PUBLIC MEETING

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

Thursday, May 14, 2015
10:08 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[10:08 a.m.]

Session 1: Planning for MACPAC Mandated Study on Disproportionate Share Hospital (DHS) Payments

CHAIR ROWLAND: I'm pleased to convene this meeting of the Medicaid and CHIP Payment and Access Commission, and we're going to begin our first session today by discussing the mandated study of Medicaid disproportionate share hospital payments that Congress has given us, and we're going to turn to Jim and Robert to present this material, which is at Tab 2 of your briefing books.

* MR. TEISL: Thank you, and good morning, everyone.

So as Diane just mentioned, Rob and I are here to update you on the status of the Medicaid disproportionate share hospital allotments -- and we're going to refer to them as "DSH" henceforth in the presentation -- as well as MACPAC's required report on Medicaid DSH.

So first I'll review some recent changes in the schedule for reductions to allotments. We'll discuss the required report and our current plans for its preparation.

And then we'll fill you in on some of the work that we've done so far. Then I'll hand it over to Rob, who will talk through some of the things that we've learned and raise some questions for Commissioner discussion.

We're not going to spend a lot of time on background today. Many of you will remember we've done a couple background sessions on DSH before. Background material was included in the packets and can also be found on our website.

In short, states are required to make DSH payments to hospitals. They have considerable flexibility in determining which hospitals receive the payments and in what amounts. There are two important limits to keep in mind: a hospital can't receive more in DSH payments than its uncompensated care costs for caring for the uninsured and Medicaid enrollees, and the second limit is that each state receives an annual allotment of federal funds for DSH payments, which effectively sets a cap on the total amount of DSH payments a state can make.

As you'll no doubt recall, the ACA included reductions to the state DSH allotments that were intended to coincide with increased levels of health care coverage,

the idea being that as more people had coverage, hospitals would have less uncompensated care and, therefore, would need less DSH payments. Those reductions were initially scheduled to begin in FY14 with the onset of the major coverage provisions and then end after FY2020. Subsequent legislation has delayed the onset on several occasions. The reductions are now scheduled to begin in fiscal year 2018 and end after fiscal year 2025, and here is the schedule of reductions in federal funds to the aggregate amount of allotments under the current schedule.

Last year, legislation also included a requirement for MACPAC to prepare an annual report on the relationship of states' DSH allotments to the factors that you see listed here in the sub-bullets. The report is required to include analyses of allotments in the current year and estimated allotments for the next fiscal year, which means the first report will focus on allotments for fiscal years '16 and '17. Because of the most recent delay in the reductions to FY18, this means that our first report due in February of 2016 is required to examine two years of unreduced allotments and the relationship to these factors.

Here's a very high level of what we're proposing

for our first report. There's a little bit more detailed outline in your materials. For the most part, it aligns with the statutory requirements, but there are a couple things we wanted to note.

First, as we've discussed repeatedly, both on the subject of DSH and virtually everything else we have talked about, data limitations are a constant challenge in conducting Medicaid payment analyses. Rob's going to talk about some specific examples, but one I wanted to mention up front is while we expect coverage expansion to have significant effects on the factors that we're required to examine, our primary data sources for this work are going to be Medicaid DSH audits and hospital cost reports, neither of which is going to reflect the effects of the post-coverage expansion by the time of our first report. So as a result, we're going to have to do some thinking and discuss these effects based on other sources of evidence or literature until the data begin to reflect them for later DSH reports.

We're also going to need to discuss our thoughts on some working definition of essential community services and identifying hospitals with high levels of uncompensated

care that provide these services for low-income and vulnerable populations.

And I wanted to point out, while not technically required for our first report, we hope to discuss the results of our work to model the effects of the currently scheduled $2 billion reduction to allotments for fiscal year 2018 in that first report.

Finally, of course, we expect the report to include conclusions, and we hope to get your thoughts on these today and as we go forward.

In preparation for this first report, here are a few steps we've completed so far, and I should emphasize this is with tremendous help both from Dobson DaVanzo and KNG Health Consultants, some of whom I know are sitting here behind me. We've estimated allotments for 2016 and 2017. Because they will not be reduced, they're generally equal to prior year allotments times an inflation factor.

We've spent significant time identifying potential data sources and determining those most suitable for our requirements. This is just one bullet point, but it has been a huge amount of work. We've developed a model that allows us to estimate reduced allotments based on CMS'

methodology that would have been used for fiscal years '14 and '15, as well as to allow us to model the potential effects on actual payments at the hospital level of the reductions. And in April, we convened a panel of technical experts to discuss our work. Participants included representatives from CMS, state Medicaid agencies, hospital associations, consultants, researchers. A full list is in the materials as well as the agenda.

And at this point I'll turn it over to Rob, who's going to talk about some of the things we've learned so far.

* MR. NELB: Thanks, Jim.

To help facilitate the discussion today about our planning for our first report, I'm going to walk through some of our preliminary findings, starting with the relationship between those unreduced DSH allotments and the three factors that are required to be included in our report.

Full information about the unreduced allotments is in your material in the appendix, but the bottom line is that DSH allotments currently vary widely, from less than $15 million in five states to more than $1 billion in three

states.

This variation is largely due to state historic DSH spending prior to the establishment of federal limits in 1993. As a result, there is very little relationship between current DSH allotments and the factors required to be included in our report. Nonetheless, I'm going to walk through each of these issues to give you a flavor of the types of data that's available and the challenges that remain.

So, first, in terms of uninsured, we've been looking most closely at the American Community Survey, which is the most reliable source of state-level uninsured estimates.

In 2013, the most recent year for which ACS data are available, state DSH allotments per uninsured individuals varied widely from $3 in DSH allotment per uninsured to more than $1,500 per uninsured. Full information about the range across states is in your materials on page 5.

Later this fall, we will have ACS uninsured data for 2014, which we plan to incorporate into our first report. Although we know that the ACA coverage provisions

have lowered rates of uninsurance, this will give us information about the state-by-state impacts.

Second, in terms of uncompensated care, our best source of data are DSH audits, which provide hospital-level data for hospitals that receive DSH payments. Just to put this in context, about half of U.S. community hospitals receive DSH payments, but they account for the vast majority of Medicaid spending on hospital services.

In 2009, DSH hospitals reported a total of $30.8 billion in uncompensated care costs before DSH payments. Most of this was due to care for the uninsured, but about a quarter of these costs were attributed to Medicaid payment shortfall.

In 2009, DSH payments covered an average of 57 percent of these costs, although, again, it varied widely by state. We have information about the variation in your materials. Six states covered more than 90 percent of their uncompensated care for DSH hospitals while five states covered less than 10 percent of their uncompensated care for their DSH hospitals.

Although DSH audits are valuable, they are limited to the DSH hospitals, so we are looking at using

Medicare cost reports to provide additional uncompensated estimates for all hospitals. Medicare cost reports also allow us to look at bad debt, which is another important source of uncompensated care that isn't included in the Medicaid definition and is required to be included in our first report.

However, I want to underscore the point that Jim made, that with DSH audits and cost reports, data lag will significantly limit outcome ability to capture the effects of the ACA coverage expansions in our first report. We have been looking at recent publications of hospital-specific projections and some state estimates, but we won't have that comprehensive 2014 audit data to provide a complete assessment.

There are a number of other data limitations and other issues to keep in mind when talking about uncompensated care. First is that the Medicaid DSH audits and the Medicare cost reports don't always align. Specifically, the Medicare cost reports don't include DSH payment information, which makes it challenging to use for our analysis.

Second, it's important to know that some states

do not currently spend the full amount of their DSH allotments, either because of a lack of non-federal share or other reasons. As a result, in some cases it may be more appropriate to look at DSH payments rather than DSH allotments.

Third, sources of non-federal share affect the net amount of DSH payments that providers receive, and we know that the majority of DSH payments are financed by providers themselves, either through health care-related taxes or intergovernmental transfers. However, accounting and sort of netting out these payments at the provider level will be challenging, although we do have some state-level estimates for these provider contributions.

And, finally, it's important to recognize that DSH is not the only payment that hospitals receive for uncompensated care. In Medicaid, there are a number of other non-DSH supplemental payments, such as UPL payments under fee-for-service and Section 1115 uncompensated care pools. In addition, Medicare also makes DSH payments to hospitals which are based, in part, on uncompensated care.

Last but not least, our report is required to assess the relationship between Medicaid DSH allotments

and, quote, hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations.

As a starting point for this analysis, we have begun identifying so-called deemed DSH hospitals, which are statutorily required to receive DSH payments based on their Medicaid utilization or low-income utilization. These hospitals account for about a quarter of all DSH hospitals, but they report about twice as much uncompensated care per hospital as other DSH hospitals. As with the other factors, there's little relationship between a state's DSH allotment and the number of deemed DSH hospitals in the state.

As we move forward, we're then looking at which of these deemed DSH hospitals also provide essential community services, and we asked our technical advisory panel to provide some feedback about potential services we might look at. In particular, the statute requires us to look at the range of primary to quaternary care services, such as burn or trauma, and we're hoping to find some of this information in the aggregate on Medicare cost reports.

In addition, the technical advisory panel discussed potentially looking at the availability of similar services in a close geographic proximity to help assess whether or not those services that the hospital provides are particularly essential for that community.

Finally, although not required for our first report, we have begun modeling potential DSH reductions for 2018, and some initial results are in your materials. To do this modeling, we have been applying the CMS methodology that they initially proposed for 2014. This methodology assigned state DSH allotment reductions based on the following factors which are required in statute.

First, the model takes into account the state uninsurance rate, giving lower allotment reductions to states with higher uninsurance rates.

Second, the model looks at state targeting of DSH payments to hospitals with high levels of uncompensated care and Medicaid utilization, basically giving lower reductions to states that better target their DSH payments to high-need hospitals.

And, finally, the model takes into account some factors of historic DSH spending, giving lower reductions

to states with historically low DSH allotments, and also accounting for states that have used their DSH allotments for coverage expansions through waivers.

In addition to assessing state-level allotments, we've also begun simulating the potential effects on DSH payments to providers. This obviously involves a lot of assumptions about state behavior. It is a challenge, but we're doing the best we can, and some information about that is in your materials as well.

So I know this is a lot, but now that we've walked through some of our preliminary findings and sort of discussed the data and challenges that remain, we look forward to your feedback and discussion about what's next as we prepare additional analyses for our first DSH report and look at areas to potentially consider for future reports since this is now an annual requirement.

We're particularly interested in any analyses that might help you draw conclusions from our work, and obviously we're also happy to answer any questions that you have about the work that we've done so far.

Thanks so much, and we'll be taking notes and looking forward to incorporating your feedback into our

first draft.

COMMISSIONER RILEY: This is important work and really complicated stuff. I admire your focus.

I wanted to focus on a little, small part of the problem, the quarter of uncompensated care that results from the Medicaid shortfall. The definition of what is a shortfall and how is it defined seems to me to require a bit more drilling down, particularly since we've all heard -- anybody who's been in a Medicaid office has certainly heard hospitals say they shift those costs to commercial payers. Whenever the Medicaid budget issues come up and payment issues come up, you often hear that it is a cost shift. So how can it be both a cost shift to commercial payers and uncompensated care? So I think that requires a little bit more analysis, and I'd like to understand it better.

COMMISSIONER COHEN: I also admire your work and your focus, and I, like Trish, maybe am sort of going at an angle of this and not the whole, which I hope we will get to, but I just wanted to raise an issue that I think is really important, and this is the definition of essential community services.

This is really hard, but I think it is really critical, and I wondered a little bit when I was reading the paper and in your presentation whether the provision of primary and quaternary care services was actually comprehensive -- was actually the right way to look at what, you know, sort of essential community services are. And really it sort of goes to, you know, an underlying conventional wisdom and something, you know, that we've talked a little bit about here. Some services are paid for better than others in hospitals, and those that are paid less well related to costs are ones that -- you know, what I consider to be essential community -- or, you know, hospitals that provide them become more essential, and hospitals that have the choice often ditch them. We've had a conversation here recently about how that is true of inpatient psych, for example.

So I know it is very hard to get at that, but I think it is really -- like I think if we do, you know, some sort of really rough proxy of what an essential community service is, we will not do justice to that part of the analysis because I think there are many services that might not -- primary care is critical and certain quaternary care

I'm sure is, too, but really the question is: What are services you can't get anywhere else? And there are some -- whatever are the levels in between there -- I'm not sure I would say the right word -- you know, are tertiary and the two, you know, I think really need to be in that mix. So I don't want us to sort of leap over that and just say it's primary and quaternary. There's plenty of places that I would say are probably not providing essential services that nobody else provides that provide quaternary care. It's just -- it's too rough a proxy for me.

COMMISSIONER LONG: Just need to ask a question on other issues that you have listed here. Where it says, some states do not spend the full amount of their DSH allotment, do we know exactly -- maybe you do and maybe you don't know -- what I'm asking is, is that money reallocated to other programs, to other hospitals that need that money for greater needs or what not? How does that work? Do they --

MR. NELB: Yeah. The unspent DSH allotments are not reallocated. However, in many of those states, the state opts to make other sorts of payment, such as a non-DSH supplemental payment. But, it's worth noting that in

the latest year we looked at, it was about $2 billion in unspent DSH allotment, and, obviously, the first amount of the reduction is $2 billion. Currently, the DSH allotments don't get reallocated if they're unspent.

COMMISSIONER LONG: So, what do they do with that money? Is it just stays with that -- or does it go back? I'm just asking, because I'm really trying to get a handle on it. If it's $2 billion, that's a lot of money that could be utilized other places for consumers or what not, so --

MR. NELB: So, the allotment is -- it's an amount of federal dollars that the state can spend. If the state doesn't spend it, it's just not spent and they don't -- they just don't -- they don't use the allotment.

CHAIR ROWLAND: I think what you need to clarify is that this is not an allotment like the CHIP allotment --

COMMISSIONER LONG: Right.

CHAIR ROWLAND: This is a cap on how much the state can spend. So, they can spend up to that, but they can't spend over it.

MR. NELB: Right. Thank you.

COMMISSIONER LONG: Thank you.

CHAIR ROWLAND: So, there's no money spent until they spend it. It's not like there's $2 billion waiting to be spent.

Sharon.

COMMISSIONER CARTE: Rob and Jim, I was wondering if your working definition of essential community services, does that mean that in your modeling, you'll be able to take a look at the impact on small rural hospitals, and have you seen any trend there to date, or is it too early?

MR. NELB: So, I think by working definition, we meant that we're going to sort of do the best we can for this first report and then we can build on that going forward. We have been looking -- we have some information about rural hospitals or Critical Access Hospitals. There's sort of different criteria that are in the cost report. So, we have been looking at some of those factors. But, at this point, we're kind of limited to, basically, what's in the cost reports, and then the American Hospital Association also has some sort of just broad hospital characteristics that we can look at at this point. In the future, we can bring in some other data, like claims or other things, but --

MR. TEISL: And, just to add on that, as Rob mentioned, this issue of geographic proximity to other hospitals that provide the same type of services was an important one that, at least when we brought our technical advisors together, they talked about a lot, and with particular interest in this issue of hospitals in rural areas.

COMMISSIONER GABOW: I think this is important and a good start to the work. I have three comments, not four.

The first is, I think it would be really useful if you can create a picture of really what is the funding terrain and think about, for example, DSH payments versus FMAP. That would be a very interesting graph, I think, to look at. DSH payments versus non-DSH supplementary payments, particularly UPL, and look at that both as a total graph and as a state by state, as you've done some of your other graphs.

My second comment is about essential community providers. While this data isn't going to be available, I understand, at first, I think in looking -- as you look at claims data, I think there are four things that are

important as essential community providers. One is trauma, because that tends to be quite expensive, given the 24/7 nature and the complexity of that, and sort of in trauma I put burns in the same bin. Behavioral health inpatient service, because that is really, as we've talked about, often the first thing that's cut by other providers. Dental services. I know that our dental clinic -- clinics, we had five of them -- were overwhelmed, largely because there is no other good source. So, if you provide dental services, that's important. And, the last is specialty care, which, again, is hard to access. So, I think those four make up a very good picture of what makes you an essential community provider. Public health may be another one, but it's harder to get access even to that data.

The third point I was going to make is I think it would be very interesting, not for this report but for the long term, to look at DSH payments versus a measure of state quality. So, if you went to, for example, Commonwealth's ranking of states on the 37 variables and, you know, DSH payment versus whether you're in the first quartile, second quartile, third, or even where you stand one to 50, would be very interesting, as well. I'm not

sure I would know what that graph looked like. But, I think trying to get at some way, what does this mean for the health of the population? At the end of the day, that's what we care about. So, I think thinking that through, and maybe this state ranking is not the best, but thinking about what might be a good way to begin to look at that, I think, would have some utility.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: Thanks very much for this. This is incredibly difficult to think through.

So, I have a question about the interaction between -- back to Trish's point -- the Medicaid shortfall here and the fact that it is the single largest area of community benefit expenditure by hospitals that are nonprofit hospitals. When they file their 990 reports, if you look at where they are spending -- allocating their community benefit spending, as I recall, the largest single allocation is Medicaid shortfall. So, somewhere along the line, the two issues really need to be thought about together.

I have to say parenthetically, I -- we know that in Medicaid -- the financial assistance for uninsured

patients is probably going to come down, at least in the expansion states. There is some suggestion that Medicaid shortfall may or may not come down. But, on the other hand, if hospitals are allocating their community benefit spending to the Medicaid shortfall, the question is, should the Medicaid shortfall be declared here, or, in fact, from a public policy point of view, is it better for Medicaid to, in fact, come up some and to have the community benefit spending allocations go into specialty services that are available to the entire community. That's another -- I think looking at the community benefit spending categories may help us with essential community service definitions because they overlap, especially with Patty's excellent list. You see a lot of those also showing up there.

So, somewhere, we've got a choice to make, and I think Congress ought to see the choice clearly in the work about is this something that we're better off encouraging through tax-exempt expenditures, or is this something that we're better off paying directly for and how do we know. I mean, what are the criteria we use to decide, you know, whether we're better off. But, the point is that these kinds of investments should show up on one side of the

ledger or the other because we really should only be paying for them once.

COMMISSIONER CHECKETT: Thank you for your work. You know, it always warms my heart to read a chapter on disproportionate share funding --

[Laughter.]

COMMISSIONER CHECKETT: -- because it is interesting. You know, I know, Jim and I, we've had this for years, but it is interesting and very, very important.

And, so, one area that I'd like to see addressed either here or subsequently is the tantalizing concept that states aren't spending all their money because they can't figure out a way to match it. And, so -- and I think that's very important. We've had, as we know, as a Commission, we've talked about UPL and taxes and whether they're bad or good or legal or not. But, I was just, I think, very surprised to realize that we had that amount of money not being spent, and from what you are -- what I'd like to know, one thing is, is it because the states can't come up with the match? Or, is it they really don't feel like there's a need, they can't figure out a payment methodology distribution? I think it's an important area

I'd like us to address, if not here, at some point.

CHAIR ROWLAND: And which states are contributing to that.

COMMISSIONER CHECKETT: Yes. Thank you.

