. The Association has been working with many organizations to extend funding for this provision,
14 and we do see it as an important step towards expanding access to care for children and others enrolled in
15 Medicaid.
16 Prior to the enactment of this provision, pediatricians were reimbursed generally about 30 percent
17 under Medicaid than Medicaid provided for comparable services, and we recognize that there's been
18 challenges with implementation and getting data on this information, but we do believe that -- and from

1 what we have been hearing from our hospitals that this has been very critical to access to care.
2 Pediatricians and pediatric specialists are able to get access to the payments, which has been huge, and we
3 do recommend that you help encourage to extend funding for the program. And we're happy to work
4 with you on any information related to that.
5 I also did want to mention, since CHIP and quality came up earlier today, Children's Hospital has
6 been very active in trying to get funding extended for the CHIP program, and as part of that effort, we have
7 been working to extend funding for the pediatric quality provisions that were enacted through CHIPRA.
8 As we mentioned, the reports that have come out, that was the first thing, to begin investment in
9 pediatric quality measures, and the funding does expire, and so we still need that funding to continue to
10 develop new measures, to maintain the existing measures that we're able to get some of this great data on.
11 We're for the first time seeing -- you know, able to get data on trends, and it's really exciting. The pediatric
12 quality has been a little bit behind on the adult side, and just as you're thinking about quality, just remember
13 that these provisions are expiring.
14 Thank you very much.
15 CHAIR ROWLAND: Thank you.
16 MR. MASON: Good evening. Dave Mason representing the National Association of Pediatric
17 Nurse Practitioners. We very much appreciate the opportunity to provide some comments.
18 I won't repeat what my colleagues have said, but I do want to support it and reinforce, particularly

1 when it comes to the Medicare primary care payment increase, and appreciate Commissioner Henning and
2 the rest of you revisiting a discussion you've had before about some of the difficulties with nurse
3 practitioners and other essential primary care providers not being fully included in the program, the way it's
4 come forward.
5 I think my cautionary note to you -- and I appreciate the discussion around the timeline that we all
6 face with the expiration of this program, but just the recognition that this is an easy program to find some
7 fault with. But the things that are said here and particularly what you may recommend or communicate
8 will have an impact at the other end of Pennsylvania Avenue.
9 So I think to the extent that it is possible to recognize the difficulties with the program, but also to
10 recognize the potential strengths of it or the potential opportunities in it, and perhaps more importantly, as
11 you've discussed here, the need to take action to increase access to primary care services in the Medicaid
12 program, the more positive that we can keep that message going forward, probably the better off we'll all be.
13 Thank you again for your debate, and if there is anything that we can do to contribute to it, we look
14 forward to participating in it.
15 CHAIR ROWLAND: And thank you for giving us credit with having a potential impact.
16 [Laughter.]
17 MS. GREENHALGH: Good afternoon -- or evening. My name is Michelle Greenhalgh, and I
18 represent the American Academy of Family Physicians. I apologize. I am the last one here, and I have a

1 very lengthy commentary to read to you. I will try to go through it quickly, because I'm sure you all want
2 to get to dinner.
3 As a representative of the American Academy of Family Physicians, AAFP, we represent over
4 115,900 family physicians in 55 states and territories. We appreciate the opportunity to submit the
5 following comments for the public record.
6 As the nation's largest organization for primary care physicians, we respectfully address the
7 Commission's findings on the Medicaid Primary Care Parity Program. The goal of this program is to
8 ensure access to primary care for millions of newly eligible Medicaid beneficiaries under the Affordable Care
9 Act's historic expansion of Medicaid.
10 The AAFP respectfully requests that the Commission recommend to Congress to fully extend the
11 Primary Care Parity Program for a two-year extension. The continuation of this program is essential to
12 ensure access to primary care services for the growing number of Medicaid patients.
13 Two-thirds of AAFP's member physicians accept newly entered Medicaid patients. About
14 one-fifth of AAFP's family physician patient panels historically had been Medicaid beneficiaries.
15 According to CMS, more than 66 million patients are now enrolled in the Medicaid program, making it the
16 largest source of health coverage in the United States.
17 Enrollment is projected to continue to grow for more of our low- and moderate-income
18 beneficiaries and for coverage. Policymakers must ensure that these valuable patients -- vulnerable patients

1 -- I apologize -- can continue to receive the health care they need from physicians they know and trust.
2 For state Medicaid programs to continue providing the newly eligible access to primary care, federal funding
3 should continue to reimburse these physicians for primary care services that Medicare rates.
4 As this Commission has recognized in its publications, higher payment -- higher physician
5 reimbursement rates in the Medicaid program are associated with more physicians adding Medicaid patients
6 to their patient panels.
7 In the case of the Medicaid Primary Care Parity Program, specifically the Kaiser Commission on
8 Medicaid and the Uninsured, has reported that through its 50-state survey, casual connection between
9 payment and physician participation in at least some states. In particular, we wanted to note that in
10 Connecticut, they reported significant new provider participation in the Medicaid program due to the
11 increase.
12 While qualitative data via MACPAC interviews discussed today with the Medicaid officials, state
13 Medicaid society leadership, and other parties has not yet persuaded the Commission to recommend
14 extension of the program, that some data also has not moved the Commission to recommend allowing the
15 program to sunset on December 31st of this year.
16 Thus, it appears that Commissioners' minds remain open as to the effectiveness of this program.
17 The AAFP has received positive feedback from our members about the increased capacity to serve
18 Medicaid patients as a result of this provision. Over 350 family physicians have written 642 letters to

1 congressional legislators describing how the enhanced payments have helped them add Medicaid patients to
2 their patient panels, for example, by hiring administrative staff to assist with office paperwork, thereby
3 freeing up their time to see more patients.
4 The AAFP has collected numerous stories from our members that depict their interactions with
5 newly entered Medicaid patients. These stories are meaningful, and they are moving. They document
6 often in detail what our family physicians have done to serve these patients, some of whom have not seen
7 doctors in years, some of whom would have visited the emergency room had they not had insurance, and
8 some of whom desperately needed management of their chronic conditions that was made possible by
9 forming a lasting relationship with a primary care doctor.
10 Our physicians voiced grave concerns that the chance for these patients to continue building strong
11 trusting relationships with their primary care doctor would be in jeopardy if the provision is not extended
12 beyond the end of this year.
13 The AAFP respectfully requests that the Commission consider its position and recommend that
14 Congress prevent the pending serious cuts to payments for primary care by extending full funding for the
15 Medicaid -- full federal funding for the Medicaid Primary Care Parity Program for at least two years. The
16 extension will make it possible to garner appropriate data on how the program affects patient access to
17 primary care.
18 The AAFP also requests that the Commission assist the Centers for Medicare and Medicaid Services

1 when the agency begins to receive initial data on how the program affects access to primary care services.

2 Thank you for the opportunity to present these remarks. The AAFP offers its assistance as the

3 Commission continues to work to evaluate the Medicaid/Medicare Primary Care Parity Program.

4 Thank you for sitting through that lengthy briefing.

5 CHAIR ROWLAND: Thank you for all of your comments and for your patience in listening to us

6 throughout the day.

7 We will now stand adjourned until 9:30 tomorrow morning when we return for public session.

8 Thank you.

9 * [Whereupon, at 4:43 p.m., the meeting recessed, to reconvene at 9:30 a.m., Friday, October 31,

10 2014.]

11

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

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

Friday, October 31, 2014
9:41 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
DENISE HENNING, CNM, MSN
MARK HOYT, FSA, MAAA
NORMA MARTÍNEZ ROGERS, PhD, RN, FAAN
JUDITH MOORE

ANNE L. SCHWARTZ, PhD

AGENDA PAGE

Session 6: Managed Long-Term Services and Supports: Overview and Themes from Site Visits

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1 P R O C E E D I N G S [9:41 a.m.]