[Off microphone comment.]

COMMISSIONER CHECKETT: Right. I think Yvette raised the issue very well. I mean, I think we need to really look at why, in a program with so much need, these funds are being left untapped.

CHAIR ROWLAND: Okay. Then, I now have Mark, Peter, and Chuck.

COMMISSIONER HOYT: I don't know if you're able to get this or not, but I thought I'd ask. It seems like at a higher level, there'd be interest in just knowing the movement in uncompensated care. If you have all the reports somewhere that add up to $16 billion in DSH payments and then you're going to reduce that by $2 billion in a future year, how much did uncompensated care go down? Even though there's reasons why you can't expect that to just match perfectly, I would think there would be interest in seeing that across the country and state by state, if you can get that.

COMMISSIONER SZILAGYI: Yeah. I'm trying to -- first of all, this seems so complicated analytically that it's kind of blowing my mind, and this is way out of my field, but here is a question I have. Part of the complexity that I'm seeing is that we're trying to compare across states when there are so many different factors that go into the differences across states that have nothing to do with specifically DSH. I'm getting back to the specific question about the relationship between DSH and uninsured rates or uncompensated care. Whereas what we would really want to do, in a way, is do a thought experiment. If other things didn't change except for DSH payments, what would happen? So, that's almost a longitudinal analysis within the same state. The problem there is that other things change over time.

So, my question is, are there cases or states where very little other factors changed across the years except for DSH payments, or are there case reports -- so, in other words, not comparing across states but within states over the years where something significant changed in terms of the DSH payments, and that could get us maybe a little bit closer to this relationship between DSH and

uninsured or uncompensated care, which is the central question we're asked to answer.

I don't know if I even made my question clear --

MR. NELB: No, it's a good point. We can -- we'll look into it. One thing to point out is, I think, at least prior to the ACA, some states used their DSH allotments for coverage expansion, so, like Massachusetts or D.C. or other states. So, as you'd look at the relationship between their DSH allotment and uninsured, those are the states that it looks like there's high DSH allotment per uninsured, but part of that is because they used their DSH allotment to give people coverage.

I'm not sure there's other similar examples, but that is one we can certainly discuss.

COMMISSIONER SZILAGYI: The concept of drilling down to a state or to where there were major changes and can you relate the DSH to the uncompensated care more closely than trying to look at the whole country and variations across states when there are so many other factors.

CHAIR ROWLAND: Chuck, then Gustavo.

COMMISSIONER MILLIGAN: So, I want to wish you

the very best.

[Laughter.]

COMMISSIONER MILLIGAN: Two comments. The first is, I think you're being asked to create a rational framework out of something that was never rational, ever, and because DSH back in the bygone days was never itself particularly well tied to uninsured rates and it was capped because of perceived and real state abuses of federal maximization, and it was capped at levels that related to how much states got away with before the caps were imposed. And, so, a lot of the variability had a lot to do with how aggressive states were at various points in time before there was a new sheriff in town.

So, I do think that -- my suggestion is, I think it would be helpful to add contextually when you get to this some of the history to belie the view that this was ever rational or ever tied to uninsured rates, because that's a fiction.

The second comment, I want to build on something Sara said. In the ACA, there was clearly a view that as more people got coverage, the need for uncompensated care would be reduced and the need for DSH would be reduced, and

there were various reforms, and I'm doing this from memory, but I think it was Section 5003 about some community health needs assessments for hospitals that are tax -- have tax-exempt status.

And, I will tell you from having been part of a study about that issue, there was a high correlation between DSH hospitals and hospitals that receive a lot of tax breaks by having tax-exempt status, either as public hospitals or as nonprofit tax-exempt hospitals. And, the interesting part of the study that I was involved in a few years ago at the Hilltop Institute at UMBC was that the bigger tax breaks actually were at the state and local level, not at the federal level. So, if you look at Section 990 reports that Sara alluded to and Schedule H, which is where all of this stuff is found, you'll see a lot of justification for ongoing federal tax-exempt status tied to not only uncompensated care, but also what's called the Medicaid underpayment, you know, paying 80 percent of costs.

But, that creates an exemption from federal taxes, typically, you know, FICA and income taxes. But, at the state level, it's often correlated to property taxes,

which are bigger, and state and local sales taxes and other things.

So, I think when you look at the all in subsidies that go to help support the DSH payments, it adds a more complete story, and I wouldn't suggest that you try to track down all that data, and at the state level there are some resources that maybe can give you some aggregate data that the research has been done.

But, I think, contextually, if we don't reflect the fact that in the ACA there was a link between tax-exempt status and uncompensated care and Medicaid payment, I think that we're too narrowly looking at the DSH issue in isolation.

COMMISSIONER CRUZ: I was just wondering, due to the many data issues and lack of definitions, and I'm not sure this is within the Commission's purview, but couldn't the report also include a set of recommendations for data standardizations and definitions of what essential community services are, uncompensated care is, so in the future it could be much easier for you and for everybody to understand what's going on?

MR. TEISL: The Commission has previously made

recommendations about improving data.

[Off microphone comments.]

CHAIR ROWLAND: He's asking for definitions as well as data.

Sara, and then Steve.

COMMISSIONER ROSENBAUM: Just one additional point on this 990 question. So, in a report that went virtually unnoticed that is basically not available except in .pdf form that I got from somebody, the IRS reported in February of this year on community benefit spending and the number is quite revealing. Previous, the New England Journal of Medicine study, which I think is now the leading study, reported the figure at about $35 billion. The IRS is reporting $62 billion. And, I think, if I recall properly, a third is declared as a Medicaid shortfall.

And, so, it was a letter to Chairman Ryan, but it was actually a letter to which was appended a brief report, and the IRS does a nice job of laying out the breakout of the community benefit expenditures, and this obviously eclipses the earlier numbers.

I asked the author, Gary Young, the lead author of the earlier study, how he explained the difference. He

said that the IRS, in fact, includes all the multi-facility systems, whereas they looked only at individual hospital facilities. So, it's a truer number. It's a very large number overall, and the portion going to Medicaid shortfalls is quite big.

So, if we do nothing else here but connect the dots for Congress between the two forms of spending and then pose a series of questions about, you know, what might be the possible options for dealing this with, I think it would be good.

COMMISSIONER WALDREN: So my line of comment is in line with yours about the data and the definition. But I agree that in the past we've looked at data and said the data is an issue. But I wonder, for like this mandatory report, maybe any mandatory report, think about how would we determine what the impact of the report is so that we'd understand, should we in the future make some recommendation to either change in what's mandated if it's not helpful, if something else would be helpful, or if it needs to be removed.

But the other is would you be able to determine what the impact would be if we solved some of these data

issues so that we could take that impact as kind of a value statement and compare that to the administrative burden costs that we know are going to be there for states to collect that data. So we could make some recommendation to say, you know, it's worth it to go ahead and -- because the impact of this type of report will be so much better and allow us to make these type of policy implications that we think it's worth the burden to ask for this particular data to be better.

VICE CHAIR GOLD: I just want to second Chuck's comment, it's sort of about framing, because it strikes me that you could put a whole lot of numbers out that people would draw some conclusion, but it wouldn't be a reasonable conclusion necessarily because it's mixing the context. And so we need to answer what Congress asked, but I think helping frame what was behind the question or how it reflects reality of how DSH works would be a real contribution.

CHAIR ROWLAND: You know, as I look at the map that you put in to show the relationship of DSH spending to total Medicaid spending, you see such huge variation by state. And so obviously many states are very heavily

dependent on the DSH funding, and many of the same states that I see that are heavily dependent are also states that at this point have elected not to do a Medicaid expansion.

So I think it's very hard to do this study without understanding more about how those heavy DSH states are using those funds, and also to understand what the implications of doing or not doing the Medicaid expansion have for the need for the DSH funds, because, ironically, when Congress set this up, it assumed that every state was doing the expansion because it was mandated. And the implications for the Supreme Court's option I think really need to be weighed in your analysis.

But also just that, you know, some states obviously have used the DSH funds much more directly to support uncompensated care and especially the safety net hospitals, and others have had a wider distribution of it. And I think some of those equity issues ought to also be raised in the way in which we look at this.

COMMISSIONER COHEN: I just also wanted to make sure this point is sort of clear in the chapter. DSH payment -- or DSH allotments are not free money to states. They're just another form of matching that comes with

different methodological sort of requirements -- or, I should say, very few methodological requirements. But, you know, it's not like -- I mean, it's not free money to the states for them to distribute. They have to decide to match it. Am I right? It's at the same rate that they match every other payment.

So I think one important question --

CHAIR ROWLAND: But it isn't associated with being matched for people services. It's matched for uses the state sets up for how to use it.

COMMISSIONER COHEN: Right. And there are others of those, too, like UPL. So I do think one question that we should sort of look at is what are other options for states to meet goals that Congress laid out as, you know, sort of legitimate under the Medicaid financing arrangements in the context of a reduction in DSH, and maybe that shows that there are -- the problems posed are changed. It's really hard to get, you know, rate changes through CMS. It can takes years. It's complicated. Maybe it's politics. Maybe in some states there's really no problem, but in other states there's a big problem. You know, some states could use UPL. Others cannot.

But I do think this question of what other tools are available and what are the constraints on using them is sort of an important contextual piece, too.

CHAIR ROWLAND: But, in essence, what the Affordable Care Act sought to do was to shift from providing hospitals and institutions with funds to support care of the uninsured to instead providing for the newly insured 100 percent federal matching funds to cover the cost of their care. So there's a balancing here that's going to shift from an institutional-based funding stream to an individual funding stream in the states that elected to do the expansion. And that I think is important to note.

And I think the other thing that we really need to take account of is that DSH assumes a world without a lot of managed care, and the role of managed care and how that interacts with the DSH funding strategies in states also needs to be highlighted in our report.

COMMISSIONER ROSENBAUM: The one thing that I would add to that, because those are all the correct issues, is the fact that when it comes to the new insurance markets, Congress made a similar set of choices to

subsidize coverage, but only up to a point. And so there are a lot of low- and moderate-income people left with, of course, pretty substantial cost-sharing requirements, particularly deductibles. And so as we think about essential community services, one of the things we have to think about is having facilities in a community that will forgive, you know, a substantial part of, say, a $5,000 deductible, that maybe cut some but by no means all. And studies I know that Kaiser has done and I think Avalere and somebody else did studies showing even with the cost-sharing reductions, people who are low- to moderate-income still had pretty substantial cost-sharing obligations. I'm sure this is something that you probably are beginning to experience at Children's, that people are significantly underinsured if they're sick.

And so that would show up, of course, in the financial assistance cost column, not in the Medicaid shortfall column. But I think it also underscores that we have to think about all of these parts moving together, that one reason to -- you know, that makes it such a timely set of questions is because we've essentially moved the tables -- we've moved uncompensated care around. We have

by no means eliminated uncompensated care. It shows up in different structures in different states depending on the options they take, and the Medicaid DSH payments are sort of one tool. There are these other tools, and it has to be understood in that context, I think.

CHAIR ROWLAND: So there you go. You thought you were doing a study of DSH. Now you're doing a study of financing the uninsured, the underinsured, and --

[Laughter.]

CHAIR ROWLAND: And all of that by February we'd like, please.

I think this is a great start. I hope some of these comments have helped give you a little more guidance on areas we'd like to at least note in the report and explore. I think really educating the policy leaders on how DSH is currently working and really going back to this was not created as a way to go one for one with uninsured populations and the formula now links that back and how irrational the beginning is, and just looking at, again, your Figure B.1, how many states have made such different choices and where they got on to DSH early on compared to the role it plays today I think is an important aspect of

what we could do. So good luck.

[Laughter.]

CHAIR ROWLAND: Thank you.

And just to continue with our look at the way in which the safety net functions, our next session is going to focus -- we're going to keep Jim up here and have Beth Waldman join him, from Bailit Health Purchasing as a senior consultant, to really talk about safety net accountable care organizations and how this model is evolving and what some of the challenges and issues are there.

Session 2: Safety Net Accountable Care Organizations

* MR. TEISL: Thank you.

CHAIR ROWLAND: We should also note that Beth is a former Massachusetts Medicaid director, and we've just heard how Massachusetts took its DSH funds and used them to insure people. So if you have any questions about Massachusetts, you can also ask her.

MR. TEISL: Well, thank you, and hello again. So in this session we're going to share information from this project to learn about safety net providers that have formed accountable care organizations serving Medicaid enrollees.

As you're all well aware, accountable care organizations, or ACOs, have received a great deal of attention in recent years as one approach to this idea of paying for value rather than volume. Much of the attention, however, has been in the commercial sector, and especially in the Medicare program. ACOs do exist in Medicaid as well. You won't be surprised to hear that they vary quite a bit across and even within states on a variety of characteristics, some of which we're going to talk about today.

Just for a little bit of context, over the past couple years we've had several projects looking at this issue of value-based payment and delivery system reform in the Medicaid program. We've done a series of site visits looking at program organization and administration in now seven different states, all of which were taking different approaches to payment reform -- Oregon and Arkansas and Connecticut and Oklahoma.

We've conducted site visits focused on specific opportunities that states have taken advantage of, like delivery system reform, incentive payments under 1115 demonstration programs, you'll recall the presentation last

meeting, including states like Texas and California.

We've also conducted visits looking at specific services like managed long-term services and supports.

So in most cases these visits have all been to state Medicaid agencies. The big difference in this project is that we went and visited providers themselves in an effort to better understand how these ACO initiatives are actually being operationalized, especially among providers with a significant focus on Medicaid populations.

We did, however, follow up our site visits with phone interviews of state Medicaid officials, health plans, and contracted providers working with the ACOs.

Before I turn it over to Beth, I did want to take a moment to publicly thank the providers for their willingness to participate, both by hosting us, which is no small task, but also sharing strategic and operational details, some of which would certainly be considered proprietary. Our objective for the project was to develop an understanding of safety net ACOs by synthesizing information across them. So while we do share some high-level characteristics of the individual sites we visited, we've intentionally avoided discussing individual

operational details.

Also, we're in the process of developing the final report now, so some of the details might change a little bit as we go through the revision process, including a process of validation with the sites that we actually visited.

And with that, I'll turn it over to Beth Waldman from Bailit Health. Her bio is in your materials. She helped very capably lead the project and will talk through some of the things we've learned.

* MS. WALDMAN: Thank you. So today we're going to talk about what the study was, where we visited, some key characteristics of the sites, some themes, and then we have some policy questions for you all to discuss, and Jim and I are happy to participate as well.

So in terms of the project, as Jim said, we really wanted to look at the context of providers who are moving towards alternative payment methodologies, either because of what states have done or because they see something in the market that makes them think they should move that way, and looked really to see how those changes are impacting Medicaid beneficiaries.

So you can see on the slide the areas of focus. I'm going to talk through these. We looked at the history and development of the ACOs, the governance, leadership, and organizational structure, the state and market contexts, their approach to care management, and their payment arrangements.

So first let's start with what a Medicaid safety net ACO is, and I would say this is not a definitive definition, but this is the definition that we used. You know, in some ways you hear kind of "You've seen one Medicaid program, you've seen one Medicaid program." I think you can kind of say that for ACOs. If you've seen one ACO, you've seen one ACO. They all, you know, have some things in common, but they do things differently.

So as we defined it for this project, first, the ACO had to be a provider-based organization, and a provider-based organization that provided care to a high number of Medicaid and uninsured patients. We actually started out looking for organizations that served more than half, but altered that a little bit because we didn't find that many that were ACOs that served them primarily, so we stuck with the high numbers.

Second, the organization has to have entered into a shared savings or shared risk arrangement, either with a state Medicaid program or with a Medicaid managed care organization. So it's really important to note that there are a lot of safety net organizations, if you will, that have entered into arrangements with Medicare through the Pioneer ACO or the Medicare shared savings project, but might not have done it on the Medicaid side. Those we did not include.

We also did not include safety net providers that were operating essentially as a health plan in our study. So someplace like Denver Health, which in Colorado really operates as a Medicaid managed care plan, we didn't include. But there were still a number to choose from.

On this slide, you see our selected sites. We visited five states and seven ACOs, and let me just give you a couple of highlights.

The two Massachusetts sites we visited were both integrated hospital systems, and to relate it back to your DSH conversation, the Cambridge Health Alliance is the only public hospital in the state, and we called that a big DSH -- a primary DSH hospital. And Signature Health Care

includes Brockton Hospital, which we called a baby DSH hospital because it didn't have quite as many Medicaid and uninsured members as the Cambridge Health Alliance did.

Both of these are in urban settings. They both accepted downside risk, and their participation in the program was through Medicaid itself directly with the Medicaid program. There is a primary care patient reform initiative that's happening in Massachusetts, and that's what we used, although both of them also accepted some level of shared savings or shared risk through the Medicaid managed care contracts they had directly with health plans.

Next we visited Penobscot Community Health Care in Maine, and it is an FQHC-based -- Penobscot itself is an FQHC. They are in the process of joining with a number of other FQHCs in order to create a greater organization, but at this point it really was a single organization. They're rural, as all of Maine is. Right now they don't accept any downside risk. They did have limited participation in a Medicare ACO that they stopped after a certain period of time.

In Minnesota, we also visited two sites. FUHN, which is one that lots of people have heard of and has been

visited, they were very willing to share with us even though they have very willingly shared with lots of other people. So to echo what Jim had said, all of these sites really were very hospitable and very willing to kind of open up to what they were doing so that you would all understand what they were facing in being Medicaid ACOs.

So, anyways, FUHN is an urban-based ACO that is ten federally qualified health centers that have come together in the St. Paul-Minneapolis area. They do not accept any downside risk, and they do not participate other than in the Medicaid program.

Likewise, Southern Prairie Community Care also is participating in the Minnesota Integrated Health Partnership, I think is what their program is called. This, interestingly, is a county coalition that has come together to form an ACO and has brought together a network of providers. That network also includes social service agencies. It was really in its -- not in its infancy. It's about a year old now. But, really, kind of working on implementing as it was moving along. So, it's very rural. It doesn't accept any downside risk and it doesn't participate in Medicare or commercial ACOs.

Montefiore is in New York, again, a well-visited place. It is an urban integrated hospital system. It is very big. It accepts downside risk across the board in both Medicaid and in the Medicare and commercial markets.

And, then, finally, we visited Partners for Kids, which is an ACO that is with Nationwide Children's Hospital in Ohio. It is both urban and rural in that there's -- it's in Columbus, the hospital itself, but it includes a number of rural counties. Interestingly, they only participate as an ACO for the Medicaid population. Right now, they do not participate as an ACO for either the Medicare or commercial markets.

So, here, we're going to synthesize some of the findings we have. First, why safety net providers choose to become ACOs. For many of them, it's because of the market pressure. Either the state Medicaid program, as in Minnesota, is putting together a program and they don't want to be left behind, they want to join in, or they are already doing it on the Medicare and commercial side and they want to align across the board so that there's incentives that are the same no matter who you're seeing.

And, finally, a lot of them really want to

control their own destiny. They really want to be able to say, we're in control of what's going to happen to us. We have confidence in our abilities to succeed and we don't necessarily trust other people in the marketplace. We want to hold on.

And, then, the financial pressure is a big one. I would say most of them either were on a burning bridge, felt the burning bridge coming, or feared that somebody else in the state was on a burning bridge and, again, wanted to control their own destiny. So, that's the first thing.

In terms of what was needed to become an ACO, this really doesn't matter kind of what type of ACO you are, but across the board, you need these four things. You need to change your strategic focus. For providers, that means more than just delivering care. It means thinking about health and health outcomes and it means thinking about cost savings, and that's different than what providers typically do.

You need strong leadership and vision. That's true with any sort of big change you're trying to do. It really is hard to kind of move how your organization thinks

and operates, and if you don't have that leadership and vision, it's going to be really hard to both start and kind of maintain the effort that's needed.

The third thing is partnerships. Particularly for smaller organizations, they're not able to be ACOs on their own. They wouldn't have enough of a panel size, if you will, to really change how they're delivering care. And, for some of them, they really needed some financial assistance. They couldn't do it alone.

And, finally, the last point is around capital. To become an ACO, you often need infrastructure investment. That's both for data and being able to understand kind of what is happening with your population and for things like care management and being able to invest in that care delivery.

In terms of governance, again, you really need to be a strong leader. We cannot emphasize that enough. The model is really different based on the organization. So, if you're a big hospital, then usually the big hospital is the lead and you feel it that way. If you're FQHCs, usually it's FQHC leaders.

So, here, we've given some examples. FUHN is

made up of -- their governance model, their board is the executive directors of each of the FQHCs.

Nationwide, which is the Partners for Kids and the children's hospital, their board is made up of the hospital executives as well as mostly physicians that are within the hospital system. They're hospital employees, although there were a couple of community physicians that were on the board.

And then, finally, Southern Prairie are county commissioners. These are folks that really don't understand the health care system very well except to know that it's really impacting them, and they have put together an advisory board, if you will, that's made up of a broad group of social service and health care providers, and they were just starting to form some work groups underneath them when we were there.

So, next, we're going to talk about care management, and first, let me define what we mean by care management, because, again, that is different for everyone. And, I would say that the ACOs all had a slightly different description of the care management, but essentially, it was focusing on high-risk members or those with chronic needs

to provide supports to manage their illness or their risk and assisting them with care coordination, and by that I mean helping to set up appointments, linking to social supports, that sort of thing.

For the care management, there are very different beliefs in whether or not that care management should be centralized or embedded in practices, and we saw very varying results -- not varying results, varying models. There's not necessarily a lot of results at this point.

And, then, I would say that for some of the ACOs, this was their key strategy, putting this care management in place and really focusing on these high-risk members. That is not the case for all of them, though. Although all of them had care management, some were really in the beginning stages of putting it together.

But, they had a number of other cost saving strategies, and that included improving their coding. Some people refer to this as upcoding. This is not how they presented it. They presented it as wanting to ensure that as they transitioned to global payment, they were really getting the appropriate payment to account for all of the risk that a particular individual encompassed as they were

taking them on.

The second thing was reducing leakage. So, here, they're really trying to keep individuals within their system of care, because if they're attributed to them, they want to make sure they have some ability to really provide them the care within their systems.

And, finally, improving their data collection, both in terms of collecting the data itself, analyzing the data, and then using that data to really impact what care initiatives they were putting into place.

In terms of payment arrangements, we saw some ACOs that had sub-capitations from MCOs. We had seen some that had both shared savings and shared risk in their model and some that had just shared savings. It's important to note that they really varied in terms of what services were included in the model, and for the most part, they do not now include behavioral health. Although the states do have some options to include behavioral health, for the most part, the ACOs did not feel quite ready to put that into the mix.

In terms of the state and market context, again, this really varied. In some states, the states were very

involved and had really dictated a program for ACOs, as in Minnesota. In other states, they weren't involved in all. Ohio does not really focus on ACOs. They're focusing on episode-based payments, but Nationwide had been there and performing as an ACO for a long time through the managed care organization.

And, finally, in terms of purchasing vehicles, they really varied in terms of whether or not they were going to do it through a state purchasing option, like a primary care case management plan or through their MCOs.

So, the next couple of slides just reiterate the themes that we heard. For many, the reasons for ACO formation was the financial constraints they were feeling and a belief that adopting a new payment model was necessary for their long-term sustainability.

In terms of the ACOs' characteristics themselves, they really differed based on who the sponsor was, what the market characteristics were, and, really, where their available start-up resources were, and that really drove where they could focus.

For the safety net ACOs, they pursued a small group of common cost savings strategies. We just talked

about them, the care management, the coding, the leakage, and the focus on data.

And, in terms of the state, as I said, the states were sometimes involved very comprehensively, sometimes not at all, and sometimes somewhere in the middle.

One of the questions and discussion points we had a lot with the ACOs was about the role of the MCO between where a state was putting an ACO in place and there was a managed care organization in the mix, what that meant and what the role of the state should be, what the role of the ACO should be, and what the role of the MCO should be.

We saw that the safety net ACOs are typically not fundamentally changing at this point how providers are delivering care. They're really adding care management on top of it in many cases, but haven't really gotten further down the line at this point.

And, then, the final theme I'll touch on is that safety net ACOs really face some significant challenges. A big one is lack of capital. You know, this isn't any different than anything else a safety net provider might try to do, they don't have a lot of capital. And, so, if you're trying to do something that requires capital, that

is going to be a challenge. That's particularly true for the smaller hospitals, those big DSH providers, and for the FQHCs.

In terms of access to management information, they have trouble getting data. They don't know how to use the data when they get it. They don't have necessarily the right staff or enough staff. And, then, taking that data and really being able to translate it into some sort of impactable initiative is something that's a big challenge still.

Third is what we call the hospital conundrum. That is where an ACO is also a hospital. In order to succeed as an ACO, you need to reduce your hospital utilization. But, in order to succeed as a hospital, you need to keep up your utilization, and so that can be complicating.

And, then, finally, and this isn't a surprise to any of you, it's hard to serve the Medicaid population. They have really complicated needs, and keeping them engaged in their health care is hard, and helping to kind of improve their health is a really hard thing to do. And, so, that just kind of in and of itself is a built-in

challenge.

So, up next we have three policy questions that we think it would be interesting to discuss. First, to what extent should the federal and state governments be encouraging the development of ACOs among safety net Medicaid providers? What policy changes might be necessary to do so? And, what is the relationship of ACOs to MCOs?

CHAIR ROWLAND: Thank you. You know, one of the points that you made was that they exclude behavioral health, yet we know that for the Medicaid population, many of the high-need, high users are those with behavioral health challenges, and I thought the point of coordinating care and case management was to integrate those services.

[Off microphone comment.]

MS. WALDMAN: Right.

COMMISSIONER ROSENBAUM: I had the same question. They're not excluding the service. They're just excluding it in the payment model. So, they're being paid still on an encounter or procedure or whatever.

MS. WALDMAN: Yeah. That's right. Sorry about that.

COMMISSIONER ROSENBAUM: Because otherwise, it's

impossible.

MS. WALDMAN: I think that's right. I think that either the providers didn't feel ready to accept risk for the behavioral health portion of it, not that they weren't necessarily providing the services or helping people link to them, but they didn't feel ready. Either because they didn't have the data or they didn't have the experience, they weren't ready to do that yet. They were just starting as ACOs. They wanted to see how it went first as a kind of baby step with what they felt most comfortable with.

But, the states really are moving towards it, and, for example, in Massachusetts, where they have the patient-centered primary care initiative, in year three, I think, they're required to have behavioral health in. So, I think it will be in eventually. I think people are just phasing it in now.

MR. TEISL: There is -- if I could add just one other example, I recall visiting one where the model they had begun under didn't include behavioral health costs in the total cost of care that they were at risk for, but this particular provider actually thought it was a real competency of theirs and they were working to get it put

into the cost.

COMMISSIONER GRAY: Similar to the behavioral health question, the social determinants of health question. We're one of the surviving, in Detroit, one of the surviving pioneer ACOs in Medicare, and, I mean, this is a huge issue in an underserved community. So, issues like transportation, housing, social isolation, I presume that this is also sort of all over the place in terms of how they're addressing this, or presumably, they are addressing it. That's why --

And the other sort of corollary to that is what kind of community-based organization or relationships do they have? You know, you have partnerships up there on the slide, but are those active formally contracted partnerships, or they're sort of these are the good guys in the community that know and understand the community. How are they using those partners?

MS. WALDMAN: Well, I'm glad you brought that up, because I skipped over that bullet point. So, yes, social determinants was something that they were all thinking about, I would say to varying degrees, though, and they had varying relationships with community-based organizations.

So, for example, the Southern Prairie Community Care, because they're a county and the county actually runs the human service agencies, they were very connected and that was a key part of what they did.

Likewise, Cambridge Health Alliance in Massachusetts is also -- it's a public hospital and it is run by the public health agency within the city. So, there, they had connections built in because of who they were.

I would say, otherwise, they really varied in terms of whether or not they included community-based organizations in any formal way on their boards or kind of in their advisory groups, but each of them recognized the importance of addressing social determinants of health, reaching out and working within their communities to improve population health and to take things not necessarily just from the perspective of health care, but life in general, helping with housing, helping with improving the schools in the area. So, I think there were a lot of really interesting things, but it definitely was not consistent across the board, how they were addressing it.

COMMISSIONER GRAY: For those ACOs that are either physician or hospital driven in particular, I mean, this is just not a sweet spot for them and, you know, there's really limited experience, even when there's recognition that that is a significant issue.

MS. WALDMAN: Yeah.

COMMISSIONER COHEN: I'm going to have to try really hard to contain myself, because I think this is such a great topic. I'm so glad that we are doing it, and great presentation, and I have about 50,000 questions and comments --

[Laughter.]

COMMISSIONER COHEN: -- and I'm going to try and really hold myself back. So, I will stick with a few big things.

First of all, on the policy questions, I certainly -- I think that Medicaid should be encouraging sort of exploration of this model, because this is the model that the rest of health care is moving in and Medicaid is part of a continuum of health care sort of payers and there is a lot of optimism, but, you know, there's fads in health care, too, so you have to sort of

temper trends and fads. But, there is just a lot of optimism about the potential for accountable care models to have us thinking more about sort of the value that we get out of payment rather than paying service by service, which I think has not served many users of the system well. But, that, I think, is a fair statement, but there are many, many sorts of buts and cautions. So, I do think this is a really important area to explore.

I want to raise two big issues that sort of I think about in this regard, and one is a question and one is really more of a statement.

I think a really big question for us to think about is how much Medicaid sort of policy in this area should align with other payers that are a little bit more advanced in having developed the policies, for example, Medicare, and to what extent it needs to be really customized because the population is different and there are populations that Medicaid serves that Medicaid just does not, and children being a very obvious first one, and payment and many other things are really different for special populations.

So, I think that this question of aligning for

reducing complexity but not ignoring the very special things about Medicaid is going to be a really tough balance for policy makers. So, that's a comment.

My question, but it also sort of is a comment, too, you didn't talk at all about, you know, there's sort of, I think, two halves of accountable care, at least in the Medicare design. One is there's some sort of a shared savings construct or risk -- pushing risk down to the provider construct, but nobody gets any savings unless you meet quality measures.

MS. WALDMAN: Yeah.

COMMISSIONER COHEN: You didn't -- and without a program, it's kind of -- you know, there's probably no standardized quality measures across all these things because they're all operating under different sort of authorities and things like that. But, the question of quality measures is obviously really important, and as I always say, there's a lot of ways to save money in health care and not all of them are good. You know, you can just not provide a lot of care and be an accountable care organization. You can save a ton of money. But, having that sort of -- having the quality measures and having the

right ones for the population that you're serving is just so critically important.

So, that is a comment, but it's also a question. What did you find with regard to what quality measures kind of were? Was there any consistency? Did they make sense for the population? Were they borrowed from other programs, like kind of just --

MS. WALDMAN: So there was quality measurement required everywhere, I should say. Whether or not those quality measures aligned, it really varied. So in some states like Minnesota where they have a quality measurement set, the integrated health plans, health partnerships were required to meet those quality measures to even qualify for any of the shared savings.

I think in some other states, one of the sites told us they have like 720 quality measures. I might be exaggerating a little bit, but it was definitely at least 320. I can't remember if it was 320 or 720. But it was a huge number of different quality measures that they had to report on, and they really saw that as a huge burden, and actually not something that improved care in any sort of way because they were often overlapping quality measures

that were just a little bit different that they had to submit, and they really saw that as very burdensome, particularly when it was in the same state across different managed care plans.

COMMISSIONER ROSENBAUM: So two questions. This is just great. I have been sort of mystified by ACOs since the beginning. I think actually, I mean conceptually, totally understand that this was a way to incentivize providers to organize themselves, so that I certainly get. But this question that you have up here, which is the relationship between a risk-bearing entity, an insurer, and a provider that bears risk, again, conceptually you can imagine one is a subcontractor to the other.

But I guess what I'd like to know is all the states that you were in are big managed care states, so can you be a little bit more specific about exactly what these guys are doing? Are they subs to a prime? What are they doing? That's number one.

And, number two, I think particularly from the Minnesota models, which I've followed pretty closely, this is really the future where FQHC payment reform is going. So it's that, it's Oregon, California, where we're starting

to see some really promising demos around getting health centers off encounter-based payment and onto payment systems that don't -- that minimize this problem of cost shifting onto grants, but do not keep driving volumes of services.

So I wonder if you learned anything from the Minnesota models or from the other places where there are health centers in the mix about how payment reform is unrolling for them.

MS. WALDMAN: Okay. So I think there are two questions and they're -- on the FQHC first, my understanding of the Minnesota model is they're still being paid on an encounter basis, and then they would be eligible for any shared savings on top of that. And I think that's pretty true kind of across the country, as they're doing FQHC things.

COMMISSIONER ROSENBAUM: So they haven't moved yet.

MS. WALDMAN: There's very little -- except for Oregon and California, which is trying to move towards it but hasn't implemented yet, there really isn't a lot of movement.

In Massachusetts, in that same PCPRI program that these hospitals participated in, the FQHCs also participate and, again, they are still paid on an encounter basis, and then anything is on top of it.

And your second question was about the MCOs. So that really depended. In Massachusetts, the two providers that we looked at had different relationships with different MCOs, so the PCPRI is part of the primary care case management program, but they also had different kinds of risk. One had a subcapitated arrangement. The other had a shared savings arrangement.

In Minnesota, for those of you who don't know, the ACOs really -- the MCOs are required to take on the responsibility of passing through savings to the ACOs. So the state made the requirements requiring the MCOs to play ball, and then the ACOs are being paid any shared savings.

COMMISSIONER ROSENBAUM: So I would just note the other thing is that on the agenda item that we're probably not going to get to because the rule is not out yet, I would assume that the managed care rule, in fact, is going to have something significant to say about accountable care organizations since they are risk-bearing entities. And so

I think probably we'll want to have follow-up discussions to relate the proposed rule and whatever we have to say on the proposed rule back to your work. So thank you.

MS. WALDMAN: And then I would say for Nationwide it's a pure subcapitation, so -- I'm not sure about --

COMMISSIONER SZILAGYI: Actually, my major question had to do with quality, and Andy already asked that. But I had several other questions.

I'm surprised that these ACOs didn't bring up the issue of the size of the population and the concern that-- or maybe you just didn't -- and what did they say about that? That was my first specific question.

MS. WALDMAN: So they did, and I tried to get through it through the partnerships piece. A lot of them partnered, like the FQHCs in Minnesota is a good example. Alone, most of those FQHCs could never participate, as ACOs, because they just don't have a big enough panel size.

The other thing that we heard actually also in relation to managed care and implementing through managed care is -- you might have enough Medicaid beneficiaries across all of the different plans in a particular state, but not in a single plan. And so they were really

interested in aligning the programs or policies that each of the different managed care organizations had so that the panels would be big enough so that they could participate in an active way. And for a lot of them, it really is difficult to get to that magic number in whatever states. In Massachusetts, it might be 5,000, and some just missed the cut off by really small numbers. But if you looked at kind of the rest of their population, they'd be well over that 5,000.

COMMISSIONER SZILAGYI: It would be helpful in that table to indicate the population size.

MS. WALDMAN: Yeah.

COMMISSIONER SZILAGYI: Because in the commercial world, people talk about far larger numbers, you know, like a million.

MS. WALDMAN: Yes, absolutely.

COMMISSIONER SZILAGYI: Like a million.

COMMISSIONER GABOW: I have four comments.

One is I think it would be good to just know how many Medicaid ACOs there are or some estimate. I mean, you've looked at these seven, but is that all there are? Or are there 700? So just some order of magnitude.

MS. WALDMAN: I think that depends on how you define it. NASHP actually has a site of accountable care initiatives that is much bigger than what we considered an ACO, because they're more accountable care model. So I think it's really hard to get to the number. There might be a handful more that would have fit into our study, but I'd say there are about 10 to 15 that fit into this definition.

COMMISSIONER GABOW: I think something about magnitude, given the magnitude of the ACOs in Medicare.

The second is I think it would be very good to list -- to sort of takeoff from Andy, how do these Medicaid ACOs differ from Medicare and commercial ACOs? What are the chief differences in characteristics? Is it governance? Is it shared savings? Is it size of the population? I mean, and then a second part of it is how should they differ, or should they differ at all? So I think thinking about that, because we always want to come back to how does Medicaid fit into the context of the whole health care system.

The third really gets at what Sara brought up. I really don't understand why you need ACOs if you have MCOs

and you're a safety net provider. What you were saying is that the MCOs are contracting with the ACOs, so we've just added a new layer to the mix, and another point to take funds off the table, it seems like.

So, I mean, thinking about how do these differ really, if you have a well-run MCO for the Medicaid population that's run by a safety net system, like Denver Health, for example, why would you want an ACO? I mean, I don't get the picture very well. So I think peeling that onion a little bit more, I agree with Sara, would be good.

My last comment is when you look at the hospital systems that you looked at, like Cambridge and Signature and Montefiore, they have a robust -- at least I think they do, a robust array of both primary care and specialty care as well as a hospital, so you could understand how they can do coordinated care across the continuum. But when you have FQs creating an ACO, they historically don't have specialty care or hospitals. So I think some discussion about how does that work to create coordinated care if two big cost components of the delivery model are not there.

And so I think, again, peeling that onion would be worthwhile, because I don't really see how FQs could do

this. And maybe they do it because they're only getting upside risk. I mean, if they had downside risk and they didn't have hospitals and specialty care -- but I don't see even how you can meet quality measures, robust quality measures, without the rest of the continuum of care.

So I think talking about that a little bit, maybe I just don't understand it, but --

MS. WALDMAN: No, I think it --

COMMISSIONER GABOW: -- it seems unusual.

MS. WALDMAN: Yeah.

VICE CHAIR GOLD: Yeah, I think we need to think a little bit more, picking up on some of what other people said about -- I can't answer these policy questions because I don't know that we've framed the debate right, and I think I'm a little concerned it's too narrow. But I appreciate -- I like the fact that you looked at ACOs that were not health plans, because as far as I'm concerned, if a provider-sponsored organization is acting like a health plan, it should be regulated like a health plan, and one may or may not favor them.