2 CHAIR ROWLAND: Okay, if we can please reconvene.

3 We're going to open this session of the Medicaid and CHIP Payment and Access Commission and

4 welcome those who have joined us this morning.

5 I wanted to alert you that if you came to hear us discuss the review of HHS reports on the use of

6 adult and child quality measures in Medicaid, you missed your opportunity because we accelerated our

7 schedule yesterday and added that feature in. So today we will be focusing only on the first two items on

8 our agenda, which are the findings from our Medicaid long-term services and supports site visits and also

9 the Medicaid policy issues concerning the Medicare savings programs.

10 I'm particularly happy that we have these two topics today to discuss because so often in the

11 discussion of the Affordable Care Act and Medicaid expansion or non-expansion and Medicaid's role, we

12 leave out one of the biggest roles that the Medicaid program plays, which is its support of long-term services

13 and supports for many of the nation's neediest elderly and disabled individuals, as well as the important way

14 in which it helps support Medicare coverage for the low-income Medicare beneficiaries. So today we're

15 going to be looking at both of those topics, and I'm pleased that we're going to start with Kristal Vardaman,

16 our principal analyst on long-term services and supports, to give us her presentation. But if David wants

17 to offer any welcoming comments, he can do so before we begin.

18 VICE CHAIR SUNDWALL: Thank you, Diane. No, I have enthusiasm for this issue as well.

19 I used to be a medical director of a nursing home many years ago, and we taught family practice residents

20 geriatric medicine in that setting. Since then I've been amazed how important this kind of phase of

1 Medicaid is. It was a big spending item when I was head of the Health Department in Utah, and I think
2 it's a challenge for the future even more.
3 So I look forward to your comments and what MACPAC might do to shed some light in this area.
4 ### *SESSION 6*:
5 **MANAGED LONG-TERM SERVICES AND SUPPORTS: OVERVIEW AND THEMES FROM**
6 **SITE VISITS**
7 * MS. VARDAMAN: Good morning, Commissioners. My name is Kristal Vardaman, and I will
8 be speaking with you this morning on managed long-term services and supports, or MLTSS.
9 In the June 2014 report, you noted that MLTSS was an area for future inquiry, and the first part of
10 this project was conducted this summer as MACPAC staff, along with our contractors at Mathematica,
11 conducted five site visits to states with MLTSS programs in order to get a better view of how these
12 programs operate on the ground. The contractor is still working on the final report, so today I'm just
13 going to give you an overview of some of the key themes that we found across our site visits.
14 So this morning, following a general introduction to long-term services and supports and managed
15 care's growing role in this area, I'll be providing you with a brief overview of the themes that emerged from
16 the site visits. Following the discussion of themes, I'll go over some of the policy questions of the analysis
17 of the site visits as well as our review of the literature. And also we'll discuss some of our proposed next
18 steps for your input and review.
19 By means of background, long-term services and supports, or LTSS, for individuals with physical
20 and mental disabilities generally focuses on helping people maintain and sometimes improve their

1 functioning, particularly on activities of daily living. As you're well aware, Medicaid is the primary payer
2 for LTSS in the country, spending about 61 percent of total LTSS spending in 2012.
3 In response to beneficiary preferences to remain in their home, legal requirements falling out of
4 decisions such as Olmstead, and cost considerations, an increasing proportion of LTSS is being provided in
5 home and community-based settings. Services that are provided at home are very wide ranging include
6 services such as personal aides, adult daycare, and transportation. Some of these services touch
7 beneficiaries as often as daily, things like personal aides in the home to help them with various activities of
8 daily living. This can differ from medical care, and they are being seen and interacted with on a very
9 frequent basis. This gives them the opportunity to remain in their home as well as engage in the
10 community and avoid isolation.
11 An increasing number of states are choosing to deliver LTSS through arrangements with managed
12 care organizations. Under MLTSS, these MCOs are responsible for providing the broad range of LTSS
13 services within their capitated rate.
14 We'll cover some more of the program details and program design later on, but I just wanted to note
15 here that some MLTSS programs only cover LTSS services, while other Medicaid services are paid under
16 fee-for-service or provided through a separate managed care plan. However, in some states they have
17 integrated plans that cover the full spectrum of Medicaid services.
18 The number of states with MLTSS programs has increased rapidly over the recent years, and there's
19 interest among some additional states which suggests continued growth in the future.
20 This figure shows the number of MLTSS programs that have existed over time, and the time frame

1 of implementation. You can see that in recent years there has been a great deal of activity in the number
2 of states that have implemented MLTSS. But one thing I wanted to note here is that some of the states in
3 the left column and the middle column that have had existing programs may have had smaller voluntary
4 programs, but in the past few years may have also made some changes to either make smaller programs
5 statewide or make voluntary programs mandatory. So it's an evolving situation, and these programs aren't
6 static.
7 VICE CHAIR SUNDWALL: Can I just ask a question? Are those states you said that started in
8 2004 and then phased more, of the ones that started, are they all continuing and those other --
9 MS. VARDAMAN: These programs are all continuing, but in some states, like Florida and New
10 York, they've made changes to the program that have made mandatory programs and expanded them
11 statewide where they weren't before.
12 VICE CHAIR SUNDWALL: Okay. Thank you.
13 MS. VARDAMAN: MLTSS programs vary widely, and each state's program is unique. Typically
14 they're building off of their existing home and community-based services and managed care waivers,
15 stakeholder input, legislative mandates, and other factors such as their existing provider market and data
16 infrastructure.
17 This slide lists some of the program characteristics that states might vary on. I'll just go ahead and
18 highlight some information on each one.
19 In terms of populations covered, some states have limited programs to the elderly and physically
20 disabled, while others also include the intellectually and developmentally disabled.

1 In terms of mandatory or voluntary enrollment, as I noted, some programs are voluntary and give
2 beneficiaries the choice to opt in. They might do so because there are additional benefits that are available
3 that aren't available in fee-for-service. However, some other states have mandated MLTSS for individuals
4 that would like to receive LTSS services.
5 In terms of the inclusion of nursing home residents, some states began their program by enrolling
6 beneficiaries residing in the community and may have delayed or excluded current nursing home residents at
7 the time of implementation.
8 Again, in terms of the stand-alone MLTSS plans, some states have chosen to have a stand-alone
9 approach while others have more comprehensive plans that cover all Medicaid benefits.
10 Next, in terms of geographic reach, in some states they have limited MLTSS to certain regions.
11 For example, urban areas might be included where -- but where rural areas are excluded, particularly because
12 fewer beneficiaries may make plans less financially viable.
13 In terms of the number of MCOs participating, some states have chosen one or only a few
14 contractors per region. Others may open it up to more in each region. This gives beneficiaries more
15 choice, but some criticisms have been raised that that can be overwhelming and could also complicate
16 oversight efforts.
17 And, finally, in terms of the types of MCOs participating, there were at some point concerns about
18 managed care's experience dealing with LTSS services. However, given the number of states that have
19 implemented MLTSS, this seems to be subsiding. There are several large plans that are involved in the
20 market in several states as well as homegrown MCOs that are working in one state or another.

1 So in August and September of this year, we conducted site visits to five states with either recently
2 implemented or established MLTSS programs. The states that we visited were Arizona, Florida, Illinois,
3 New York, and Wisconsin. The states were chosen to include variation in the implementation stage,
4 program design, and for geographic diversity. So, for example, Arizona has an established statewide
5 program that they've had in place since 1989. Wisconsin has an established program that's not currently
6 available statewide but is being expanded to more counties. Florida and New York were both in the
7 process of replacing older voluntary programs with mandatory statewide programs. And Illinois had
8 recently completed a voluntary MLTSS program implementation.
9 We told states that we would not identify them specifically publicly in terms of the details at this
10 point, but I'm going to go over some of the themes that we heard across the states.
11 I also just wanted to note that we did spend about two days in each state, and so during that time we
12 met with state Medicaid staff, managed care organization representatives, provider associations, as well as
13 beneficiary advocates to get a wide view of what's going on there.
14 So in terms of the key themes from our site visits, I just want to start off talking about assessment of
15 service needs. Beneficiary advocates were most concerned about this and about potential reductions in
16 service with the implementation of managed care. States have implemented a number of protections in
17 order to address some of these concerns during the transition. For example, they mandate that plans
18 maintain the current service levels for 60 or 90 days during the transition, and also they must cover those
19 with the same providers, even if they are not in their network for a certain period of time during the
20 transition.