There is -- I've followed this awhile, and I think that somehow or other two things have to be behind

any policy. One is the desire to move to value and how we shift reimbursement from providers to encourage them to be value-based, or whatever that is. And the second thing is the different markets and that they're all different, and what the right answer may be for some places or even some providers in some places versus others is going to differ. So I'd hate to be prescriptive and say we should all do this.

The part that I think gets messed up -- and I've been very critical, I think, of some of the ACO policy in Medicare in the sense that it doesn't come out of what -- the reason it came about, I think, is that people thought there was a managed care backlash; they didn't change provider behavior. So they were trying to get more providers to have skin in the game, but they didn't pay attention to the contracting with health plans. They worked in Medicare. Back then most of them were fee-for-service. So the attempt was how do you get providers there. But I think it missed a critical linkage that sometimes you were a contractor with a health plan, and in those markets, the providers either were or weren't doing ACO things or were or weren't doing it well. But I think

the way you've set that up helps it here.

Where Medicaid, I think, is different is that Medicaid has had much more capitation, at least for the general population. So these intermediate entities or whether a provider system like Denver Health wants to be the health plan becomes much more important.

The other thing I don't see discussed that I think is related to this is the whole PCMH movement in Medicaid and, you know, there has been a lot of debate as to whether the ACO goes this way and the PCMH goes that way, and somehow or other they need to somehow be fit together, and a lot of states have relied on them. So somehow the -- and there's a lot of innovation grants which are all sorts of alphabet soup. And I think what's important as we do this is not to create more silos but to think about the different strategies that seem appropriate and what protections are needed and sort of to recognize that which way you go may vary across the country and across providers, depending upon where they're starting out.

MS. WALDMAN: Yeah, and I'll just say to the PCMH point that the states where there had been a lot of PCMH

activity are where you see the providers really leveraging that as part of their care management, and that's where the care management is the key strategy. So I would say that for a lot of them they couldn't have become ACOs if they had not first been patient-centered medical homes.

CHAIR ROWLAND: Okay. I have Trish next, Chuck, Donna, Mark, Norma, and Steve.

COMMISSIONER RILEY: Good thing this isn't an interesting topic.

I guess I was sort of where Marsha is, and it strikes me -- I can sort of understand a movement about ACOs around safety nets because that's more the Medicaid model. But as you think of the first policy question, it seems to me the real question is: Shouldn't it be a multipayer initiative? And if so, an ACO is accountable to whom if there are multiple payers? And where's the regulatory structure and the nexus for accountability? And it seems to me that's a big policy question we need to take on as these things take on steam.

Secondly, I had a more focused question, I guess, Beth. As you think about accountable care organizations and their efforts to be more population health, to Herman's

points about social determinants, it's a lovely concept, and you talked about the Prairie one being very connected because it's a social -- the county function.

MS. WALDMAN: Yeah.

COMMISSIONER RILEY: But it feels like the beginning days of sort of trying to do home care for the elderly. Everybody's a case manager, and everybody's referring to everybody, and everybody hopes that good things happen.

In the Prairie model, have they done anything in the capitation model itself to pay for any of those services, or is still just a referral mechanism?

MS. WALDMAN: It is a referral mechanism right now, although there is some potential if they receive shared savings to invest those savings in those social services. I think that's part of what they're thinking. But they're not that far enough along that they would have received any savings yet.

COMMISSIONER RILEY: And where are they on sort of holding the -- it's the old MCO question. You know, the early days of managed care, you couldn't keep the population. They kept moving. How do these various models

address -- how can you be held accountable for a population you don't hold?

MS. WALDMAN: Right. That's right, and I think the attribution models are really complicated across all of them. Nationwide is the easiest example, so they get all of the children in the 34-county area regardless of whether or not they ever set foot in Nationwide. So they take responsibility for all of it and get a subcapitation. So in that case, there are people there that they never see, and they're betting on the fact that they can impact the others and make it work for them.

I think for the FQHCs -- and Southern Prairie is similar in that it gets the whole region, people who are attributed to particular providers within that region. And so there's less kind of ability for leakage within the area, but there are issues around moving kind of from the rural area that they cover to the urban area to get their specialty care and how that impacts their total cost of care. So that is an issue there.

So, I mean, I think that's still something that they're trying to figure out. I think in a system like Montefiore where they have everything, it's easier. But,

you know, clearly in these FQHC models, it's not quite so easy.

COMMISSIONER MILLIGAN: I have a few comments and then a couple questions.

First, I guess I want to begin with the -- is it on? Okay. I'll just project. I think to me that question isn't framed quite the way I would. I think policy should drive payment reform that places more emphasis on value rather than volume and on outcomes. And I think that ACOs are a tool, but the ACOs I wouldn't emphasize that as a policy question. I would emphasize the broader goal as the policy question.

The second comment I want to make is about the all-payer issue. I think that -- I'm of two minds about it. I think all-payer reform is really necessary if no individual payer has sufficient percent of a panel to influence real delivery system reform and changes. So to the extent that you're dealing with a private practice, for example, that's 20 percent Medicaid and 40 percent Medicare and, you know, commercial, I think you need to think more all-payer, but maybe some of the safety net providers that we're talking about here less so.

I do think that it is a tricky issue, as Andy said, partly because the populations in Medicare are more static over time, and the benefits are more static over time, and Medicaid isn't like that, so it's hard to make sure you marry the right payment model and incentives. So I just want to leave that comment out there.

I have a comment in response to Patty's question about how do you deal with ACOs and MCOs together. I think actually to me there is a clean path, and I'm seeing it in New Mexico with a few of the MCOs working with a few of the very large FQHCs, which is the MCOs are paid capitation. There's a very comprehensive benefit package. A lot of people get care through the FQHCs in rural parts of the state, and they don't want to change, to Sara's point, really, the fundamental BIPA and PPS and all of that model. They want to get paid for encounters. But if they can help keep people out of the hospital, reduce ED rates, or reduce inpatient, they want a piece of the action, and the health plans typically want them to have an incentive to do that, too. And so it raises the hospital conundrum. But if the hospital isn't a partner with the FQHCs, there's an upside for the MCO, there's an upside for the ACO as part of a

network strategy to engage broader than in some ways a PCMH model. So there are ways of, I think, pulling that off.

I want to close with a couple of questions. In Medicare ACOs, one of the challenges is trying to compare shared -- whether shared savings happen because it's an attribution model where your group last year and your group this year might not be the same group in terms of risk and acuity. And so if there are savings over time, is that a function of the population mix changing over time? Or is that a function of effective interventions?

And to make that example in New Mexico with some of the Medicaid conversations, we've seen with some of the FQHCs we're talking to that their ED rates per thousand are going up, but it's largely attributable to the expansion population coming into the plans.

So I have two questions. The first is: In these shared savings models, how do they control for risk? Do they risk-adjust? How do they measure shared savings when the underlying population itself might be changing over time in terms of acuity and risk?

MS. WALDMAN: So I think they use pretty blunt instruments at this point. So, for example, in Minnesota

you have to show that the integrated health partnership cannot obtain any shared savings unless that shared savings is more than 2 percent. And so that's kind of to try to get at some stability, so that if it's below 2 percent then it could just be a change in the population or an anomaly and not really something for care.

So that's one thing.

I would say that for some of them, most of them did not actually share in the risk. They only shared in the savings, at this point. There were a couple that shared in the risk, and so some that had subcapitations just capped whatever they didn't spend and that's where they got their savings from, or if there was risk. So there wasn't really another way to account for it.

So I think that still needs to be developed.

COMMISSIONER MILLIGAN: Yes, and I think it begs the question because -- are there savings? Because if you're comparing ED visits this year versus last year, is that a function of an effective intervention or is it a function of the population being different this year than last year? Which is one of the criticisms of the Medicare ACOs.

The other -- and it's a risk-related question and it's my last question -- one of the things that is a different criticism of Medicare is that you can generate shared savings by bringing into the ACO providers who have healthier panels. And how the network management happens inside of an ACO can deliberately change your mix, your population mix, and you can produce savings based on panel management at an ACO and attribution based on who their panel consists of.

And so I'm wondering whether the states that you looked at try to gauge network management contract strategies inside of the ACO as a component of evaluating the effectiveness of the ACO?

MS. WALDMAN: You know, that's a really good question. I don't think we saw any states actually look at that in terms of evaluation and it's not something that specifically came up in any of our site visits. I don't think that means that they don't do it but it's not something that was raised.

COMMISSIONER CHECKETT: Following up on, I think going back to the issue that Marsha raised, you know, I love the idea of value-based purchasing and I'm all for

getting rid of fee-for-service that ties to nothing in particular except billed services and what someone cares to pay for it.

But I do have a concern -- first of all, I would say assuming we go further with this discussion and this research, I think we have to really set any discussion about ACOs within the bigger context. And it's an important discussion that's going on about payment reform.

But I continue to really have concerns about ACOs and possibly some degree about health homes. As much as I like the concepts, in managed Medicaid I think there has been such a struggle, and there has been so much progress in recent years, to moving away from carve-out to having a single entity managing all of the dollars for all of the services for a population.

As I like to say, we can't separate the heart from the head. It's hard to have one person managing behavioral health and someone else managing physical health.

So my concern with these models are where I see these little fragmentations and spinoffs going. And I think we have to not take our eye off the potential

negative implications of that.

And particularly, even with ACOs that are hospital-based, they can really manage the services their hospital is providing and really can't manage the services that people are getting from other providers, or frankly, even from other hospitals.

MS. WALDMAN: Exactly.

COMMISSIONER CHECKETT: And that is a real challenge, and it's something that we've struggled with in full risk managed Medicaid for so long, I think we just have to be very eyes open about what we could be potentially duplicating here.

The other point I think we also have to be very aware of, and it's one that Sara raised, is when someone is going to take, an entity is going to take full financial risk, there are departments of insurance in every one of the 50 states that are licensing these individuals for good reasons. There have been situations when managed care companies, insurance companies, have just disappeared. Providers are left with claims. People are being billed for services. There's a reason for it.

And I am very concerned that there may be a

trend, and I see it frankly more with the PSN language that's being bandied around a lot, ACOs a little less, that there's some implication that these systems can take full financial risk. And I think we have to be very cognizant about the reasons we have licensing standards and requirements by departments of insurance. It is to protect -- in the end, it is actually to protect the consumer and protect the provider.

And I just think we can't lose sight of that very important issue.

Thank you.

COMMISSIONER MARTINEZ ROGERS: You can take my name off. She addressed the issues that I was going to.

COMMISSIONER HOYT: This is weird, but the longer I sit next to Patty, the more questions I have.

[Laughter.]

COMMISSIONER GABOW: It's catching.

COMMISSIONER HOYT: So I had one question about provider participation, whether you could comment on whether use of ACOs improves provider participation or it falls? Is it new docs or the existing docs who are willing to see more Medicaid patients?

We are kind of OCD about data, for the most part. Has the use of ACOs improved data reporting? Or does it go the other way? If you have anything to say about that.

Also, administrative costs. Do we know what it costs to administer an ACO? Really maybe it varies depending on the type? Or if they are embedded in an MCO what is the impact on the MCO's administrative costs?

And then it may be preliminary at this point, but I would think at some point people would be interested in what the cost trends over time for ACOs either by themselves if we can establish the appropriate benchmark against them might be a challenge, or again the MCOs cost trends where they are using an ACO versus not.

MS. WALDMAN: Okay, so I will try to take each of your questions.

The first, on the provider access, some of the sites we visited specifically focused on getting more providers into the Medicaid program. And that was a key strategy that they had, but that is not true of all of them. Some of them remained kind of within the providers that were in the group and didn't try to bring others into the program. So I would say that varies on whether or not

it improves access to providers.

In terms of data, I think that also depends. I would say that for all of the ACOs we visited data was a struggle and some had come further than others. But some had a hard time getting data from the states in order to analyze the population. Some had trouble getting data from the different health plans. And then even when they got the data, it wasn't necessarily good data. Or if it was good data, they didn't necessarily know how to use it.

So I would say that data is a big struggle.

MR. TEISL: Yes, just one thing I wanted to add on that. I mean, I'm not sure that we saw that the fact that there were ACOs had any real effect on data that we could access regarding the program necessarily. But this issue of the sort of critical importance of access to data by the ACOs to manage their populations and all of the struggles that they were having getting it seemed to be pushing the conversation at the state level.

And so it may be sort of a downstream benefit, if you will, of the existence of the ACOs that there seem to be more attention being given to getting the different sources of information in their hands.

MS. WALDMAN: Right. To your last two questions about administrative costs, I don't -- I think it really depended on the model, whether or not there were increased administrative costs anywhere in the system, whether it be the state, a managed care plan or the provider organization itself.

In some cases, there certainly was additional administrative costs and a fair amount of staff dedicated just to the ACO, a lot focused on the data and trying to get the data.

In terms of the cost trends, I would say it is, for most of them, too early, too early to know anything.

MR. TEISL: Yes, a couple of the bigger cost items that I recall people mentioning is like predictive analytic software to try to identify the target population. And then the other were analytic resources to actually to make sense of the data that they were able to get.

CHAIR ROWLAND: Steve, Sara, and then we're done.

COMMISSIONER WALDREN: Two quick comments.

One, I think as we think about the term ACO, it means many different things, like automobile. It's like when you say automobile, it could be an Escalade, it could

be a Prius, it could be a Porsche 911. So I would want us to try to take a look at what are the different characteristics. Of course, having 10 makes it really challenging to do any type of analytics for that, so I understand that.

And that's the same thing, I think, with like the PCMH. We have run into that problem. In EHR we have run into that same problem. The literature shows that both of those are highly successful and other literature shows that they are highly unsuccessful at being positive.

The other piece I would say is the commentary around ACO versus PCMH. They're not even apples and oranges. It's like apples and farm subsidies. The ACO is a governance and payment model and PCMH is the delivery reform model. So it's really about how do you take care of patients and how do you change that?

One of my concerns about when you talk about the ACOs, that are listed here in the report, they really didn't change fundamentally the delivery model underlying the ACO payment model. So I wonder how much success it really will have.

MS. WALDMAN: The way I would look at the ACOs is

maybe a little different, that the idea of the ACO is to eventually get to both changing the payment model and the delivery system model. I think, though, that for the most part the sites we visited were on the younger side and hadn't quite got to the full care delivery.

Or, if they were on the older side, they had been able to be successful without really changing their care delivery but were starting to.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: I want to take one last run at what a number of us have all flagged now, which is we are looking for a way to think about all of this stuff.

So I think it's worth nothing that, although Congress was quite extensive in the statute on Medicare ACOs, it was absolutely silent -- Medicaid ACOs, except for the pediatric demonstration, do not exist. So whereas Congress recognized the need, if you were going to allow a new kind of organizational and financial structure to develop for Medicare purposes, it very deliberately did not establish any framework for the Medicaid ACO world.

And in fact, CMS -- it sort of fell to CMS to invent these things, which is why I'm assuming that we're

going to see the results of its thinking in the rule.

I don't -- I'm agnostic on the issue of whether Congress does all of its thinking in the statute or whether an agency does it, but I think that it is the case that the model came into being for both reasons. I mean, certainly for financing and also for service delivery. But I think really, at its heart, it came into being in order to have a regulated entity structure that would justify waiving normal antitrust and fraud rules.

And so I think we have to come to grips with the fact that a lot of the purpose of this was to allow entities to assume some market power and to engage in otherwise prohibited practices under the fraud and abuse statutes. And that rationale either does or does not carry over into Medicaid. I mean, I think it does, but as the entities assume more and more market power across multiple payers there are issues.

I also think that, although this has been done in various ways before, it would really behoove the Commission, in writing about this, to construct a taxonomy that basically recognizes a series of different related entities in the Medicaid statute, one being something that

we call a managed care entity, one being an agency-created ACO entity, one being a patient-centered medical home, and then the other being sort of classic providers. And begin to think about what role the regulatory framework plays for each.

I absolutely agree that operationally they might fit -- especially ACOs and patient-centered medical homes, whether they are primary or for specialized populations. But I also think, in echoing Donna's point, that we are beginning to skirt dangerously close, at this point, to enabling entities that are not set up to accept substantial financial risk to begin to undertake way too much financial risk when they do not know enough about managing financial risk and we haven't thought enough about how much risk we want to downstream.

We had the same discussion about managed care 20 years ago. And finally, in '97, the statute caught up with where the world was going. And of course, it gets a little dated, but still it caught up.

I think we're at another incredible evolutionary stage. The managed care rules that are going to come are not even a normal set of important rules. They are a super

rule. And I think that -- going back to the point that Marsha made and everybody has made by now -- we have got to spend some time backing up to come up with a way for Congress to think about what it's allowing here and what the purpose of each model is, what relates to what, and how much risk downstreaming we want. And how much market -- you know, how much you want to allow entities to depart from market rules, quite frankly.

And then advise Congress as to whether or not you need actually some statutory regulatory framework or, in fact, things are developing fine at the agency level and at the state level, let it go on a little bit longer before you try to intervene.

But I think otherwise, I completely agree with Donna that we are going to be looking in five years at collapsed providers, at a lot of confusion about how to deliver care to this population, how to pay. We won't have made the progress we want to on payment. And we will have little to show for what might have been a promising way to do a tradeoff between total market freedom and some market organization that merits fraud and restraint of trade exemptions.

CHAIR ROWLAND: So we started with safety net ACO development and now we've gone to total payment and delivery system reform. But I think that this has been a good starting point to think through what the real issues are in the transformation of our health care system for the low-income Medicaid population and in general.

And I think, from the discussion we had today, to me it gives the Commission a way of organizing a set of questions that we should be asking not just of this model but of all of the other models and that is then a framework for really reviewing and analyzing the models going forward.

So I thank you for starting what I think is a very important discussion and for laying out, among all of the Commissioner's comments, perhaps a set of criteria for looking at and thinking about all of these transformations that we can use and apply to our future discussions, as well as obviously being able to put out a snapshot of what this particular set of ACOs looks like.

But I think it really is saying this is where we're going to be examining the relationships and, as Sara points out, leaning toward recommending where there's

issues that are in the regulatory model that need to be changed.

And it also gives us a better context for how to look at the new managed care reg when it actually does come out.

So thank you very much.

And with that, we're going to close this session, but we did allow for some time -- even though some of our commissioners used some of it up -- for comments from the audience if anyone wants to make a comment.

We will have another comment session later this afternoon, but the mic is open right now for anybody.

Public Comment

* MS. LIPSON: Thank you. My name is Debra Lipson. I am with Mathematica Policy Research.

I wanted to pick up on a couple of things on this last one [inaudible.]

It seems to me that ACOs, we were moving toward -- [inaudible]. We were moving towards paying for outcomes, paying for value. And so I was surprised, I guess, to hear that, you know, an ACO is paid for their encounters, an encounter basis, and then, in addition, some of the shared

savings.

So it brings me back to the question of data. Are we putting this unbelievable burden, and administrative expense perhaps, on the ACOs for reporting? Now they have to report on as many as 300 quality measures related to outcomes, as well as all of the encounter data. And therefore, for some entities, it could really become a barrier to entry. They can't possibly do all of this.