1 States varied in the development and implementation of assessment tools that are designed to assess
2 service needs, and this is an area I'll point out later that we're hoping to look at more in the future.
3 Next, in terms of the need for appropriate quality measures, this was something we heard in most
4 states. First, we heard from plans and states that oversight primarily relies on process measures, and all
5 stakeholders really noted a need for better ways to assess MCO quality when it comes to providing LTSS.
6 Another theme was the integration with medical care or lack thereof. Again, in terms of
7 stand-alone LTSS programs, there were some concerns that these plans are not incentivized to consider the
8 full spectrum of Medicaid benefits. And also where beneficiaries are enrolled in an LTSS plan and a
9 separate managed care plan for their other services, there was a concern that there could be duplication of
10 case management, also that there could be communication challenges and confusion for beneficiaries, as
11 well as their providers.
12 Next, a key theme from the states that were in the process or had recently undergone
13 implementation was the preparation of the provider community to changes. Providers faced challenges in
14 adapting to the new billing requirements and contracting requirements, and there were some reports of
15 payment delays in these states. It's important here to note that some LTSS providers are smaller
16 operations, and they are moving from dealing primarily with the state as their sole or predominant payer,
17 and are suddenly having to contract with one or multiple plans. And so given that, a variety of groups
18 have stepped forward to conduct education efforts. We heard that states, plans, and provider associations
19 were providing educational opportunities for providers to assist them in the transition. For example,
20 several plans noted they had developed new payment portals to assist providers in their billing.

1 In the interest of time, I'm just going to highlight some of these other site visit themes quickly.
2 However, there's more information in your packets on each one of these.
3 First, care management intensity, plans told us a lot about the training that their case managers go
4 through and the amount of high-touch intensive services they provide. There were some concerns from
5 advocates about the consistency of case management across plans.
6 In terms of state capacity for oversight, several states noted that they were concerned about their
7 resources for conducting things like desk audits and reviews, and that if they had additional resources, that
8 was an area that they would deploy them.
9 In terms of data infrastructure, we heard from some plans in the states that had recently
10 implemented MLTSS, that there were concerns about the information that they received from either the
11 state or the enrollment broker. And so that was an area where improvement was needed.
12 Next, in terms of stakeholder engagement, we heard that states were engaging providers, MCOs, and
13 beneficiary advocates in a number of different ways through things like work groups, and there was a lot of
14 discussion in each state about the level of interaction and input that each stakeholder group felt they were
15 getting with the state.
16 And, finally, in terms of transition concerns versus long-term issues, we tried to pay attention to
17 which of the issues that we heard about were things that might be more temporary and would subside after
18 implementation had been completed versus those that might be more long term and sustained.
19 One thing that we heard in states that had more established programs is that they have moved
20 beyond some of those transitional issues and were more concerned with finding out ways how to better

1 approach oversight as well as looking into new ways for incentivizing better performance.

2 So next I'm going to just walk through some of the policy questions that were raised by the site

3 visits. First, how similar or dissimilar are service level determinations across states using these assessment

4 tools? What level of services would a beneficiary with similar conditions receive in each state?

5 Next, what lessons can be learned that will assist other states that are interested in implementing

6 MLTSS?

7 Next, which problems reported by stakeholders are, again, transitional versus those that are more

8 systematic and likely to persist?

9 Next, we wondered what are the advantages and disadvantages of having these stand-alone LTSS

10 plans versus those that are more integrated to cover all Medicaid services.

11 Next, what quality measures could improve oversight of MLTSS programs?

12 And then, finally, what will recent regulatory changes such as the new HCBS rule, which has some

13 new requirements for what can be reimbursed for HCBS under Medicaid, how will that affect existing and

14 future MLTSS programs?

15 So, finally, I'd like to tell you some of the next steps in our analysis of this issue.

16 First, we plan to review uniform assessment tools to better understand they vary across states and

17 what their effects are on service determinations.

18 Next, we plan to monitor state and federal initiatives to develop performance measures for LTSS,

19 given the concerns we heard across a variation of stakeholder groups.

20 Finally, we plan to determine how the new regulations for community-based settings will affect the

1 breadth of MLTSS options in terms of the services they're able to provide.

2 That concludes the presentation. I look forward to your comments.

3 CHAIR ROWLAND: Thank you very much, Kristal. I think this has been extremely helpful,

4 and we look forward to seeing the full report when it's put together.

5 Also, I think that it really does fit very well into our interest in looking at the delivery systems and

6 the role of managed care across the spectrum of Medicaid beneficiaries, so this is a nice start at getting to

7 that point.

8 I also think that we should note that while we discussed the quality measures letter yesterday, that

9 one of the themes we wanted in that was to say we really need better quality measurement on the long-term

10 services and support side. So I think this could be noted in the letter being drafted for our comments on

11 the Secretary's report.

12 Comments from other Commissioners? David, then Mark.

13 VICE CHAIR SUNDWALL: Thank you. Very nice to know you've gone to all this effort to

14 visit these states and see what's going on.

15 Do you have an impression, though, aside from these things that need to be further, is this working?

16 Is it keeping people out of institutions? Are they happy at home? In other words, is it working to save

17 money, keeping people out of long-term-care institutions or hospitals, and what's the patient satisfaction?

18 MS. VARDAMAN: Well, some of the states that we visited were pretty early on in their

19 implementation, so I'm not sure if they have the evidence yet to see how this shift has had an effect.

20 However, at least one state we visited that has had longer experience was able to provide us with some data

1 on how their proportion of home- and community-based services had increased, while the nursing home
2 residents had decreased over time.
3 VICE CHAIR SUNDWALL: One last question. Is there a difference or did you make a -- did
4 you include in your places you studied, for-profit versus not-for-profit programs? Is there a difference
5 noted among the two yet that you can detect?
6 MS. VARDAMAN: We spoke with plans of both types, but we have not looked at the data in that
7 way or reviewed our write-ups and whatnot that way. So I don't really right now have a good answer, but I
8 can get back to you.
9 CHAIR ROWLAND: Okay, Mark.
10 COMMISSIONER HOYT: I had talked to somebody who is active in this nationally, in addition
11 to the trip that we made to Arizona together. I wish my favorite health care lawyer was here, but I guess
12 Sara had to be somewhere else.
13 CHAIR ROWLAND: She is working on that lawsuit.
14 COMMISSIONER HOYT: I am going to butcher this, but the DOL lawsuit -- I think it is a
15 lawsuit -- it is pretty significant around overtime and health care being provided to the personal care -- it has
16 a specific name that I am spacing out. And I think we should mention that probably in the paper and
17 follow that. If that goes, if they were to win, then that will have significant cost implication, I think, and
18 on the service delivery and all of that.
19 EXECUTIVE DIRECTOR SCHWARTZ: It's not a lawsuit. It's a rule from the Department of
20 Labor on pay for home care workers, and my understanding is that it's been delayed for at least six months

1 at this point.

2 MS. VARDAMAN: That is something, though, in at least one state that we heard concern about

3 that, so we will keep an eye on it.