I'm sort of amazed that 10 FQHCs got together, they must have a good data infrastructure to be able to do all of that.

And at the same time, the data flows. As a researcher, of course, I'm very concerned -- as I'm sure all of you are -- about what happens, not just with the data coming from the state to the MCO, to the ACO, to enable them to do care management. But then what happens up the chain? Because, as somebody who is very concerned about the managed care capitation rate-setting, which you're going to get into tomorrow, states still need that data -- the encounter data -- to do good rate setting.

So, you know, I mean, these issues are all interrelated. I'm very concerned about what are we paying

for? What are we willing to give up? What do we still need, in the essential data, both coming down as well as going back up to the state level and to the feds, and to us researchers.

CHAIR ROWLAND: Thank you.

MS. LOVEJOY: Hi, I'm Shannon Lovejoy with the Children's Hospital Association. Thank you for the opportunity to provide comments.

As MACPAC continues its work on the role of the DSH program and particularly looking at uncompensated costs in DSH, we ask that you continue to look at not only the costs associated with the higher rate of uninsured, but those costs associated with Medicaid underpayment.

The Medicaid DSH program is very important to children's hospitals because they treat large numbers of Medicaid children. We've done a pretty good job as a nation taking care of the uninsurance rate among children. And so a lot of the expansion coverage options under the ACA are really targeted at adults and really do not impact the children as much.

And given that Medicaid is the largest payer of children's coverage, we are anticipating that Medicaid

reimbursement rates will continue to be an issue under the program. And this is why it is really important that MACPAC continue to look at those uncompensated costs that are associated with Medicaid underpayment as it continues its work on DSH.

Thank you.

CHAIR ROWLAND: Thank you very much, and we will now adjourn and reconvene at one o'clock, to continue our discussion then of Financial Alignment Initiative Demonstration, known as the Duals Demos.

Thank you.

[Whereupon, at 12:13 p.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION

[1:02 p.m.]

CHAIR ROWLAND: If we could please reconvene. I want to welcome Tim Engelhardt, the Acting Director of the

Medicare-Medicaid Coordination Office in the Centers for Medicare & Medicaid Services. You will all recall that we've been trying to monitor the rollout and the implementation of the financial alignment demonstrations for the Medicare and Medicaid dual eligibles, and Tim is going to give us an update on those projects, and there's a little summary of which ones are underway in your briefing book. But this is really just to let us know how it's going and, also we're very interested in knowing what the plans are for the evaluation of these demos. So welcome.

Session 3: Update on the Financial Alignment Initiative Demonstration

* MR. ENGELHARDT: Thank you, Diane. Thank you all for having me. I'll try to be really brief in the hopes that we'll have time for questions.

I want to thank the Commission for your work leading up to the March chapter on cost sharing for dual-eligible beneficiaries and impacts on access to care because it is an important issue and one that few people fully understand and messy and arcane in all those other ways. So thank you, guys, for that very much.

I also want to thank the great MACPAC staff,

especially for their work on the dual-eligible beneficiaries data book that they do in conjunction with MedPAC. It seems like a distant memory now, but just even a few years ago, we had no good data on duals that included both kind of Medicare and Medicaid analysis. And so that's exciting to me, and thank you.

And because of that great staff, because of all your backgrounds, you know a lot of things about dual-eligible beneficiaries already, but indulge me for like two seconds to remind you that there are about 10.7 million beneficiaries who are on Medicare and Medicaid. Of that number, like 3 million are what we call partial duals in the sense that they don't have access to Medicaid benefits as we know them, but just have access to support for Medicare cost sharing. That means there's somewhere between 7 and 8 million people who have actual to the full suite of Medicare and Medicaid services.

And a reminder, too. It's not a homogeneous group. We define them in different categories, but it is older adults, it is young people with physical disabilities, it is people with serious mental illness, individuals with developmental disabilities, ESRD, and on

and on and on.

Also, you know that it's a population that is difficult to serve in so many ways. They are more likely than non-dually eligible beneficiaries to experience avoidable hospitalizations, hospital readmissions, placement in long-term care facilities. Forty percent of them have mental health conditions; 72 percent, cardiac conditions; 35 percent, diabetes, hepatitis C, substance -- and on and on and on. So it's a difficult population to serve and a reminder that it's a complex group.

Collectively, the states and the federal government spend annually something close to $300 billion a year to serve those 10.7 million dual-eligible beneficiaries. And, finally, as you also know, they account for a disproportionate share of Medicaid spending and of Medicare spending. On the Medicaid side, our last numbers were 14 percent of total Medicaid enrollment accounting for about 35 percent of total Medicaid spending nationally. Of course, as everything, it varies by state.

Despite all of these things, dual-eligible beneficiaries in this country are in a health care delivery and financing system that fragments accountability across

two different payers and is characterized predominantly by uncoordinated fee-for-service. And Slide 2 of our very brief slide deck here summarizes that current state a little bit and helps to visualize a little bit about what we hope a future state would look like.

We have been testing new financing and delivery system models through a vehicle that we have called the Financial Alignment Initiative, and that is what this group has been briefed on in the past and what I'll dedicate the rest of this time to today.

We rolled out the new initiative in 2011 with two models to it. The first is a capitated model in which a health plan or similar organization would receive capitation payments between both the state and federal governments to reflect the totality of Medicare and Medicaid services. We would execute not separate contracts but a three-way contract between all parties involved, and that plan would be responsible for the full suite of Medicare Parts A and B, Part D, and Medicaid services.

The second model we called the managed fee-for-service model. To oversimplify, it is something like an ACO model except the state is the entity that is eligible

for shared Medicare savings. In other words, the state makes an investment in a thing -- for example, in Washington State, it's a new Medicaid health home benefit -- and if that investment in that thing meets certain criteria and improves outcomes and reduces Medicare costs, then we would share in those Medicare savings with the state directly.

The next slide talks a little bit about what was behind the initiative, characterized first and foremost by a desire to move the system to someplace slightly more person-centered than where it exists today, developing something more easily navigable. A reminder that this population has multiple sets of ID cards in their pockets, multiple sets of materials to read, multiple 1-800 numbers to call, none of them terribly well coordinated typically. The hope is that we would increase access to those services in the community -- primary care, and substance abuse treatment, home and community-based, and long-term-care services with a net effect of reducing reliance on expensive institutional care.

The next two slides show in different formats where the financial alignment demonstration models are in

play today. There are 12 state on this map, nine of them with a capitated financial alignment model, two of them with that managed fee-for-service model, and one that is different. And that different one is Minnesota, and I'm happy to elaborate, but I will not at the moment.

Slide 6 says that same information in text form with the bottom bullet also highlighting that we continue to work with Rhode Island and Connecticut on potential capitated and fee-for-service models, respectively.

The Financial Alignment Initiative and the models within it are subject to testing. They are Innovation Center models, and like all Innovation Center models we have an external evaluator. The CMS Innovation Center oversees the work of that evaluator, and it's RTI International. With great interest when this first began, we decided to make this as transparent as we thought we could. We have published on our website literally thousands of pages now of evaluation design reports for each of those separate demonstrations.

We are evaluating each one of them on a stand-alone basis, so the demonstration we have in Massachusetts will have its own set of analysis and its own report. RTI

will do kind of a meta-analysis afterwards, but we're individually evaluating each one of those, and they're each on a slightly different time schedule.

We'll have annual and final evaluation reports that likewise we have committed to publish on our website. And RTI, consistent with, I think, the complexity of that, which they are trying to evaluate, is using a mixed-methods approach, lots of qualitative work, including focus groups, site visits, and key informant interviews, as well as all the different types of quantitative analysis related to cost, quality, and utilization.

RTI will also separately analyze different subpopulations, for example, people with serious mental illness or younger people with physical disabilities or whatever the case may be in a given state to try to get a better sense of how this is working for some of those different groups.

We are excited by the fact that we will have this extremely rigorous and lengthy evaluation. It is certainly -- I think it's fair to say it is quite different from what we would have in a Medicaid 1115(a) demonstration context. It is also already confronting us with many timing

challenges and technical challenges which we think we will be able to overcome.

The first reports we will have will be for Massachusetts, Washington, and Minnesota, the first three states to go live. The first major deliverables will be ready by early 2016. I will digress a second to say that was probably not well planned because that's going to come after the Commonwealth of Massachusetts, for example, has submitted a budget that will overlap the scheduled end date of that demonstration. It will come a little bit after many of the Medicare Advantage plans will have to submit bids for that market for the next coming calendar year. And so we have to spend a little time trying to better align our evaluation results with some of the decisionmaking time frames we have, because we are currently at risk of underinvesting in our own product because -- while we wait for the evaluation findings. And it's on our mind and something that we'll work on over the course of the next several months.

While we anxiously await RTI's findings and anxiously await the focus group summaries that will come immediately after my part of the agenda, we have learned a

lot already, and I want to talk about some of those things.

First, there's some positive stuff. We have had a dramatic increase in the number of dually eligible beneficiaries who are in what we would think of as fully integrated products. There's lots of different ways to define that, but if you think about really financially integrated or total cost of care models, we probably had something like 20,000 people in a model that would fit that description in 2010. We have 400,000 now. So that growth is impressive. It is still only a relatively small fraction of the overall population, but something that we're pleased with.

The health plans associated with the capitated models are all required to perform health risk assessments on beneficiaries early in the enrollment process. The health plans have completed over 150,000 of those to date. That number grows by the day.

The plans, in the case of the fee-for-service models, the states have made really incredible investments in care coordination infrastructure, to pick one example. The plans that were live in 2014, just in five different states, had hired over 2,500 care coordinators as part of

that work. So the magnitude of the new investment is exciting for us. These are really preliminary milestones on the path to where we actually want to be -- better outcomes, better independence in the community, and hopefully at the same or reduced cost. But they're positive signals really on the process.

Recall, though, that these are demonstrations. Some of them will probably fail at some level, and I don't want to gloss over that potential fact. Somewhere a health plan will decide to leave the market. Somewhere a state will decide not to proceed, as we already have had in a couple of instances. And so we'll learn and we'll adapt as we go.

Some of that early learning, communications with beneficiaries, first of all, important to reflect on the status quo in which beneficiaries probably don't get a lot of stuff that they understand today. A beneficiary who's in a Medicare Advantage plan and is also in a Medicaid product is getting multiple things is probably not great. We have done a lot in the context of these demonstrations to try to improve that. It is still really hard. We managed to take two member handbooks and combine them into

one, and we were exceedingly proud of ourselves, except it's still 100 pages long, and the appeals chapter alone is like 40. So we're proud of consolidating and streamlining a lot of things. In some cases, we even have -- we're so proud that we have in New York State a completely and totally integrated appeals process such that it doesn't matter if your service was a Medicare service or a Medicaid service or whatever. There's the same appeals -- it's great. It's still complicated for beneficiaries to understand, and the balance between making sure we convey all of their rights with keeping stuff simple and understandable is one that we're still struggling to find.

Similarly, the enrollment process in some of these capitated models has been challenging, confusing in some cases. The earliest example is that we have used passive enrollment into different health plans. When we do that, it triggers this completely automated process by which everyone is a Medicare beneficiary, they are in a prescription drug plan, triggered a completely automated process in which they would get a notice from their PDP that they were being disenrolled. Well, that notice didn't say anything about the fact that they were going to

continue to have all of their Part D benefits covered in another -- we missed -- like, we made mistakes like that, and thankfully we fixed that. The PDP enrollment notice people get actually explains a little bit now -- and probably not enough, but something. So the beneficiary communications aspects of helping to move people into an integrated environment has been an unbelievable challenge, and one in which we've made a lot of progress but have a lot further to go.

The enrollment process itself, again, characterized primarily by passive enrollment, has been a work in progress. I think the fact that we have had passive enrollment into health plans is the reason why we have those 2,500 care coordinators who were hired last year, and the reason why we have 65 health plans, the reason why we have a market where, frankly, we don't think we really had a market previously.

That said, many, many transactional and technical challenges to make sure that we effectuate the process right, and if you had a set of health plans or state officials come up here, they would probably tell you that they cannot count all the hours they have spent fixing

enrollment transaction problems. Thankfully, there have been only very few cases in which those have had any access-to-care implications, but it's been a messy process administratively and one that we'll have to continue to improve.

Second, provider outreach and engagement has been an ongoing priority and challenge for us. There are many instances in which providers have embraced new opportunities to change the way they serve a really challenging population in the context of these models. There have been some instances where they have resisted participation in some of these models, and in some cases that's directly linked to whether or not beneficiaries choose to participate. In fact, we often hear that providers are the driving force of whether someone enrolls or disenrolls from a particular thing, and that's something that we've had to pay a lot of attention to.

Similarly, we have designed these models as in some ways aspirational visions for team-oriented interdisciplinary care, and it's easy for us to write a contract that says everybody has to have a team that meets and discusses all these things. And in operational

reality, sometimes the physician isn't around or sometimes convening a team is a barrier to approving a service that somebody needs. And so we've had to adapt to some of the operational realities while trying to uphold kind of what I think is a great vision for team-based care.

Third, we've had ongoing challenges and many successes in what I would call earning beneficiary engagement. One of the primary challenges is that we enroll people into new products, and we have a hard time finding them. The health plans will tell you it's a population that is sometimes transient, is sometimes homeless, and oftentimes conserves their pre-paid cell phone minutes. So if they get a phone call from a number they don't recognize at a particular point in the month, they're just not going to answer it. It is a population, like many of us, that has been trained over the years not to answer the phone and talk to strangers about your health information. And so we're going through a phase of building trust with beneficiaries who are in a complex environment. We actually -- the process of simplifying things and saying this is the place where you get all of your long-term care and behavioral health and all of your

Medicare and all of your Medicaid, there's a lot of complexity behind that, and we're working through that process right now.

That being said, some of our very earliest and most inspiring kind of success stories are a direct result of that outreach effort. It's the process of engaging someone and trying to get them to open up the door to their home, realizing they have massive unmet, and often social needs and health care needs with them.

And that brings me to my last point, which is the early work is just early work. We're excited about the promise to really have -- I hope that two years from now we come back to this Commission and tell you about reductions in hospitalization rates, more people receiving care in the community instead of nursing facilities. But right now our primary observation is that there's massive and systemic unmet need among the population that is often about behavioral health services, and it's the primary thing that has characterized the very early engagement in that care management outreach process.

In my opinion, I think it just reinforces the importance of what we're trying to do and the importance of

making sure that we get it right.

The last slide shows you our website, which I hope you will visit. As I told Anne previously, it is more like the old MACPAC website than a new, good-looking one, but there's lots of information there, and we hope you'll visit it.

And with that, I'm happy to answer any questions.

CHAIR ROWLAND: Well, thank you very much for both complimenting us as well as coming to talk to us about your efforts.

In terms of what's going on, the cost side of it is also another piece, and when will there be any information on whether this is actually saving money. I mean, we know it will if it reduces hospitalization, but if you've got all this unmet need, it seems like you might be needing to spend more rather than less on this population?

MR. ENGELHARDT: There are multiple levels -- first, to separate, we have a fee-for-service model and a capitated model. There's so much more action on the capitated side. That's where I'll a focus a little bit more. There are multiple levels of the cost part of the equation. One is, Did we set rates right? The rate-

setting methodology we used was intended to be almost tautologically achieving savings. The idea was we're going to set rates based on what more or less we were spending in the absence of this model and then shave it by half a percent or a percent the first year, a little bit more in the future years.

As you all know better than most, that's easier said than done from a methodological perspective, but that was the intent. There are factors of selection bias and projection error and all these other things that may or may not work right in every market where we try them.

Below that is at the health plan level where some of them in the very early stages of this are still grappling with whether or not this is a financially viable product under a capitation rate set in such a way, and our early returns on that are mixed. Some of them are struggling from a financial perspective. Some of them are doing fine from a financial perspective. And we'll spend the next several months trying to unwind that.

So, it's still early for us to know. Obviously, if we don't have plans that can sustain the product, then we have a problem we'll have to revisit. But we don't know

that yet, and we'll struggle with it.

On the fee-for-service side, the primary financing challenge is one of -- it continues to be one of alignment and budgeting. We tried to set this up in a way that would counter the pervasive financial disincentive to ever do anything to serve dual-eligible beneficiaries. On the Medicaid side, the age-old problem that if we actually do anything, all of the savings will be achieved in the Medicare program where they would pay for all the hospitalizations we would have reduced, and all the SNF stays we would have prevented, and all the polypharmacy we would have fixed. That is probably a reason why only two states to date have signed on to that model. Basically they need to make a fiscal investment with a balanced budget that will maybe pay off with Medicare shared savings next year or, in a future budget cycle. We're working through challenges with that in Washington State right now where the general assembly is asking themselves tough questions about whether they're even going to continue to fund their health home model beyond its 90 percent FMAP life.

And so that continues -- I hate to talk about the

money because at the end of the day this is about people and how we serve them. But you guys know the money drives how this system is structured and explains a lot of its perversities today, and getting it right really is our most important challenge.

COMMISSIONER GABOW: Thank you for coming, and most of all, thank you for trying to make sense out of this complicated system.

I've always been perplexed about why there are dual eligibles who are in one government program to pay the other government program's premium and cost share. So how are these programs dealing with those duals who are only in Medicaid to pay Medicare premiums and cost share?

MR. ENGELHARDT: Well, first, all of the financial model demonstrations I talked about here are only for what we call full benefit dual-eligible beneficiaries. So those partial duals wouldn't even be in this model. Our focus on the partial -- I hate to use that term, but those partially dually eligible beneficiaries has been in a couple different ways. One is helping to remind states and providers about their obligations related to the prohibition on balance billing, which we believe to be

violated with great regularity.

Second, the analytic work of this group to help shine a light on access issues related to state coverage of cost sharing that we will eventually complement with our own analysis as well.

And, third, helping to promote awareness about the Medicare Savings Programs in general.

COMMISSIONER CHECKETT: [off microphone]. Does that work better? Thanks. I was curious. I think there's been a general sense of disappointment in the high number of opt-outs in a number of the states. I've seen all different numbers, some as high as 30 percent and 40 percent, and I don't actually know it's true. I'm sure you do. But I'd be interested in your thoughts on why that is happening? And is that a good or bad thing? And if it's a bad thing, is there something we can do about it?

MR. ENGELHARDT: Yeah, so this is what everybody knows. The basic model on the capitated side, in almost every single instance we start a new demonstration in any of those nine states. There's a period of usually a couple of months in which the health plans are live and marketing and serving beneficiaries, but the only people who are in

them are those who choose to enroll affirmatively.

After a few months, we typically trigger passive enrollment. Much like Medicaid processes that we know about in most of the Medicaid instances, it's mandatory enrollment. You just have to choose one of the plans. In this case, passively assigning you to a plan, you have a choice of multiple plans. You also have the choice to receive your services outside of the demonstration context, which in many cases means Medicare fee-for-service or choosing a separate Medicare Advantage plan.