4 COMMISSIONER HOYT: One other comment related to what David said. We all know --

5 we've talked about this before -- how expensive the long-term LTSS enrollees are. I'd like to see us make

6 some kind of movement towards getting our hands around the dollars, even though there's all these

7 differences state-by-state of voluntary, mandatory. This number you just gave me is DDN, as DDN, is

8 this just elderly and physically disabled?

9 But specific to your point, because I worked on the ALTCS program in the early years, ALTCS

10 had negative trends for like 10 to 12 years because of the shifting of people, from the mix of people, which

11 would be the key statistic we should try to collect, if we can, and just for elderly, physically disabled. I

12 don't know how it is normally gathered now, DDs in, and we should just state whether they were in or out.

13 What you'd want to see is the proportion of people in the community increasing and then what does

14 that do to the trends in that state, even if it's just radical, apples and oranges, between which services are in

15 the number you are looking at. The trend should be negative if people are shifting in the right direction.

16 VICE CHAIR SUNDWALL: What do you mean by negative trend?

17 COMMISSIONER HOYT: The actual cost per person is dropping. Dropping, so yeah.

18 VICE CHAIR SUNDWALL: So that's a good thing.

19 COMMISSIONER HOYT: Yes, absolutely.

20 VICE CHAIR SUNDWALL: A negative trend is a good thing.

1 COMMISSIONER HOYT: Yeah. It was a huge deal in Arizona, and the evaluations that were
2 done of the 1115 waiver, long-term care was the key driver of the savings behind the entire waiver for a
3 number of years.
4 EXECUTIVE DIRECTOR SCHWARTZ: I just want to mention, Mark, that we have another
5 project that's sort of a companion to this. The site visits were really started to help us understand sort of
6 the structure and the decisions and the experience, not so much to collect the information, the specific cost
7 information.
8 We do have a project with your former colleagues at Mercer to draw on some of the data from the
9 states that they have worked on to look at that, to look at payment strategies and how that affects
10 rebalancing. So it's in its early stages.
11 CHAIR ROWLAND: And for the record, Mark had nothing to do with the contract with Mercer.
12 EXECUTIVE DIRECTOR SCHWARTZ: No, absolutely, he didn't.
13 COMMISSIONER CHECKETT: He said you didn't know anything about it.
14 [Laughter.]
15 CHAIR ROWLAND: Richard and then Judy and then Andy.
16 COMMISSIONER CHAMBERS: Thank you, Diane.
17 Kristal, thanks for the report. Interesting early information. What's particularly interesting is the
18 benefits of what you're doing is informing states that are just getting into this.
19 Being in a state, California, that has just launched in some of the counties, some of the larger
20 counties, managed long-term services and supports. So I'm personally going through and see some of the

1 things you found in your five-state findings.

2 One thing is talking about preparation to provider community to changes. The biggest thing we
3 found is in the custodial long-term care industry. That is like the biggest transition in the provider
4 community, is dealing with managed care plans or managed long-term services and supports, because
5 uniformly they have been dealing with fee-for-service, Medicaid, you know, in these states, the education
6 process, going through and learning all of those things, as you pointed out, of new billing requirements and
7 how to deal with getting prior authorizations for stays and long-term care.

8 But another preparation that we have found is where you are interacting with other state agencies or
9 local agencies, that, for instance, in California, the in-home personal care services provide it through the
10 Department of Social Services and local county agencies, and even their preparations in dealing with new
11 partners that are responsible financially for this, so I'd be curious to see how that has worked in states in
12 preparation of -- the state Medicaid agency preparing its sister agencies for those transitions going forward.

13 And then just your comments about what's transitional problems versus long-term issues -- and
14 again, as we're all feeling the same things, six months in, in California, is what we're dealing with, with those
15 issues.

16 I'd also be really curious to see, as you report on where LTSS is contracted out to specific LTSS
17 companies versus integrated companies. We have decided as a company to do everything in the health
18 plan and not bifurcate delivery systems, which is we are constantly approached by entities that want to slice
19 off a piece of LTSS and take it on as a risk basis and manage that, and as we struggle almost like a state
20 Medicaid agency, do you want to have specialists doing it versus fully integrated agencies. So I'll be curious

1 to see how that goes long term of examining as to how that works in states where there is specialized LTSS
2 providers versus integrated.
3 So I look forward to your work going forward. Thank you.
4 CHAIR ROWLAND: Judy.
5 COMMISSIONER MOORE: I thank you, Kristal. This is very interesting, and I wanted to ask
6 two questions along the lines of what Mark was bringing up. And I should know the answer to part of
7 this.
8 Do we have in MACStats or plans to put into MACStats any basic information in terms of numbers
9 of people that we see in managed long-term supports and services? Can we do that? Is it easy to break
10 out? What are the requirements for reporting? What kind of reporting requirements are in place, so that
11 we can measure that over time? That's one question.
12 The other thing is a little bit related. You mentioned, I think at the beginning, that the contractor
13 was still doing some work in the states. What kinds of things are they continuing to look at that we'll learn
14 a little bit more about in the future?
15 MS. VARDAMAN: Okay. In regard to your first question in terms of MACStats, one of the
16 things we are looking at is what we can do to update our future information on LTSS.
17 Some of these programs are newer, so we may be relying more on state data and websites more so,
18 rather than existing data. In terms of
19 COMMISSIONER CHECKETT:
20 CHAIR ROWLAND: Kristal, could you pull the mic a little closer to you?

1 MS. VARDAMAN: Sorry.

2 CHAIR ROWLAND: We have a lot of Trick-or-Treaters out in the hall, I'm told.

3 MS. VARDAMAN: Sure.

4 I was just saying that in terms of MACStats, we are going to be looking at probably over state
5 websites and other information, since some of these states are new, newly implementing MLTSS programs,
6 and the data might not be in some of the national datasets yet.

7 In terms of the work with states, Mathematica is working on finalizing the report for us, so they're
8 not still doing work for us, at least in these states, but we'll have a more full report with some more details
9 on the findings at a later date.

10 CHAIR ROWLAND: Okay. Andy.

11 COMMISSIONER COHEN: Thanks, Kristal. Great presentation.

12 I was interested in just getting a little bit more of your insight about the use of universal assessments
13 or -- yeah, I guess they're universal within a state, one hopes.

14 Two parts to that. One is, are states sort of in a position yet or the ones that may had one in place
15 for a longer time to sort of assess the results of the assessments and the services that people get as a result
16 of them, and do they do sort of cross-state comparisons for any standardization or anything, or is that just
17 something that is not done? I've always been curious about that, just sort of how, presumably, there is
18 some relationship between what your health care -- what your long-term services and support infrastructure
19 is as compared to what your needs are may not be able to be filled, say, in a rural area in the same way that
20 they might in an urban. But I'm just sort of curious whether that kind of analysis happens at the state

1 level, even.

2 And then my second question is just any other, sort of more observations about challenges or other

3 things that states have sort of talked about as key issues around implementing these universal assessments.

4 Do they use similar ones?

5 MS. VARDAMAN: We are hoping to conduct some work to take a closer look at uniform

6 assessments used in different states. I haven't seen much or heard much about comparing across state

7 tools.

8 Some of the states that we talked to had either recently revamped their tool as a part of

9 implementing MLTSS. Others were using tools that they have had in place. One state, they talked about

10 constantly refining the tool and how that they have a work group that works on some of that, that they do

11 make adjustments as time goes on, so perhaps they can learn from other states as they do that.

12 CHAIR ROWLAND: Andy, you will recall that when the Long-Term Care Commission folks

13 came to talk to us, the universal assessment was their strongest recommendation.

14 Sharon?

15 COMMISSIONER COHEN: Do you mind if I just follow?

16 It is interesting, though. I mean, the point of the universal assessment is, I would think, largely to

17 allow you to make sure that when somebody has an assessed need that they get a service that matches it. I

18 don't know if we're at that point anywhere. That's one thing I'm curious about. Hopefully, that's where

19 it's going.

20 CHAIR ROWLAND: Sharon and then Richard.

1 COMMISSIONER CARTE: Kristal, I'd be interested to find out -- and I think it's an important
2 policy concern -- if there are any managed care strategies that help to look at the question of family support
3 or other individual supports tied to assessment for those individuals who would be at a level where they
4 could meet institutional care needs, nursing home needs, and what strategies support either families or an
5 independent living situation, such that people do not have to go into a nursing home or another group
6 setting.
7 MS. VARDAMAN: We did hear quite a bit about natural supports during our site visits, but it's
8 something we can look at as we further look into the uniform assessments.
9 CHAIR ROWLAND: Okay. Richard.
10 COMMISSIONER CHAMBERS: As one of the policy considerations we are looking at, are we
11 looking at all, asking questions about states' objectives in meeting all the state goals, about promoting
12 independence and community living? I would be curious to know how that is entered to a sort of design
13 and implementation.
14 What I have seen, at least in California, because the implementation has just started in 2014, is that it
15 appears that it is like first it is to get the program off the ground and to get everything organized and
16 working well, but as sort of longer term goals of how you put the system focused on ultimately reducing use
17 of nursing facilities for custodial care and more independence and transitional homes. I would be curious
18 how the Olmstead requirements or goals are sort of woven into state plans on how to change really the
19 delivery of care over the long term versus just change the management of the services that are currently
20 existing. So it's more just a question that would be interesting to know how that's specifically being

1 addressed in the states as they implement these programs.

2 CHAIR ROWLAND: Well, Kristal, I think you have seen that there is a lot of interest on the part

3 of the Commissioners in broadening the scope of what you are working on, but in presenting this today,

4 thank you. You have really set the stage for future deliberations and for really good information, so thank

5 you very much.

6 And now we are going to turn to the Medicaid policy issues concerning the Medicare savings

7 programs, and in this aspect, we are looking at it through the Medicaid lens of how this program works on

8 the Medicaid side. Obviously, there are other issues that those who focus on Medicare in the MedPAC

9 world will be looking at, but we wanted to at least acknowledge the fact that the Commission has raised, in

10 many instances, the complexity of the way in which the Medicaid role works for the Medicare savings

11 programs. And so this begins our discussion of some of the data issues as well as some of the policy

12 issues.

13 And I don't know who's going first, Katie or -- Katie?

14 ### *SESSION 7*:

15 **POLICY ISSUES CONCERNING THE MEDICARE SAVINGS PROGRAMS**

16 * MS. WEIDER: Hi. Good morning. So April and I will be discussing policy issues concerning

17 the Medicare Savings Program.

18 First, just to give you an outline of what we'll be going over today, I'll start with an overview of the

19 Medicare Savings Program, the MSPs. April will then review findings from a new study on state Medicaid

20 payment policies for Medicare cost sharing. We've included an executive summary of this study in your

1 binder in Tab 8. We'll then discuss policy issues on payment and access, followed up by a review of MSP
2 eligibility and enrollment, and then policy issues on MSP eligibility and enrollment.
3 Pending your interest and reactions to the policy questions that we present today, we plan to
4 develop specific policy options for our upcoming meeting.
5 So before we dive into the MSPs, we want to provide context for why we're reviewing this issue.
6 The MSPs are a mechanism by which Medicaid pays for Medicare premiums and cost sharing for certain
7 low-income Medicare beneficiaries. The MSPs are particularly important because most Medicare
8 beneficiaries have to pay premiums and cost sharing in order to receive Medicare services. These costs can
9 be a substantial burden for dual eligibles who typically have very low incomes.
10 Furthermore, the MSPs provide Medicare premiums and cost-sharing assistance to a large number
11 of dual eligibles. You see here that in 2013, 8.8 million of the total 10.7 million dually eligible beneficiaries
12 received MSP coverage.
13 Now, you are familiar with the four MSP programs. The first is the qualified Medicare beneficiary
14 program. The second is the specified low-income Medicare beneficiary program. The third is the
15 qualifying individual program. And the fourth is the qualified disabled and working individuals program.
16 In our next slide, we'll review how each of these programs evolved and expanded over time and also
17 how they serve different people, offer different benefits, and also are financed differently.
18 We'll also discuss the federal minimum standards for MSP eligibility. However, it's important to
19 note up front that states can expand MSP eligibility beyond these minimum standards by either removing
20 asset tests or raising income thresholds.

1 Finally, it's also important to recognize that states, not the federal government, administer the MSPs.

2 So here in this table, we review the Medicaid assistance for Medicare costs. There's a more detailed

3 table provided on the background paper on page 3, which is also in Tab 8 of your binder.

4 The first MSP program is the qualified Medicare beneficiary program. It was created by OBRA in

5 1986 as a state option and then mandated in 1988 through the Medicare Catastrophic Coverage Act.

6 The QMB program requires states to cover Medicare Part B premiums and Medicare cost sharing

7 for Medicare beneficiaries with incomes below 100 percent of the federal poverty line. The QMB program

8 also pays for Medicare Part A coverage for a small number of beneficiaries who do not qualify for free

9 premium Medicare Part A.

10 The second MSP is the SLMB program. It was created through OBRA in 1990, and it provides

11 Medicare Part B coverage for Medicare beneficiaries who have incomes between 100 and 120 percent of the

12 federal poverty line. However, it's important to note that if an SLMB beneficiary receives full Medicaid

13 benefits, the state can choose to cover their Medicare cost sharing through the state's Medicaid plan.

14 Our third MSP is the qualifying individual program, which was created through the Balanced Budget

15 Act of 1997. The QI program covers Medicare Part B premiums to Medicare beneficiaries who have

16 incomes between 120 and 135 percent of the federal poverty line. The QI program is unique compared to

17 the other three MSPs in the fact that it's completely federally funded and states receive an annual allotment

18 for this program. The QI program is also dependent on congressional appropriations and periodic

19 reauthorizations. Most recently the SGR fix extended the program until March 31, 2015.

20 Our fourth MSP is the qualified disabled and working individuals program. It was created through

1 OBRA in 1989. The QI program pays for Medicare Part A premiums. It's specifically designed to allow
2 individuals with disabilities to maintain Part A coverage after returning to work. It's also the smallest of all
3 the MSPs. You'll see that in 2013 only 105 people were enrolled in the program.
4 And, finally, you see that 1.9 million full-benefit, dual-eligible beneficiaries did not receive MSP
5 coverage. However, these individuals can still receive Medicare premiums and cost sharing assistance.
6 States may use their own funds to pay for Medicare premiums, and in addition, states can pay their Medicare
7 cost sharing through the state's Medicaid plan, but may also only elect to pay for Medicare services that are
8 also covered by the state's Medicaid plan.
9 However, it's important to note that statute permits states to pay less than the full Medicare
10 cost-sharing amount if that provider payment would exceed the state's Medicaid rate for that same service.
11 As a result, states may pay either the full Medicare cost-sharing amount or the lesser of either, one, the full
12 Medicare deductible and coinsurance; or, two, the difference between the Medicaid rate and the amount
13 already paid by Medicare.
14 These lesser-of policies can be traced back to the beginning of the QMB program. Legislation
15 required states to pay QMB Medicare cost sharing, but did not specify if the state had to pay the full
16 Medicare cost-sharing amount or only up until the Medicare rate -- or Medicaid rate, excuse me. However,
17 in 1997, the Balanced Budget Act provided states the explicit authority to use these lesser-of policies.
18 You'll remember that in our March 2013 report we documented policies for all states and noted that
19 states are more likely to use these lesser-of policies.
20 However, this previous work did not examine the effect of access -- these payment policies' effect