That model, we could talk a lot about Medicare versus Medicare perspectives on enrollment and what those means. That model means people have the opportunity -- we inform them of the opportunity multiple times -- to decide not to participate, and we focused a lot on making sure they're aware of that right. And our earliest market where we applied passive enrollment was Massachusetts. We had about 30 percent of beneficiaries in the first wave choose to opt-out. In other states, we've hovered around that number, in Virginia, for example, in Ohio, in Illinois. California has been higher than that. New York, which started very recently, has been a little bit higher than

that.

Those numbers have evolved over time. They're a function of many things, some of which maybe will be discussed later in this panel. In some cases, we hear a lot that it's provider suggestions that people not participate. We also hear that it's a person genuinely figuring out their provider's not in a network that can be covered. We've tried to mitigate transition problems by having continuity of care protections that range from 90 to 360 days basically where you get to see the providers you've been seeing regardless of whether in network or not, but at the same time we want people to make thoughtful decisions about who's in network or not. And there's confusion.

So the trade press and others have framed that as a disappointment. I don't know if it is. I mean, I think we're learning as we go. In Ohio right now, more than 50 percent of all the full-benefit dual eligibles are in a completely capitated, integrated product. That's really exciting. I don't know where the ceiling for that is in an environment where no one is required to participate. So we're learning.

I think the process has worked because it created a marketplace where there wasn't one before, so I'm happy with that aspect. If the opt-out enrollment numbers were lower, we'd have more enrollment. We'd also have more challenges with startup and phase-in, and so I don't view it as success or failure either way. We didn't go into it with a target number we had to hit. We went into it with a mindset that we want people to be able to make informed decisions to the best of their capability. And, unfortunately, in some places there's so much noise, I'm not sure that that's happening effectively. But it's something we're observing and are interested in, but neither success or failure in and of itself.

COMMISSIONER CHECKETT: Thank you.

COMMISSIONER COHEN: Hi. Thanks so much for your presentation. It's a great and important topic.

I wanted to pick your brain, and I hope it doesn't feel like I'm picking on you, because I know that this is a perennial challenge for government programs. But, because the Coordination Office is really in an exciting way taking a fresh look at a lot of things, I wanted to get some insight from you. Why is the

beneficiary communication issue such a challenge in this sort of world and environment where there are, you know, it seems like millions and trillions of communication firms, strategies, and other things sort of available to all of us in ways that they weren't in the past? It's such a more developed field. What are the barriers to sort of communicating more effectively with beneficiaries, because I think it's a huge issue for all of our programs, and you've had a fresh start at it and still hit those challenges. So, I'm just curious what you perceive that they are and what could be done about them.

MR. ENGELHARDT: First and foremost, we can't lose sight of the fact that we're starting from a platform that is confusing, right. I mean, you have Medicare and you have Medicaid. We all know that people think Medicare covers all their long-term care services, so we start from a point of, I think, complete understanding on just about everything.

Secondly, we've developed over the years many processes and beneficiary protections between the two programs that are just kind of similar and kind of not, and it's important to us that we articulate in writing

everybody's rights to take advantage of all of these different things, and in doing so, we make it very difficult on ourselves to actually convey something without 100 pages of disclaimer and discussion. That's not an excuse, that's just kind of the reality of the challenge.

And, then, third, I don't mean to be flippant, but we're CMS. I think we have a challenge, as I am illustrating to everyone now, in articulating ourselves clearly all of the time. And, so, we've worked on that. We have applied, for example, reading level standards. In Medicaid, it's common, sixth grade reading level materials. It's, like, a very normal thing. Medicare, we don't have that, right, so we started from the platform of let's do the thing that is most beneficiary protective when there's differences between Medicare and Medicaid.

That's just one example of, like, so we spent thousands of man hours to make member handbooks and explain appeal processes at sixth grade level. It's better. It's not where we need to get, and we need to continue to work on it. We did beneficiary testing and focus groups recently in Los Angeles and Chicago and elsewhere and will continue to learn from that and continue to get better as

we evolve.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: So, I have a question -- thank you very much for coming today -- about the dynamics of negotiating a three-way contract. It's very hard to negotiate a two-way contract, but, obviously, this is just absolutely crucial to making this work. It certainly offers the potential for a way to bridge, you know, between two programs that, in all fairness, really probably should be one program at this point. We know better than we knew 50 years ago.

So, I wonder if you could talk a little bit about what the challenge has been in attempting to align interests, responsibilities, oversight activities between the two and whether, in your view, this has proved to be successful or whether one of the lessons, maybe -- and I don't know whether the RTI analysis will look at this specifically, but whether it's possible to successfully bridge the chasm between these two programs by use of a contractual instrument.

MR. ENGELHARDT: So, we have two-way contracts. The three signatories would be the state, CMS, and then a

health plan. So, in any given state, we basically have one three-way contract that all of the health plans are separately signing. We don't really negotiate them separately with all the different plans, just for clarity.

That doesn't diminish the challenge of it, because it is the document in which we try to get into the real nuts and bolts from an operational perspective of who does what, and certainly, we ourselves have learned over time about a hundred things that we wish we clarified things we didn't think of, and we're working through that process to update many of those contracts now.

I can use one example that I hope would be insightful, and it's on the monitoring and oversight side with the health plans. We currently, if you went to Texas and picked a health plan that participates in the state's STAR+PLUS program, you would have a team of people in HHAC in Texas who actually monitor the heck out of these plans. They fine them for how many rings of the phone before somebody answers the call. So, they do all this stuff, very impressive. And, all of those plans are also Medicare Advantage plans. And, so, up in Dallas in our regional office, we've got someone else who is monitoring their

delivery of Part D services and someone else who is monitoring their delivery of all the other non-Part D stuff. And, we're monitoring them, regulating and fining them, doing all these things. Those people never met each other before we started a demonstration in Texas a few months ago.

So, we created what we call a Contract Management Team, which is effectively like a state representative, a Part D rep, it had Medicaid and Medicare reps from the regional offices, from CMS. And, that process -- you guys could quickly imagine that that's cool and exciting and innovative and totally challenging at the same time, because people bring to the table different perspectives on punishment, on cajoling, on partnership, on information sharing, in ways that they create like a dynamic tension that I think is great, that I think works, that we now have people on the Medicare side of the house -- I'm using air quotes -- on the Medicare side of the house who actually care that a health plan maybe isn't keeping up with doing all of its assessments or didn't have -- had a network problem or a customer service problem in its nursing facility benefit. They know about that now in a way they

didn't before. And, similarly, the state folks know that they're having a drug problem, a Part D compliance problem or whatever.

So, it's exciting, but it's also -- it's, like, you can't imagine the depth of issues, big and small, that we argue -- constructive -- I shouldn't -- strike that from the record -- that we discuss in those forums, appeal processes, beneficiary notices. We fight like cats and dogs with the states over letters that we send out to beneficiaries, always, because both parties think they have the beneficiaries' best interests in mind, and one party thinks we should send a paper that has all these different caveats and disclaimers and the other party says, no, we should send a paper that says, call this 1-800 number and someone will explain it to you. I mean, totally different philosophical orientations that I just think the positive way to approach them would be to say all those parties are learning from each other in constructive ways. There's probably a negative framing of that, too.

COMMISSIONER ROSENBAUM: It's one of the most interesting federalism exercises going on right now, and I don't think it's gotten the attention, actually, that it

should. I think there's a tremendous amount to learn from the process of designing the agreement and then implementing it, so --

MR. ENGELHARDT: Network adequacy reviews. I mean, all these things, like, every once in a while we say, oh, they could learn so much for us, and then on the flip side, go, oh, my God, the state is doing that. That is really innovative and cool. It's fun.

COMMISSIONER MILLIGAN: So, nice job, Tim, and I wanted to just sort of put a little bit of framing around this for a second, because for many, many years, the duals were an afterthought in policy, and certainly an afterthought in the discussions, in my view, in sort of the D.C. circles about a lot of this, and there's been a lot of progress, really, in a very short period of time in the historic arc of this. And, because of the demographics, such that the Baby Boomers are now going to -- the dual eligible count is going to go up pretty fast in the next few years. The work is great. So, I just want to acknowledge that.

I have one question, which is we've talked a little bit this morning about the Medicaid managed care

rule that is expected to land sometime this year, and so the question is, within the context of these demos, how do you address the moving part nature of federal policy changes involving Medicaid and Medicare like the forthcoming Medicaid managed care rule?

MR. ENGELHARDT: We structured the demonstrations in a way that basically said, all of the rules apply, both Medicare and Medicaid, unless we have waived or superseded them with some specific thing that overlaid them. And, so, we've left ourselves, probably in a positive way, subject to kind of automatic compliance with shifting sands unless we had really specifically established something to the contrary.

And, it's a positive thing. It also keeps us reactive to some of those developments and we're going to have to constantly reevaluate what they all mean for, not just these demonstrations, but for dual beneficiaries writ large.

The managed care reg, which you've all been waiting for for years and years and years now, is so great, and I can't wait for everybody to comment on it. One of the things, I hope, is that a lot of people will comment on

it with that dual kind of alignment lens in their head, because I just think there's so much, and it is so complex that we're going to get a lot out of the comment period that we can learn from. But, more or less, those things are going to apply, and I think that's actually going to be great.

CHAIR ROWLAND: We are anxious to comment on it, too, as soon as we --

[Laughter.]

MR. ENGELHARDT: Yeah. You'll have some number of days, yeah.

VICE CHAIR GOLD: Yeah. You know, as you mentioned, I think, you're trying to create a market that wasn't there to deal with these health plans, and one side effect of that is that there's varying experience, probably not perfect experience everywhere, some more experience in some of the participating states than others and some more in some of the health plans than others and some populations better than others, and I was just involved in a study that sort of just documented that. How does that play in both to your monitoring effort and to sort of drawing conclusions from the evaluation?

MR. ENGELHARDT: I don't know -- first of all, your observation is a hundred percent correct, and to illustrate it, we have -- I'm making up a number -- of the 65 health plans, a little bit less than 60 but probably more than 55 had a Medicare Advantage -- you probably know the number -- had a Medicare Advantage background to begin with. A smaller number had a Medicaid footprint in a given state, but many of them Medicaid backgrounds, as well.

So, we started not from zero, but it was a new thing. In New York State, New York City, there are these very small home-grown plans that are long-term care plans. That's what they are, and several of them never did acute care before. And, on the flip side of that, you have Humana or other big Medicare Advantage plans who just had not -- there's not a lot of Medicaid work to begin with, much less long-term care work.

So, it's too early to -- well, I haven't reached any kind of judgment on whether or not, like, starting from one place or the other has been more successful or less. We have, like, all right, we did a readiness review process for all of the plans before they could go live. We did systems testing and network reviews and site visits and all

this stuff, and we just learned a lot from that. Saw some things that maybe weren't intuitive, that some of the small and local plans had the best IT capacity because they built a system to serve this population or to manage long-term communities. Some of the big multi-state organizations had the hardest times with IT capacity because they had a system that they needed to adapt from a corporate perspective to local circumstances.

So, there were a lot of those kind of very early observations. I don't know how they translate yet into outcomes or beneficiary experience, but the diversity is there and I hope that's something that we -- I hope that makes it a better set of demonstrations for it.

CHAIR ROWLAND: Tim as you noted, many of the individuals who are dual eligibles have cognitive and other real behavioral health challenges. How are those being addressed with both the enrollment side, because it's kind of hard to give proper information to some of those individuals, and also with the service side, since we know that has been both a big gap in Medicare's coverage as well as in Medicaid's.

MR. ENGELHARDT: Certainly, another place where

that communication part just gets a little bit harder than we might be used to. We -- one of our early challenges has been in the enrollment process, effectively recognizing authorized representatives. This has become a very hot issue in California and Michigan and elsewhere, I think in a good way, ultimately. But, the apparatus to even know who is a legally authorized representative for another individual in a way that guards against a circumstance when it's some renegade family member who's doing the wrong thing, yet doesn't put a barrier to working things over the telephone, is a balancing act that I don't know if we've found the perfect equilibrium on that. It's a total challenge.

On the delivery side, I hate to single out any one anecdote, but we had a health plan in Boston, Commonwealth Care Alliance, who, they basically built a crisis intervention unit. They built a new set of community-based capacity that just, like, totally didn't exist before. Before, somebody in crisis, they go to the hospital, $1,100 a day on the Medicare dime. Surprise, surprise. There was probably no great incentive for -- financial incentive for the state Medicaid agency to

cultivate other levels of service that Medicaid would have covered and Medicare wouldn't have. Under the umbrella of capitation, they invested millions of dollars and are on the verge of opening their second unit, small crisis intervention units at half the cost and in a much more integrated environment to serve people who are in the stages of psychiatric crisis, but one that does not necessitate institutionalization.

And, so, it's stuff like that that's kind of most exciting about the mechanism and what we're trying to establish, and it's just unequivocally, every example we get from the field is, I met somebody who just had untreated psychiatric conditions and we connected them with services for the first time in their lives and it helped them get their life in order. And that's, again, those are anecdotes now. I hope that they will become data later, but it's unbelievable.

CHAIR ROWLAND: Well, thank you very much for continuing to work with us and to update us, and also for continuing to give us back some of the both positive and negative lessons as you go forward, because I think much of what you're talking about is going to apply to managed care

generally and to all of the other kind of developments that we're looking at as we spent the morning talking about Accountable Care Organizations for Medicaid and managed care. So, stay in touch and we'll keep trying to stay focused, as well. But, thank you for coming.

MR. ENGELHARDT: Thank you, Diane. Thank you.

CHAIR ROWLAND: And now just to reinforce some of the comments that Tim has made, we are going to turn to look at the results from focus groups with enrollees in these Financial Alignment Initiative Demonstrations in California, Massachusetts, and Ohio, and Katie is going to set up the discussion, and Michael Perry is joining us to present the results.

Results from Focus Groups with Enrollees in the Financial Alignment Initiative Demonstration in California, Massachusetts, and Ohio

* MS. WEIDER: Thanks. Before Mike presents his findings from the focus groups we conducted, I want to first briefly provide an overview of the purpose of our focus groups and also provide context to the three states we visited.

As you heard in Tim's previous presentation, CMS

has a contract with RTI to conduct a comprehensive evaluation of the demonstration. That evaluation will include focus groups, key informant interviews, and analyses in changes in quality, utilization, and cost.

As that evaluation is underway, we wanted to provide the Commission with early effects of the demonstration on beneficiaries. Specifically, we examined the enrollment process, beneficiaries' knowledge of the program, communication to beneficiaries, and beneficiaries' experience receiving care coordination services and accessing services.

We conducted these focus groups in three states: California, Massachusetts, and Ohio. We chose these states as they were some of the first to implement the demonstration. Mike will go into more details about our methods, but in choosing these states, we were able to speak with individuals who had been enrolled in and receiving services through the demonstration for at least six months prior to our focus groups.

On this table, we highlight some of the key dates and enrollment information to provide context and to highlight differences in the structure and size of these

programs.

For example, Massachusetts, which was the first state to begin enrollment, limits enrollment to dually eligible beneficiaries under the age of 65. While California and Ohio had later start dates, they both target young and elderly dually eligible beneficiaries. You will also notice that all three states limit enrollment to specific geographic regions and exclude beneficiaries receiving certain services or residing in certain facilities.

In general, enrollment into the program started with a voluntary enrollment period in which beneficiaries could choose a health plan or opt out of the demonstration. This was then followed by a passive enrollment period in which eligible beneficiaries were assigned a plan.

However, we will note in California some counties only had this passive enrollment period. For example, we visited San Mateo County and San Diego County during our visits, and both had different enrollment processes. San Mateo County only had the passive enrollment period while San Diego County had the voluntary and the passive enrollment period.

The April enrollment numbers you see listed here are from the April 2015 Medicare Advantage enrollment data file. These data are updated monthly, so we can continue to track the demonstration. And you see here that Ohio has the largest percentage of individuals eligible for the program who are actually enrolled in the program. This is followed by Massachusetts and then California.

We plan to continue to track the demonstration and are developing a document comparing all nine of the capitated models to be posted to our website. But at this time we'll shift focus from comparing the characteristics and enrollment numbers of the demonstration to our findings from the focus groups.

I'll turn it over to Mike.

* MR. PERRY: Thank you for letting me speak today. As much as possible, I'm going to try and be the voice of beneficiaries who are experiencing these demonstration projects. We talked to 55 beneficiaries. That's not a lot, but it's a beginning. A good start to what I hope is more consumer feedback on how these models are going.

Let me tell you specifically what we did. We held seven focus groups total. We were in, as Katie said,

California, Massachusetts, and Ohio. The individuals in the focus groups, the ages ranged from 33 to 89,had a variety of different physical disabilities. We had a number of individuals with mental health challenges, diverse individuals were around the table. We held one focus group in Spanish.

We also had a mix of voluntary enrollment versus passive. There was a difference there. That was interesting to learn, so we had that mix as well.

CHAIR ROWLAND: Could you speak to how you found these individuals? Were they provided by the plans or how did you identify them?

MR. PERRY: A mix of ways. We used service provider organizations that serve duals in the communities as our main source. We wanted diversity of opinion around the table, so we tried to go to multiple sources, but we mainly used service providers in the community who provide a range of services to duals.

COMMISSIONER MARTINEZ ROGERS: So did they select them [off microphone]?

MR. PERRY: Pardon me?

COMMISSIONER MARTINEZ ROGERS: Did they select

them or were they randomly picked?

MR. PERRY: We rescreened them, so they gave us individuals who then we screened to participate in the research.

MS. WEIDER: I will just note that in San Mateo County, we used the Health Plan of San Mateo to recruit our beneficiaries. Some of the community-based organizations that we used in the other states included Centers for Independent Living, a couple of senior centers, and a LEAP, Linking Employment and Abilities Potential organization.

CHAIR ROWLAND: These are all individuals who did not opt-out, so these are people who were actively participating.

MR. PERRY: We had one individual who had opted out and then got back in, so we do have a little bit of insight into the opt-out issue, which came out earlier.

VICE CHAIR GOLD: Were they all able to get there on their own? Or how disabled were you able to get people to have a range here?

MR. PERRY: Fairly disabled. In some cases their care attendants came with them, added and complemented what the individuals were saying themselves. We had a number of

individuals with wheelchairs, for example. We paid for their transportation to come there. So we had a number of people with pretty serious and challenging disabilities around the table.

Great. These are great questions.

So let me give you the context, set the stage for what I'm about to go over. These demonstration programs were new, and so what that meant was there were growing pains in every single one of the communities that we were in. We got a lot of -- it's sort of a mixed bag, is the big finding from these focus groups.

There are some individuals who are really starting to benefit from this. They think this care-coordinated approach, having a care coordinator, having these additional services, they think it's really improving their health and their well-being. They seem happier as a result. So there are some individuals who were really in a happy place. They noticed the difference. They're understanding how to use this new model of care, and they are really benefitting.

But we had a large number of beneficiaries who were still struggling to understand this approach. How is

it different from what I had before? Or what are the new services that I'm able to access? Challenges connecting with a care coordinator.

So for some, it was really working. For others, it was really still challenging.

I will say that most of these sites were about six months in, as Katie said. So some of the initial rollout problems were starting to fade away. So a lot of the challenges we were talking about were, you know, a month ago, two months ago, and had been since resolved. So we were seeing and they were seeing some improvements in all the sites.

How did they feel about this model? We thought this a sort of important early slide to talk about before I get into the challenges. They liked this model. They don't understand this model of care, but they like it. And what we did as a key point in the focus groups is we tried to explain it. We gave them some details about how the model works, and for some I think it was the very first time anyone had ever explained the model to them.

So they grabbed hold of certain pieces of it that they really like, that there be more coordination, said,

"Oh, I like that. My care right now is really fragmented. My doctors are not talking to one another. The burden is on me to bring all the information to my different providers." So they liked care coordination. They really liked that someone would help them, have a go-to person who would help them solve problems, tell them about the program, tell them about the new services. They liked the idea there would be someone on their side.

And they really liked the expanded services. Dental in particular was something that they were really excited, not just extractions anymore. "Now I can get dental care." Once they understood that, that was really a good moment.

Transportation, which is so vital for a number of these individuals, the fact that they could use transportation services for non-medical reasons was really important for a number of these individuals. And then expanded behavioral health services. So once they got it, they really liked this model of care. They really want to be part of it. The issue is a lot of them just don't understand it right now, even though they're in it.

So knowledge. There were good questions about

communications to beneficiaries about this model of care, and that really is where the problem is, I think, from the focus groups that we did. They don't really have a clear understanding of this model of care. When we started the focus groups, we asked them general questions. They didn't know the name of the program they were in. They couldn't identify the different services that they would now have access to. They couldn't really explain how it was different from what they had before.

There were exceptions in every single focus group, savvier beneficiaries. In every case, they tended to be people who had attended a seminar, an informational seminar, who had really plowed through the materials and learned about it, who were really assertive or had someone in their life who was very assertive who did this for them. But they really had to -- I think the difference is they really had to look into this, put a lot of effort into learning this. The others who didn't do this, they were confused.

The issue is of print materials. Print materials in every site were -- beneficiaries said they were just not understandable. They were too thick. The letters they got

were in too technical language. So I'm hearing sixth grade, but from their point of view, there was some terminology they just could not understand. And so the print materials were a real challenge.

In our Spanish-speaking group, interestingly, it wasn't that there was a language barrier, because the materials were translated into Spanish. It was the understandability of the terminology in Spanish was what was so hard with that, with those materials. And that group, the Spanish-speaking individuals, lagged behind all the others in understanding how this model works.

The ones who seemed to know better are those self-starters, but also we noticed those who had a personal touch along the way, that made the difference. So when you're talking about what is a way to communicate to this population, it doesn't have to be CMS talking to everybody, but having a care coordinator explain what's going on made a big difference. Having a provider - and providers, I think, have some challenges understanding this model, but when they understood and explained to the beneficiary, that made a difference. When a family member or care attendant understood things, that made a difference. So some sort of

personal touch around it made a difference.

Feedback we received from these beneficiaries on the providers is that the providers have some challenges understanding this model of care. They will call up a provider. The provider will not recognize the name of the program, will be confused if they participate or not.

Dentists were mentioned a lot around the confusion of accepting this coverage or not.

Pharmacists were another place of confusion around prescription drug coverage, but primary care also. In some cases, it was the beneficiary educating the provider about this new program. So there are some challenges there.

Enrollment. So it was already explained. In every site there was voluntary enrollment, and then it moved to passive enrollment. So those who voluntarily enrolled, I have to say we got pretty good feedback. It went pretty smoothly for those who voluntarily enrolled. The key was keeping their provider. A number of these individuals, because they need so many services, did call their provider, and that was a key thing for them. They really wanted to make sure they could keep their provider,

and that drove a lot of this, but also those who had help enrolling.

But we did not hear a lot of complaints about the active enrollment process. Most of the tension was around the passive enrollment process, and it was there that we ran into beneficiaries who had received letters but didn't understand them, didn't know what it meant for their care, thought they were still in the same plan, same providers, tried to then get care and then couldn't get care, or were charged a co-pay. Or in one case, an individual who has a personal care attendant, there was a real long lapse of that care attendant getting paid, and so had to pay out of pocket, lost a care attendant. That's a big deal, you know, if you have a care attendant you've had for a long time, so there were some disruptions in personal care attendants along the way. So there's some challenges with the enrollment process there.

The transition, I started to talk about that. The first weeks and months of the program were where the challenges came up. So lapses in care, we had a number of them. We had individuals who could not fill prescriptions because they went -- particularly, I think we heard,

particularly in Ohio, difficulty keying in some new code for the new program that got the appropriate co-pay, and so pharmacists didn't know how to process a prescription in this new model. So we had a number of cases of that. So we had mistaken co-pays.

We had some transportation issues, and Boston comes to mind. There was a change in transportation services, the company that was providing that. There were delays, rude transportation providers, a lot of unhappiness in Boston about the transportation services that were part of this program. And then I mentioned the personal care attendants. There were some issues there.

Those who passively enrolled had the most issues. They knew the least. They had the most surprises. They had the most lapses in care. They were the most concerned. They were the most likely to have lost a provider, although most kept their provider, but a few of them lost it. So there were challenges there.

Also, trying to make appointments, that first appointment with the dentist, with the provider, there were some challenges doing that. So the transition was rough for some.

Let's talk about some of the positive outcomes, because there were a lot of positive outcomes.

First of all, most could keep their providers. That was a huge deal for the beneficiaries to keep their providers. So most could keep their providers. That meant there was a sort of underlying satisfaction. Even though there was a lot of confusion among some of these beneficiaries, the fact that they could keep their provider, their primary care provider, gave them sort of a sense of security and a continuity of care that they really appreciated. So that was key.

Some did lose their specialist and had to find a new specialist. I think those using behavioral health services for the most part were able to keep their behavioral health providers, but some lost them. But it tends to be on the margins. Most of these individuals could keep their providers, and they were happy about that.

And then the new services. Some are starting to use the new services, the expanded dental, for example. There is a backlog of dental needs that are coming to the forefront. So there was some difficulty finding a dentist, but real excitement that once they could access that, they

would get some new services.

Vision. In Boston they were excited about contact lenses now being covered through the program. Am I right on that? It was Boston? All right. Good. And there was, again, about three or four individuals for whom that was a brand new day. They were so excited to get those contact lenses, and they were going to go get those. So they were excited about that.

We had a woman -- and she's quoted on the slide -- in Worcester. And, by the way, Worcester seemed to be a site where everything was going right and where the beneficiaries there were really happy with things. But an individual who taught an English class, and she felt that teaching that class was essential to her well-being and happiness. And so it was covered as part of this program, and that made a world of difference. She had no other way to get to those classes. So the new services, those who were using them really appreciate them.

And then the cost. You know, they understand, they believe they're getting more through this model of care, and yet they're not seeing their costs go up, and they're happy about that. They're happy about their out-

of-pocket costs have not gone up. There's a few exceptions. Some issues with durable medical equipment came up in one site, and some prescriptions. But for the most part, their costs either stayed the same or went down, and they were happy about that.

Some of the challenges. The care coordinator role seems to be where a lot of the issues are. I'm thinking of Boston and I'm thinking of the two sites in Ohio where this was problematic, where some don't even know six months in who their care coordinator is. They've had multiple care coordinators. They're unclear of the role of the care coordinator. I think that's an important finding because those who had a care coordinator, it makes a world of difference. They were really much more savvy about their program, and they were much happier, and they were accessing services.

I'll tell you, those beneficiaries in Boston, they perceived that the program was overloaded. It was overloaded. There had been such demand that there just weren't enough -- that was their take. There weren't enough care coordinators to go around.

The team approach. Some are not yet seeing the

care coordination, or they're not knowing how to recognize it or access it. So they're still carrying their files around and still thinking they need to be the main conduit of information. So they're not seeing their providers work as a team. But a number are. A number talked about electronic medical records, for example, and this doctor "knowing what medications I'm on." You know, "She didn't used to know what medications I took." And so they were happy about that. So many believe there's more communication, but the idea of them working as a team, that's a concept that's still not there with them.

Then, lastly, the health risk assessments and care plans, again, an important part of these models of care. They're not having an impact. The beneficiaries, if they've had them, they don't remember them. They say, "Oh, I think I had that." They don't seem to -- they like the idea of them when they understand the purpose, but they don't see them being used yet in guiding their care. So there's a lot of potential around those two, the initial health risk assessment and then the development of a care plan. They really like the idea of that, that they are guiding their care. But it wasn't explained to them that

way until they were in the focus group that that's what that's supposed to do and that that is an important part of their care. So a lot of them had it but didn't understand the importance of these two features.

So, looking forward, what are the implications of this? What is their thinking about how their care is going to go? Actually, despite the challenges I've gone over, optimism that their care is going to get better. They really, as they begin to talk about it, they really like this model of care. They think that they are going to be healthier as a result. They really don't want as much fragmentation in their care as they've had in the past. So they are really excited for the potential of it. So that's where it was when we were there six months in, challenges but overall positive about where this could go and what this could mean for their care. And we think as if I would go back six months from now, then I think I'd start to hear more understanding of the program and more appreciation and more use of services. But when we were there, they were still struggling with those elements of the program.

So that's it. That's the big picture from the focus group. I'd welcome any questions.

COMMISSIONER CRUZ: Hi. Thank you for the presentation. Very good. I would like to see if we can expand a little bit more about the difficulty of finding a provider, specifically a dentist. Were they given, for example, a provider list or directory for who they want to call? Were they supposed to find a dentist on their own? If you had a directory, was it comprehensive enough to sort of being able to meet the need? Because as we know with this population, since they have had no access to care for such a long time, there is pent-up need. So I want to know if these plans sort of prepare for this and sort of, you know, try to avoid all of this confusion.

MR. PERRY: That's right. Great question, and I think Katie is probably going to jump in and answer with me, too, which is great.

What we heard from the beneficiaries is that when they would call a dental practice, there was sometimes confusion. Often there was, "Oh, yes, we accept this coverage," and we had a number of beneficiaries who then made the trip--which is not an easy thing for many of these beneficiaries to make that trip. That means transportation is scheduled, they go, and only to go and be told by the

front office that there was a mistake, that they don't accept this coverage. We had a number of stories like that where there had been confusion on the dentist's side or their front office staff side.

VICE CHAIR GOLD: All in one state or in multiple states?

MR. PERRY: The dental issues were across all states. It was a common -- that was a point of frustration. So the first problem was being told it's accepted by the dental office, to find out that it's not.

COMMISSIONER CRUZ: Being told by the plan?

MR. PERRY: By the dentist's front office staff, that it's not covered.

COMMISSIONER CRUZ: But when they got there, they go another story.

MR. PERRY: That's right. They got another story. That was the most common experience we got.

Also, having to call numerous dentists to find one that would see them, so they had to work through four, five, six to find one.

And then the third thing was appointments far in the future, so it wasn't going to be an immediate kind of

appointment. It was going to be far down the road. Those were the three.

Your question about where they were finding the dentists, I don't know, Katie, do you remember if they were being directed there by --

MS. WEIDER: No, I think that was one of their points where they were actually getting confused. They didn't know where to go or who to turn to for help, and I think that goes back to the lack of that care coordinator role that they saw, because most of them just didn't have someone to turn to to ask, "Well, now what do I do?" But we didn't -- nothing came up about a provider list that they had received or anything.

COMMISSIONER CRUZ: Directory, no.

MR. PERRY: Nothing.

COMMISSIONER MARTINEZ ROGERS: Just a couple of things. You know, Spanish is spoken differently by subsets, so\ to have one Spanish translation may not work throughout the United States, is one thing.

The other is that the newspapers -- I don't know how they are in other states, but the newspapers in Texas are at a fourth-grade level because most people read at 10-

year-old level, not sixth-grade level.

Thirdly, I wanted to ask a question. Were all these from urban -- were the beneficiaries -- I mean people in the focus groups, were there any from rural communities?

MR. PERRY: You know, so we went to different size cities, but rural, I'm not sure. I mean, we were in Worcester, Massachusetts, and then we were in Boston, and they were very, very different. They were very different focus groups. We were in San Mateo, which is very urban. We were in San Diego. I think we pulled mostly from an urban kind of population, yeah.

COMMISSIONER MARTINEZ ROGERS: The other is health literacy. The majority of Latinos that predominantly speak Spanish really are illiterate, and even many non-Hispanics are illiterate when it comes to health literacy. And to have publications that I assume they are not able to read, even though they may say they comprehend them, I would venture to say they probably don't.

MR. PERRY: Yeah, I think it was the health literacy issues we were hearing, because they said, "Oh, yes, it was in Spanish. I could understand the words, but I just did not know what they meant." So I think you're

right.

COMMISSIONER MARTINEZ ROGERS: Okay.

MS. WEIDER: And let me just say one thing about the rural issue. When we were looking at counties and areas to visit, we heard from some of the community organizations that we were talking to help recruit say that you are going to have a really hard time getting 10 to 12 people to come to your focus group in, let's say, a more rural county, which was one of the reasons we went to the more urban settings. It was just to get those numbers. And we did have some difficulties at first just getting people to come and find them.

COMMISSIONER GABOW: Thank you. I know it's very hard to do focus groups. Nonetheless, I want to raise a concern. Given that this is 55 people out of a program of 400,000, and the people are not homogeneous in any criteria, and the program was new, I'm a little uneasy about drawing generalizations from n's of one or two. Particularly if those are used in some way to create policy or operational change. I mean, I know this is an issue with focus groups across the board, but given the importance of the change that this program has brought to a

group that was really on their own, I would -- I just think we need to be very cautious about extrapolating n's of one or two.

The second comment is that particularly as you look at knowledge and, for the Medicaid piece, enrollment, I suspect that this would not be different if you talked to a group of Medicare enrollees about do you understand what you get from Medicare about what's covered, or even commercial patients. I mean, when I get this stuff from my health plan, I'm like, "What are they talking about?" And I think the same for Medicaid.

So I think, again, in interpreting it, is there a bigger gap in knowledge of being able to read the material than there is for other people going into Medicaid or Medicare or even -- or subsidized premium on the exchange, another new terrain. So I think just a note of caution here.

MR. PERRY: I agree and I'll respond, though. I think it would be very hard to survey this population. I mean, because of the challenges that they have, I think the storytelling and getting into their lives is a way to actually do research with this population. You were right,

it's too few, but this is valid research, I think, a really important way to capture this audience. And, I work with duals a lot and I think this -- what we heard is consistent with other work I've done with this population.

So, I think your point is right, but I think it's hard to capture the complexity of their lives and of this issue in other kind of research methods. So, I think, just doing more of this is probably a smart thing to do. But, there are some challenges in studying them.

The second point is, I think you're totally right. Having worked with Medicare beneficiaries just recently around how they choose a Part D plan, for example, their understanding of materials, I think the stakes are just higher with this population. They use more services. They have a lot of needs. They have more complexity to their lives. So, yes, I hear the same things, and also in the marketplace, talking to a lot of people who just signed up for coverage for the first time. The stakes are just higher with the duals. The challenges are that much harder.

So, I think that, yes, it's commonplace, but I think the stakes are just higher with this audience.

VICE CHAIR GOLD: Let me try and sort of address maybe some of Patty's concerns in a slightly different way. It was helpful to hear that, on average, or maybe at most, these people had been in the plan six months, because I didn't know that. And, reading -- your text in the report was a little more tentative than your slides were --

MR. PERRY: Yeah.

VICE CHAIR GOLD: -- which I think is good. Let me sort of take away how I read the report. I read that -- especially taking the six months -- that we don't know a lot about what actually happened to these folks in the plans because they hadn't been there that long and we're not sure whether they used services or didn't use services in the plan. There seems to be a reasonable indication that they're not so understanding of how to negotiate their way in the plan, which probably is partly the new system and may partially reflect confusion over Medicaid in general.

What I couldn't tell, and I don't -- maybe it was too soon to tell -- if I looked across at some of the text, it wasn't clear to me, and maybe it was because it differed a lot across plans and across beneficiaries, how much

really changed? Was the system that they were getting that different, and some of this is an evolution? You're not clear whether the plan had developed its way of managing care or just hadn't gotten to them yet. And, so, it wasn't -- that part of it -- I think what you documented was when you explained to people how it was supposed to work, they liked that idea.

MR. PERRY: Yes.

VICE CHAIR GOLD: I don't think we know a lot yet whether -- how their experience with that is and how firms are doing that. Is that --

MR. PERRY: No, that's right.

VICE CHAIR GOLD: Do you think that's a fair take?

MR. PERRY: That's a fair take, yeah. I agree.

CHAIR ROWLAND: And, because they were duals, though, most of them had in six months, I assume, used some range of services.

MR. PERRY: Yes.

CHAIR ROWLAND: This is a very high-need, high-use population --

VICE CHAIR GOLD: Do we know that? Did you ask

them?

MR. PERRY: Yeah, we asked them use of services. So, you know, have you had a primary care visit? Most of the hands would go up. Have you seen a specialist? A lot of hands went up. Prescriptions, all had filled prescriptions, multiple prescriptions, and that's where a lot of this hit the fan, was actually at the pharmacy.

CHAIR ROWLAND: So, even though it's six months, there already is some sort of issues there.

VICE CHAIR GOLD: But -- yeah. But, I couldn't tell --

CHAIR ROWLAND: But not enough experience --

VICE CHAIR GOLD: -- not enough experience to know whether they got really managed with stuff, and also the ones who have selected themselves, it sounds like, because they were continuing with the same provider, which may be fine, but it's not necessarily what someone else would experience if they didn't know that.

CHAIR ROWLAND: Peter.

COMMISSIONER SZILAGYI: Yes, just two points, one about the methods and then a question about coordination.

So, about the methods, I think -- I'm a health

services researcher, among other hats, and I've increasingly used mixed methods, so a combination of qualitative methods like what you just did and quantitative methods.

MR. PERRY: I agree.

COMMISSIONER SZILAGYI: So, qualitative first, to identify themes, which I think you've done nicely about knowledge and enrollment and transition, but you can't hang your hat on any numbers or percents, obviously.

MR. PERRY: Totally agree.

COMMISSIONER SZILAGYI: And then quantitative studies to try to get those numbers, and then qualitative studies after that to interpret what you found in the first two. And, I commend you for really asking our patients, because they really do know the best.And I take seriously Patty's comments, but I think this gives us some insights that quantitative studies just can't do.

The question I have is about coordination. I wore a couple hats until recently, one running a very large patient-centered medical home, and we had a bunch of care coordinators.Another was helping to run a very large Medicaid managed care plan, and we had a bunch of care

coordinators. Did you -- and, one of the things that we worried about, or we wondered, is there confusion -- to what extent is there confusion among patients and how well would patients react to care coordination at a plan level instead of at the doctor's office level. Did these themes emerge in your qualitative -- in your focus groups?

MR. PERRY: The role of care coordinator, the confusion around that did come up a lot. A number of these individuals had a case manager, had other people doing some kind of case management for them in the past. So, the thing is, they didn't -- they weren't able to separate this new person, who's phoned them up a couple times, from some of the things they've had in the past. So, that this person has other responsibilities and interacts with their care team, I don't think they understand that part of it. So, there was confusion about where this person fits into this team that they're now going to be dealing with, for sure.