1 on access. As a result, we conducted a study using Medicare and Medicaid enrollment and claims data to
2 examine whether Medicaid payment policies have an impact on utilization of selected Medicare services by
3 dual-eligible beneficiaries in fee-for-service.
4 Now I'll turn to April to review the findings of the study.
5 * MS. GRADY: Thanks, Katie. Before I get into the details of the study, I want to acknowledge
6 Susan Haber and her colleagues at RTI who did the heavy lifting for us on this project, as well as Anna
7 Sommers, who served as the project officer at MACPAC.
8 As Katie just mentioned, the study that we conducted looked at whether Medicaid payment policies
9 for Medicare cost sharing are associated with access to care for dually eligible beneficiaries. As you know,
10 access to care can be measured in a number of ways, and in this particular study, we looked at service
11 utilization as our measure of access to care.
12 There are a number of reasons why we might expect to see an association between payment and
13 access. For example, providers may respond to low Medicaid payments by choosing to not participate in
14 Medicaid at all, by accepting fewer Medicaid patients, or seeing Medicaid patients less frequently.
15 In turn, dually eligible beneficiaries might find it more difficult to see a provider at all, or they might
16 end up having fewer visits once they do get in to see a provider.
17 I won't get into the details of the statistical model, but I'll just say that the purpose of the model we
18 used was to isolate the effect of the Medicaid cost-sharing payment policy on Medicare utilization.
19 Unfortunately, it's not just as simple as comparing utilization among dually eligible beneficiaries in
20 low-payment states to the utilization of dually eligible beneficiaries in high-payment states. That's because

1 there are many factors aside from cost-sharing payment policy that affect utilization.

2 We control for as many beneficiary and market characteristics as we can in the model. We also use

3 Medicare beneficiaries as a comparison group to control for unmeasured, state-specific factors that might

4 contribute to differences in dual-eligible utilization across states.

5 In terms of the data sources, we used Medicare and Medicaid enrollment and claims data for 2009,

6 and in particular, we used these data to calculate the percentage of Medicare cost sharing that was paid by

7 Medicaid and to construct measures of Medicare service use. I'll also note that we looked at 2005 data and

8 found similar results that are not presented here today. We did exclude some states for a couple of reasons

9 --

10 CHAIR ROWLAND: Noting that 2009 is the most current year that you can do this data analysis.

11 MS. GRADY: At the time we started the study, 2009 was the most recent. I think we're up to

12 2010 now, and about half of the states are available for 2011 -- on the Medicaid side. I'll say Medicare is

13 light years ahead of us. I think they have 2013 ready now.

14 Some of the reasons we had to exclude states included the fact that we were focusing on

15 fee-for-service beneficiaries, so we excluded a handful of states that had high managed care enrollment.

16 We also had to exclude some states because of data quality problems. I'm sure you're shocked to hear that.

17 One of the primary reasons we excluded states was having a high percentage of crossover claims in

18 the Medicaid data that didn't have procedure codes, and we needed the procedure codes. That was a key

19 variable that we used to make sure that we were selecting comparable Medicare and Medicaid claims when

20 we did this analysis.

1 So when all was said and done, we had either 18 or 20 states included in the analysis depending on
2 the service use measure that we were looking at. I will say despite these exclusions, the 20 study states still
3 reflected about 40 percent of dual-eligible beneficiaries nationally. So it's not everybody, but it's still a
4 good chunk.
5 All right. Moving on to the study findings, as expected, based on our knowledge of state policies,
6 we found that the percentage of Medicare cost sharing paid by Medicaid did, in fact, vary across states when
7 we looked at the data. We also found that higher Medicare payment of Medicare cost sharing is associated
8 with an increased likelihood of having a Medicare outpatient office visit, using preventive services, and
9 having an outpatient psychotherapy visit.
10 Higher Medicaid payment of Medicare cost sharing is also associated with a decreased likelihood of
11 using safety net provider services, which were defined as FQHC, RHC, and hospital outpatient department
12 services. So I want to walk you through some examples on the next few slides -- or in the next slide-- that
13 shows the magnitude of the potential effects that we found in the study.
14 Okay. There's a lot going on here, but stick with me because I'm going to walk you through this
15 table step by step.
16 The first column here that we're showing just lists some of the Medicare visit types that we
17 examined, so as I mentioned, we looked at office or outpatient evaluation and management, or E&M,
18 services, and those are sort of routine office visits for new and established patients.
19 We looked at those office visits specifically with primary care providers, or PCPs. We looked at
20 any FQHC and RHC visits, and we looked at outpatient psychotherapy visits. That's the left column.

1 If you continue to the center of the table, these columns in the middle here are showing the
2 predicted percentage of beneficiaries with a visit under two different Medicaid payment scenarios. The
3 first scenario is where Medicaid pays 66 percent of the Medicare cost-sharing amount, and this 66 percent is
4 approximately the median percentage of Medicaid cost sharing paid for outpatient E&M services in states
5 that have a lesser-of payment policy. So, you know, we didn't just pick this out of thin air. It's about the
6 midpoint for the states with a lesser-of policy.
7 The second scenario is where Medicaid pays 100 percent of the Medicare cost sharing amount, and
8 as we move to the far right side of the table, the last column in this table is showing the effect of the
9 increase in Medicaid payment for Medicare cost sharing on dually eligible beneficiaries relative to
10 Medicare-only beneficiaries. And if that's not clear, don't worry. I'm going to walk through that, and I'll
11 repeat it in just a moment.
12 One thing I want to point out here is that the predicted percentages in this table are holding
13 beneficiary and other characteristics constant so that we can isolate the effect of just the change in the
14 cost-sharing policy.
15 So now I've explained generally what you're looking at here in the table. I want to walk through a
16 concrete example.
17 The first number we see on the first row here is the predicted percentage of dually eligible
18 beneficiaries with an outpatient E&M visit under a 66 percent payment scenario. The second number in
19 the first row is the predicted percentage of Medicare-only beneficiaries with a visit under the 66 percent
20 scenario. So under the 66 percent scenario, the predicted percentage of dually eligible beneficiaries with a

1 visit is 83.9 percent, as you can see.

2 As you move farther to the right, we see the predicted percentage of dually eligible and

3 Medicare-only beneficiaries with an outpatient visit under 100 percent payment. And for dually eligibles

4 under the 100 percent scenario, the predicted percentage with an outpatient E&M visit is 84.8 percent.

5 So when we get to the final column on the right, this is showing us, again, the effect of the increase

6 in the Medicaid payment of Medicare cost sharing on dually eligible beneficiaries relative to Medicare-only

7 beneficiaries. And what we're showing here is that the difference when you move from Medicare payment

8 of 66 percent to -- sorry, Medicaid payment of 66 percent to -- Medicaid payment of 100 percent, is that you

9 get a 2.3 percentage point increase in utilization of outpatient E&M services for dually eligible beneficiaries

10 relative to Medicare-only beneficiaries.

11 Okay. So I know that's a mouthful, and you may have questions.

12 CHAIR ROWLAND: April, just one comment here. The Medicare-only column is not

13 influenced by what Medicaid pays, because Medicaid's not paying anything for them; they're paying

14 out-of-pocket. But you're just controlling for which states they're in.

15 MS. GRADY: That's correct, so it happens that in the higher-payment states, the Medicare-only

16 beneficiaries--

17 CHAIR ROWLAND: Also do better.

18 MS. GRADY: That's correct.

19 Okay. So I'm not going to walk through all the rows on this slide like that, but I do want to point

20 out a few things to keep in mind as you're looking at the numbers here.

1 The first is that the predicted utilization rates for individual services or states might be higher or
2 lower depending on where their cost-sharing percentage is -- whether their cost-sharing percentage is
3 relatively high or low to begin with. For example, the effect of moving from a 20 percent payment policy
4 to a 100 percent payment policy or moving from a 90 percent payment policy to a 100 percent payment
5 policy is going to be different or would likely differ from what we're showing here, which is moving from 66
6 to 100. But we had to pick some values to give you as examples here.
7 So as I mentioned, the 66 percent is based on the median percentage of Medicaid payments for
8 E&M services in lesser-of states. And the mileage may vary when you're looking at specific states or
9 different services.
10 COMMISSIONER MOORE: April, this is all fee-for-service?
11 MS. GRADY: This is all fee-for-service, and you're moving right up on a point I was just about to
12 make, and, you know, that is, we don't have encounter data for enrollees in Medicare Advantage plans.
13 Actually this might be surprising to you given how we've been complaining about the Medicaid plans, but
14 Medicare is in the same boat, so we don't have data available to make the predictions for those folks.
15 Another point I want to make before I turn it back over to Katie is that although it might be
16 tempting to try and extrapolate the findings of this study to other Medicaid payment situations, it's
17 important to keep in mind that the study here only looked at the potential effect of higher Medicaid
18 payments on Medicare service utilization among dually eligible beneficiaries relative to Medicare-only
19 beneficiaries.
20 When Medicaid pays for Medicare cost sharing, it's paying for a Medicare service that's rendered by

1 a Medicare provider, who also happens to participate in Medicaid. This is a bit different than Medicaid
2 paying for a Medicaid service on behalf of Medicaid-only beneficiaries where the beneficiary population and
3 the dynamics involving provider participation might be a little bit different and might result in different
4 findings than what we're showing here. I just want to use caution that this is about a particular scenario.
5 So this concludes our summary of study findings, and I'll hand it back over to Katie now for our
6 discussion of the policy questions, unless there are follow-ups.
7 CHAIR ROWLAND: On other clarification. So from the beneficiary perspective, if the state
8 only pays 66 percent to the cost sharing, the beneficiary is not obligated to fill the rest in.
9 MS. GRADY: That's correct. The statute --
10 CHAIR ROWLAND: So it really is a discount to the provider.
11 MS. GRADY: That's right. The provider just takes a lower payment. That's correct.
12 CHAIR ROWLAND: So that's why it influences -- it could influence provider participation.
13 MS. WEIDER: So the complexity of the MSPs, coupled with the findings that April presented,
14 raise a couple of factors or policy questions for the Commission to consider on addressing access to care for
15 dual eligibles.
16 On this slide, we raise a range of questions for the Commission to consider, which include: One,
17 should providers be paid the full amount of Medicare cost sharing for dually eligible beneficiaries? And,
18 two, if so, how should that be accomplished?
19 Here we present four methods in increasing provider payment. The first is to pay providers the
20 full Medicare cost-sharing amount for either all services or selected services. Yesterday Ben reviewed a

1 similar approach, specifically the PCP bump.

2 The second method is requiring states to pay the full Medicare cost sharing and to continue to

3 receive the regular federal match.

4 The third method, which is slightly different, requiring states to pay the full Medicare cost sharing

5 but receive a slightly -- or a higher federal match.

6 And then our fourth method is requiring Medicare to pay for Medicare cost sharing; however, it's

7 important to note that this recommendation would be beyond MACPAC's statutory authority to

8 recommend.

9 CHAIR ROWLAND: It would require us to coordinate with MedPAC.

10 MS. WEIDER: Correct. But before we dive into our discussion, there are more issues that affect

11 dual eligibles' access to care, which include MSP eligibility and enrollment.

12 As we reviewed earlier, each MSP has a different federal minimum income and asset standard for

13 eligibility. However, states can expand eligibility income thresholds beyond the minimum and also remove

14 asset tests. This can create inequality across states.

15 In addition, MSP enrollment has been historically low. Research suggests that low enrollment is

16 due to a lack of beneficiary awareness regarding the program and also a cumbersome enrollment process.

17 The enrollment process for beneficiaries also differs by state and requires beneficiaries to have

18 knowledge of the MSP program, and submit an application, which can also contain sensitive income

19 information. These factors raise policy questions for the Commission to consider regarding MSP eligibility

20 and enrollment. Here we present a range of policy questions for the Commission to consider.

1 The first, should strategies for MSP education and outreach be improved? Research has suggested
2 that education and outreach can increase MSP enrollment.
3 The second question: Should eligibility for MSPs be expanded? We've seen a method like this
4 proposed by MedPAC in their 2014 June report which recommended expanding the QI eligibility to 150
5 percent of the federal poverty line.
6 And our final question: Should there be a single eligibility determination and enrollment process
7 for MSPs and the Part D low-income subsidy program and have this single determination be administered
8 by SSA? And as a refresher, the Part D LIS program provides financial assistance to low-income Medicare
9 beneficiaries for Part D premiums and cost sharing.
10 The MSP beneficiaries are automatically enrolled in the LIS program. However, MSP beneficiaries
11 have to apply through their state or federal government to receive MSP benefit. Having one application
12 for the LIS program and the MSP program would simplify enrollment for beneficiaries not currently
13 enrolled in either program and also reduce MSP administration burdens for states.
14 So we've reviewed a lot and examined policy questions on payment, access, and eligibility for the
15 Commission's discussion. For next steps, we can explore additional areas that might affect dual-eligible
16 beneficiaries' access to care; and also pending the Commission's discussion, we can further develop these
17 policy questions into more developed policy options for our upcoming meeting. And from here we can
18 begin today's discussion or answer any questions.
19 CHAIR ROWLAND: Okay.
20 COMMISSIONER EDELSTEIN: Hi. Thank you. Thank you very much. I've got two

1 unrelated questions. The first one is at the beginning of the presentation where you distinguish these four
2 programs, and channeling Patty, calling for some kind of simplification as our heads spin, is there -- are
3 these programs so sufficiently distinct in who they target or so sufficiently different that there couldn't be
4 simplification as a policy question?
5 MS. WEIDER: Yes, I think that's completely a reasonable policy question.
6 CHAIR ROWLAND: But they differ by income and then by what benefit you get, and I think the
7 bigger question here that wasn't on the table when all these provisions were put in is how did these relate to
8 the Part D low-income subsidy, which is administered on the Medicare side. And I think that that piece
9 would be a useful addition to this chart for us to understand who's getting what. And then I think, Burt,
10 you're correct, you could say, well, let's simplify it, and one is -- you know, the QI program isn't even a
11 matching entitlement program. There's just all kinds of anomalies in the way it was constructed.
12 Again, you know, congressional intent and development is interesting to follow.
13 COMMISSIONER EDELSTEIN: My other question relates to the findings in the chart. April,
14 the findings for use of FQHC or rural health centers and for outpatient psychotherapy seem to reflect the
15 population difference rather than -- I mean, they just seem to be grounded in the difference between low --
16 between duals and higher-income Medicare folks.
17 MS. GRADY: Yes. So part of the difference is because there is a difference, a baseline difference
18 in utilization between duals and non-dual beneficiaries. But the way the model is constructed, we're
19 looking at the differences between those two groups, between the two scenarios in order to get our effect.
20 So you're right. But the model is exploiting the fact that we can predict the values under one scenario and

1 predict under the other scenario and get the difference, the effect of the cost sharing.

2 COMMISSIONER EDELSTEIN: So my real question is, in the model can you completely

3 discount the fact that duals are lower income and thereby more likely to use safety net providers?

4 MS. GRADY: That's a good question. I'd have to think about that a moment and get back to

5 you because --

6 COMMISSIONER EDELSTEIN: Okay, because those are where you see real significant

7 differences.

8 My other question is about the E&M, and that is, whether these differences, which may be real, are,

9 in fact, if you will, clinically significant. In the modeling, is there enough range or -- I don't know which

10 approach you used, whether it's deviation or some other measure of dispersion. But are these numbers

11 really different?

12 MS. GRADY: They are statistically significant.

13 COMMISSIONER EDELSTEIN: You've got large numbers, so --

14 MS. GRADY: Yes. Yes.

15 COMMISSIONER EDELSTEIN: -- probably statistically significant. But are they meaningful,

16 is my real question.

17 MS. GRADY: Well, I think that's up for you to decide, would be my answer. So they are

18 different numerically. Whether you find them to be meaningful differences that would motivate a policy

19 change is what we're looking for input from you on.

20 COMMISSIONER EDELSTEIN: Okay. Well, one person's perspective then is that they don't

1 look to be, if you will, clinically significantly different, although I'm sure statistically that makes sense. And
2 that I really do wonder whether the nature of a dual-eligible person being of low income really explains most
3 of or an important part of the difference in use of safety net and use of psychotherapy. So just a question
4 as to how much information from a policy perspective we should garner from the findings.
5 CHAIR ROWLAND: Okay.
6 COMMISSIONER MOORE: These MSP programs -- thank you. This was actually really
7 helpful, a good beginning for us on this subject, I think. These MSP programs have grown incrementally
8 over the last 20 or 30 years, and there were some institutional problems when they were first put into the
9 statute that limited the simplicity with which they were structured. And in the -- and I want to say this as
10 kind of a historical piece, that is, SSA did not means-test Medicare kinds of programs, and that was a very
11 big deal in the '80s and '90s when these MSP programs came into being. And I think that all states had
12 asset tests in those days, and there was a very strong feeling that asset tests were important.
13 Since that time, and as Diane said, since the LIS subsidy began with the Medicare drug benefit, times
14 have changed, and we no longer have assets for the LIS benefit, and we have Social Security in the business
15 of doing what one might call means-testing.
16 As for my approach to this whole program, I would hope that we might be aggressive in working
17 with MedPAC on these MSP programs to simplify them, to change the law as necessary to do that, to make
18 it easier for beneficiaries to go to a Social Security office and get enrolled, and to make it easier for
19 administrators to run these programs.
20 So that's where I come out on the MSP programs.

1 CHAIR ROWLAND: I think there's another issue, too, that could be brought into this, which is
2 that now that we have cost-sharing assistance for people pre-65 through the exchanges, there is also a cliff
3 in what some people will face. And so if we want to look at it, it should be kind of how do we smooth
4 that whole transition line.
5 COMMISSIONER MOORE: Sort of in the interest of simplicity and common sense and working
6 with MedPAC and looking across all of these old and new platforms for delivering health care and paying
7 for health care, I think it's important for us.
8 CHAIR ROWLAND: I'll actually try and set up a meeting with Glenn before our next meeting so
9 that we can develop a strategy that would work with MedPAC.
10 VICE CHAIR SUNDWALL: I agree.
11 COMMISSIONER CHECKETT: Well, you know, every time I say something, I always begin
12 with, "This is really interesting," because really everything we work on is interesting, but this has been a
13 sleeper issue for me. And I have always found it just complicated enough that I didn't really dig in on it.
14 So thank you for laying it out so well.
15 I think that I am so struck by the fact that the only way an individual, an eligible individual can get
16 this service or coverage is if they know to apply for it. And it's such a disservice, and I really would like us
17 to look at -- and I think it's very much in line with a collaboration with MedPAC, but I don't want to get
18 hung up in that if that proves to be protracted. I think we really need to explore are there options like
19 express lane eligibility. Could a state, just like we have presumptive eligibility for moms and kids, could a
20 state choose to have a presumptive eligibility for this program?

1 I think there are some actually great lessons out there that we have in the moms and kids program
2 that we could apply to this and not make it, you know, incumbent on someone having someone to help
3 them understand that there's this secret benefit available to them. It is really very interesting, so thank you
4 so much for starting the discussion.
5 CHAIR ROWLAND: But it also is true that while there is not as much participation in the LIS
6 program for low-income under Part D as one would want, you could do something where you automatically
7 were enrolled in one or the other versus -- but I think those are policy options we'd like to explore in the
8 future.
9 COMMISSIONER COHEN: I want to agree with Judy wholeheartedly that the argument -- you
10 know, the way this system grew up and developed, the conditions have changed in such a radical way, and
11 there are two issues, there's sort of administration and there's costs. And obviously costs are harder, but
12 the administration issues about who does this and the variation and now the federal government is in this
13 business, it just really, I think in many ways, makes, you know, sense to sort of continue this slightly crazy
14 system that we have developed. So I wholeheartedly agree that we should really do our best to work with
15 MedPAC on it and sort of try that first before going to sort of work-arounds, which could also make a big
16 difference, I agree. So that's one point.
17 On the second point, first of all, I just want to congratulate April and Anna. This is so great. I
18 really feel like this is -- I wish in some ways the results were more certain or, you know, that they were -- I
19 don't know if they're certain, but they're just -- they're not sort of as compelling as one might have hoped in
20 one direction or another in terms of pointing us in a direction, but it's like really new and original and sort of

1 really looks at an outcome. And I just think it's wonderful and congratulations, and I'm sure it was
2 extremely hard and probably expensive, but congratulations.
3 I wanted to ask, though, so, you know, to me a bottom-line sort of finding is that when you look at
4 the average or a median state's contribution to the Medicare cost share and a full 100 percent contribution
5 to the Medicare cost share, 3.5 percent more beneficiaries -- no, more basically primary care visits took
6 place. Is that right? Beneficiaries or visits?
7 MS. GRADY: Beneficiaries, not visits.
8 COMMISSIONER COHEN: Okay.
9 MS. GRADY: Beneficiaries with a visit.
10 COMMISSIONER COHEN: I mean, so it's not -- you know, that's a lot of people, and they are
11 primary care visits, which is sort of like the part of our system that we are most sort of trying to encourage
12 -- you know, the most efficient part of our system where we think or could be, you know, when you think
13 about the continuum of care. So to me it's significant. It's not sort of an overwhelming finding. I did
14 wonder -- and forgive me if I missed it -- do we have any data? Like what happens when you go down to
15 the zeroes or 20s? I guess two is the lowest that any state had. Like, what do the differences look like
16 there when you look at the state that adds the very least to Medicare, Medicare's cost sharing and the
17 difference between that and 100 percent?
18 MS. GRADY: We didn't do that by state. We can. It just wasn't part of the main analysis that
19 we did. So basically you would just predict the values using the 2 percent versus 100, and we didn't do that
20 for every state. But we could.

1 CHAIR ROWLAND: But you could imagine that the impact would be more substantial.

2 What I think would be a useful next step on this analysis is to focus on the cost-sharing analysis and

3 the cost-sharing issue, because that's a very discrete policy of whether the states need to fill in the full versus

4 the partial, and is one that is clearly in the Medicaid domain, and then to look for the next set at the issues of

5 how do we simplify and improve the way in which low-income Medicare beneficiaries get assistance with

6 Medicare cost sharing, Medicare premiums, and how that relates to the low-income subsidy program under

7 Part D as something that we'll move forward to look at it through the Medicaid lens, but we'll also

8 coordinate with MedPAC to see where MedPAC is going. But I think it has been very instructive that we

9 are really getting some data for the first time on an issue that has always been bandied about that it

10 influences whether providers will take patients. But I think this is very useful in the context of the

11 Medicare Savings Programs. So thank you both very much, and we'll look forward in December to the

12 next round.

13 And with that, we'll open the meeting to any public comment. Does anyone want to come forward

14 and make a public comment?

15 **### PUBLIC COMMENT**

16 * [No response.]

17 CHAIR ROWLAND: Otherwise, we stand adjourned until our December meeting on December

18 11th. Thank you all very much, and thank you, Commissioners, and especially thank you, staff, for what

19 has been a day and a half of extremely good presentations that have helped us.

20 [Applause.]

1 CHAIR ROWLAND: And we know we're giving you a lot of work to do, so enjoy Thanksgiving.

2 And Happy Halloween.

3 * [Whereupon, at 10:52 a.m., the meeting was adjourned.]