But, there was experience with some element of case management and care coordination before, but it was always on very specific kinds of issues. So, this is a broader care management role that I don't think they fully

understood.

Katie, I don't know if you want to add to that.

MS. WEIDER: I just noticed that one thing in California is that they were less likely to use -- or go to their care coordinator for questions. They were more likely just to go directly to their provider.

MR. PERRY: That's right.

MS. WEIDER: So, they were asking their provider questions, and their providers were, in California, relatively educated about the program. So, that's just one thing to note that was unique in California.

COMMISSIONER SZILAGYI: And, did you hear themes about resistance of care coordination at a plan level?

MR. PERRY: I don't know if we did.

COMMISSIONER SZILAGYI: Concerns about it?

MS. WEIDER: No.

CHAIR ROWLAND: You know, it would have been interesting to have the flip side of talking to the care coordinators to see --

MR. PERRY: You're right.

CHAIR ROWLAND: -- whether their views were different or what they thought the challenges were.

MR. PERRY: I think you're right.

CHAIR ROWLAND: Sara, then Donna, then Andy.

COMMISSIONER ROSENBAUM: I just have to say, as an aside to that, I actually think that the problem is that you really can't go with one, because the plan coordinator is going to know a lot more about what the benefits are in the plan. The care coordinators at the provider level is going to know a lot more about the clinical care coordination. So, the problem is that I don't think there's one answer to the fact that the person needs an understanding at both levels, and it's so hard to get.

So, I had two questions. One, I think, really, it's just a variant of Patty's question, which is, is there any reason to believe that the answers here are any different from the answers that came 20 years ago during the first wave of big time Medicaid managed care? I don't know if we have studies that go back, but it seems to me that we were through the entire litany -- your point being, of course, that these patients are more significantly in need of health care. Although their needs are more overt, I'm not sure that the silent needs of a predominately parent-child population are any less compelling. They're

just less visible. And, I'm not sure that I just heard anything in your incredibly well done presentation that I'm sitting thinking, oh my God, it's 1994 all over again here.

But, the other question I had, I thought your questions were wonderful. I thought the organization was wonderful. And even though the numbers are small, you really probed. And, my question is whether the patient satisfaction instruments that are used for people who are enrolled in plans are -- I know there are several instruments that are validated and all of that, but are they designed to get at the same quality of information that we've heard here?

And, I'm wondering whether we might, as the Commission, spend at least a little bit of time looking at the instruments that are actually being used for people who have been enrolled in these plans to see whether they're designed to get some of the nuance and richness that we heard here, because the instruments may be good at a general level, but may lack some of the things that you've been able to pick up. And, I just -- I don't know enough about either instruments or surveying patients to know whether it's possible for this very high-need group to dig

a little further, whether there, in fact, have been customized instruments for this group. I just don't know. But, you went way beyond what a standard satisfaction survey would tell us, I think.

VICE CHAIR GOLD: Sara, there's been some experience in the 1115 evaluations -- I think Mathematica did one in Tennessee where they had it with disabled populations in a survey. That would be useful. And, also at CMS, Marsha Lillie-Blanton has adapted the CAHPS instrument and has a subset of dually eligible.

So, I'm not sure, I can't recall how much they expanded the content and what it includes, but that's a wonderful opportunity to know something and we should be looking at that and thinking of what that shows.

COMMISSIONER CHECKETT: Well, I thoroughly enjoyed it and agree with the other comments about how well laid out it was. But, Sara beat me. This -- when I read it and listened to the presentation, I was actually struck that it's so similar to the same themes that we heard when Medicaid managed care for TANF/CHIP rolled out -- well, TANF only 20 years ago, it was probably called AFDC then. And, actually, I think that's really important, because

there really are, I think, just speaking to basic issues that you should anticipate when you have a major program change, a care delivery change, and when we introduce a whole lot of new acronyms and titles and program names to anything like this. So, I think it was very helpful.

I had a couple of questions for you. The HRA is a real issue for anybody in the duals business because so much triggers off of it. I wondered if you had any insights or comments from them about why -- I mean, it just says they were unfamiliar with the HRA, and if you have any more feedback about had they, like, literally never heard of it, or they got asked the questions and they didn't want to answer it? So, that's one question.

And, then, just the other is, I'm curious, with this population, are they texting? Are they using mobile apps? Are they using -- I'm serious. Are they using e-mail? I think the truth is, we all learn most when we sit down and we talk to another human. So, two questions.

MR. PERRY: Great. On the health risk assessment, I think that my main take-away was that I agree, I think that's an important -- in my reading up and preparing for this, that was a key element of this model of

care --

COMMISSIONER CHECKETT: Right.

MR. PERRY: -- and yet I was struck how the beneficiary did not see it as a vital or important part of what had happened to them. So, a lot of times, they just forgot that it had happened. They had, oh, I think I had that, oh, I think -- I mean, some did remember. Oh, yes. Someone came to my house. We talked. We did this, and then they developed a plan. I think I have the plan somewhere. They said that. But, others were vague about whether it happened or not. It just did not have the big impact.

I know that the idea that this would guide their care and this is a chance for them to guide their care does matter to them. So, I think part of it, again, was in the communication of -- of this part of it was not done in a way that really had a big impact.

COMMISSIONER CHECKETT: Right.

MR. PERRY: Katie, if you want to add.

MS. WEIDER: Just on the HRA, there were some beneficiaries that did know that they had not received one. The ones who did and definitely said that, " oh, someone

came to my house and I had an assessment done." That was when they really knew they had one done.

COMMISSIONER CHECKETT: Right. Okay. Thank you.

COMMISSIONER LONG: [Off microphone.] Not to cut anybody else off, but for a moment here, I was just listening to all of this and I just said that it just didn't make sense to me that with the HRAs. Because I do know that a lot of folks, when you call them and ask them about health information over the phone, they are reluctant to give that information out. But, it makes a lot of sense, what you said, if they didn't reach them by phone, someone came out to their home. But, still, you've still got a lot of, you know, resistance about that.

MR. PERRY: Right.

COMMISSIONER CHECKETT: And, then, the texting, e-mailing, phones --

MR. PERRY: Great question. I don't know for this population. We had a mixed bag in our focus group, but again, it's 55 people. But, I think that data is probably out there. I'm going to go look it up as soon as we're done here.

COMMISSIONER CHECKETT: Thank you.

MS. WEIDER: I remember people being on their phones during the focus group, so --

[Laughter.]

COMMISSIONER CHECKETT: Everybody is on their phones. All our assumptions about how to communicate with Medicaid and Medicare beneficiaries, throw them out the window. They've got a phone, that's how they do it.

COMMISSIONER MARTINEZ ROGERS: Who were the people in the focus groups besides -- I mean, besides the beneficiaries, who were the people asking the questions and was there someone from the --

MR. PERRY: Who were the people in the focus group? So, we had the beneficiaries. Sometimes, we had the family, like a mother, a family member, caregiver was around there, around the table. Sometimes -- I think it was in Ohio, we had some care coordinators --

MS. WEIDER: The organization that helped us recruit wanted to sit in.

MR. PERRY: That's right.

MS. WEIDER: So, they just sat in.

MR. PERRY: So, they were back there, weren't allowed to talk. But, mostly, it was just the

beneficiaries around the table.

MS. WEIDER: There were -- from what I remember, in San Mateo, we had one daughter who was not an actual beneficiary. Her father did not come. And, then, in -- it was Cleveland -- or, no, it was Cincinnati -- there was a mother with her son. And, those were the two outside just the actual beneficiaries. But, everyone else was someone who's in the program.

COMMISSIONER COHEN: I wanted to just follow up on the point about -- that we have been talking about, about how the beneficiaries in the focus groups liked the concept of care coordination and team-based care, but couldn't quite put their finger on whether they had received it. You've attributed a lot of that to maybe communication --

MR. PERRY: Mm-hmm.

COMMISSIONER COHEN: -- and I think it raises a question for us that has to be addressed -- flagged by qualitative methods, but potentially sort of followed up by more quantitative or other methods.

You know, with things like care coordination and team-based care and things that are supposed to be part of

a model and a plan, to me, I feel like I have never really seen an analysis that sort of says to what extent do people actually sort of get and use services like that that are supposed to be available to them for which there is not a fee-for-service payment or something like that, but there is just some sort of -- and they're different, but let's take care coordination to start.

To what extent does -- everyone in the program, we think, will get an HRA eventually, but how many of them ever talk to their care coordinator again? And what is proactive and what is reactive, and what is an available service and what is a used service? And, I don't think we have really any idea about the utilization of services like that. And, of course, for planning and for everything else, you have caseloads and ratios and you assume some will use more than others, and that is rational, but we certainly have no idea whether it's a one-to-one million caseload or a one-to-one hundred caseload or anything like that.

So, I do think there is a real question here about sort of the availability of some of these things and the reality on the ground. So, I just want to flag that, I

think. So, it's not a question and the presentation was wonderful, but I just think that is something for us to think about. These are harder to quantify interactions and yet they seem to be so key to where we think we want to go for high-need populations, and I am just wondering if it is enough to say people can have an assigned care coordinator or if we need to go deeper than that.

COMMISSIONER MILLIGAN: So, I wanted to just piggy-back a couple of comments earlier. I was having a similar flashback about a long time ago with Medicaid, but I was having a different moment about just duals in general. So, just, I need to provide a little bit of background.

The health plan where I work, on the Medicaid side, dual eligibles are mandatorily enrolled. So, we've got a lot of dual eligibles. And, we also offer a D-SNP. So, it's not as integrated as these models we're talking about here, but it's some of the similar challenges. With the D-SNP side, there's enhanced benefits. There's a much richer dental benefit and transportation and so on.

And, so, one of the, I think, questions presented, and however much you want to address it here, is

to what extent are these findings unique to these models versus to what extent are these findings more universal to efforts to try to integrate care for dual eligibles, because I think that a lot of what you're presenting here are themes that, I think, are very prevalent in trying to coordinate care, maybe not integrate care, but coordinate care between the two programs. And I'm trying to discern the distinctions about these particular models compared to lots of other models that exist where it's not as integrated, but it's as coordinated, where somebody might be in the same plan on both sides.

And, I'll just sort of make my other comment and then address it however you wish. So, I'm in New Mexico. A little bit of context, too. The state on the Medicaid side, which is mandatorily enrolling duals, mandates completion of an HRA for one hundred percent of the members, and in the most recent -- and this is a program that's not quite a year-and-a-half old at this point. In the most recent data across all plans, about 55 percent of the population had completed an HRA. Part of the state's design for that is that the member gets a benefit for doing an HRA. They each get a debit card. It gets loaded with

money when they complete an HRA. So, there's an incentive system underneath that they can then spend in a variety of different stores and things.

But, the remaining 45 percent-ish are very hard to find, and so what is happening is that with the HRA, and this is as much for kind of educational purposes as anything, is that the HRA completion is getting decentralized a lot more. Transportation vendors are being asked to complete it and have an incentive, because they know where people are to find them because they're picking them up for rides.

We're working through our pharmacy network for when people pick up a script, if they complete an HRA there, because that's a point of contact. There are points of contact with primary care providers of FQHCs, EDs.

So, I think part of the HRA challenge here is also the touch part of it and not doing it through a push campaign from call centers, but it's a challenge, in general, and a lot of the rest of it has to do with the reachability of the membership and the members' incentive and everybody else's incentive to sort of tolerate the phone call that shows up on a phone that they don't

recognize.

But, if you could comment to my first point about to what extent do you think this is unique to these models versus more universal to other models.

MR. PERRY: Katie may have a different answer, but I would say I've heard these themes before. A lot of focus on care coordination right now. I've done focus groups with people in the PACE model, for example, other kinds of models of care coordination. And, there almost always seems to be confusion about understanding the model and how it's different. There always seems to be an issue with the care coordinator role and understanding it. The print materials seem to be a common problem to understand. I hear issues around transportation constantly with this population. Access to dental, I hear generally. So, I think a lot of these issues, I hear outside of this model.

CHAIR ROWLAND: In terms of the focus groups, some were of people with disabilities under age 65 and others were seniors. Are there things or lessons you would extract depending on which side of that equation you were on? Are there -- you know, when Donna raises the point about people being able to text and use mobile devices,

that may be truer of the disability population than of those who are 88, for example.

MR. PERRY: That's a great question. Katie, are you going to let me answer that? Okay.

[Laughter.]

MR. PERRY: It's hard to generalize. In my mind right now, some of the younger individuals in the focus groups come to mind seeming more angry about things. Transportation comes to mind as an issue. But, also, I have to say, also, possibly, a -- some of these same individuals see the potential of this for improving their lives. So, it's hard to say. So, I can't generalize. But, the people who come to mind seem to have the most passionate interest in this, both good and bad, because of the impacts it could have on their life. But, I don't know if Katie has a different recall.

MS. WEIDER: Yeah, I think it's also -- it's hard to generalize this. I'm thinking of the two younger men in Ohio who were both in wheelchairs. They both had similar -- I'd say the thing that really resonates with me with the youngest people that were in our group were that they were both in wheelchairs and they both didn't have -- their

personal care attendants didn't receive payment for a while. And, as a result, their personal care attendant -- one of them lost their personal care attendant and the other one had their mother and their family members help them out at home, and because of that, they had a huge delay in care.

But, other than that, I think the frustrations around the room were normally throughout the entire group. There weren't specific one group had -- the younger group had these issues and the other group had those, so --

CHAIR ROWLAND: Because, it seems to me, for the implementation of the Olmstead decision, that some of the ways that this set of services could work would be very positive in terms of helping people with disabilities to be able to get the services they need in the community without having the risk of having to go into an institutional setting, and so that as we proceed, it might be worth again looking not at the model as if everyone who's a dual is the same, but at whether there are particular lessons that we can draw out for the different parts of the dual population.

MR. PERRY: That's great.

CHAIR ROWLAND: The other comment that goes back to something Tim said earlier and that comes up here is that I'm not sure that government can ever really put out a clear explanation of benefits, because you do get into the issues of the lawyers reviewing it to make sure that no one ever can read into the interpretation, and that sometimes you need almost an outside group to do a summary of what it is to put it into the kind of language that consumers can really understand. And, it might be really worth thinking about, in all these models, is there a vehicle that goes beyond, not just mobile or whatever, but goes beyond the booklet that comes out? Like, the Guide to Medicareis not the easiest thing to understand, and that's why we have SHIPS all over the country that try and re-explain it to people.

But, I think these have been really helpful comments and they really do reflect on the issues that are there for any transition, as well as some of the special issues that come when you're dealing with such a very frail and vulnerable population as the duals that are part of this demonstration.

So, thank you both.

MR. PERRY: Thank you.

CHAIR ROWLAND: And, now, we'll take a brief break and then return at three o'clock.

[Recess.]

CHAIR ROWLAND: As we reconvene, we're going to go from simple issues to a more complex issue, which is mental health parity and a proposed regulation on the application of the mental health parity requirements to coverage offered by Medicaid managed care organizations, CHIP, and alternative benefit plans. So Moira is going to key off this presentation.

Session 5: Proposed Rule for the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, CHIP, and Alternative Benefit Plans

* MS. FORBES: Thank you. So CMS recently published a proposed rule that would implement in Medicaid and CHIP the provisions of the 2008 Mental Health Parity and Addiction Equity Act, the MHPAEA, and as you know, the Commission may comment on proposed rules but is not required to by the statute.

So during this session, I'll provide an overview

of the mental health parity laws, which are broadly applicable in health insurance, and then how they've been applied within Medicaid and CHIP, talk about some of the key provisions of the proposed rule, and identify some of the areas where CMS has requested comments and where we thought that the Commission might wish to comment based on issues that we know have been important to you from prior work that you have done.

In your packets is a memo that goes through all of the provisions. There are a lot of changes proposed and a lot of areas where CMS has requested comments, and I'm happy to try and answer questions or do follow-up on any of that. We'll just hit a couple of the high points in the presentation, but I can certainly talk to any of the materials.

A little bit of background. The Social Security Act does not actually explicitly require coverage of most mental health and substance use disorder services in Medicaid or in CHIP stand-alone plans. However, most states do actually cover a lot of services on an optional basis, and, of course, children can receive mental health services through EPSDT, and adults in the expansion group

who are entitled to the alternative benefit package can receive mental health services as that is an essential health benefit. But most mental health and substance use disorder services in Medicaid are provided on an optional basis.

They're also delivered through a variety of delivery systems, which is germane to the proposed rule. There's fee-for-service, there are comprehensive managed care plans for which behavioral health services are carved in, and there are states that have managed care plans but have carved behavioral health out, either keeping it in fee-for-service or to a stand-alone specialty behavioral health plan. And, of course, even in states where behavioral health has been carved into managed care, those managed care plans may turn around and subcontract to a specialty behavioral health vendor. So there are a lot of different delivery systems, and the application of parity rules in the past has depended somewhat on the delivery system, and that's part of what this rule is trying to address, is to make things a little more consistent.

Mental health parity has been law for almost 20 years. There have been several additions over time. It

initially applied to commercial health plans, and initially it addressed the dollar limits that were placed on medical benefits and mental health benefits and to try and make sure that the annual limits that insurers put on benefits and those aggregate lifetime limits were comparable between medical benefits and mental health benefits. In 1997, Congress applied those parity rules to Medicaid managed care and to CHIP.

In 2008, Congress passed the Paul Wellstone and Pete Domenici MHPAEA, which extended it in several ways. It included substance use disorder in the definition of mental health services to which parity applies, and it also added a lot of rules regarding quantitative and non-quantitative limits. So in addition to the annual and lifetime dollar limits, there are a lot of ways in which benefits are managed by insurers. There are day limits. There are number of visits limits. There are utilization management protocols. There's medical necessity definitions. There are a lot of ways in which benefits are managed, and the big change in the 2008 law was to require parity across all of the ways in which medical benefits and mental health benefits are managed.

In 2009, CMS sent a state Medicaid director letter out explaining to states how to apply the requirements of that new law to Medicaid managed care plans that offered medical and mental health benefits. That applied to CHIP as well. The CHIP Reauthorization Act was passed in 2009, and I guess it was a state health official letter that addressed Medicaid and CHIP programs.

In 2013, CMS issued some additional sub-regulatory guidance that explained how to apply these to the alternative benefit plans and so on.

But last month, CMS issued this proposed rule that would put the previous guidance into regulation and also created some new requirements that would apply to states and to health plans.

So, significantly, CMS -- there's a preamble to the proposed rule where CMS explains its rationale for issuing a proposed rule, and part of this is in response to questions it has gotten from the states about how far state authority goes and how far federal authority goes and the necessity for regulation.

But part of this, if you read all of the changes that CMS proposes, is that while in the past the guidance

they have issued has directed states to comply with the letter of the law in terms of parity, a lot of the changes that they discuss here are really trying to get states to comply with the intent of the law, which is to make sure that people enrolled in managed care plans have parity between medical benefit and mental health benefits. So there are some significant changes that I'll get to on the next slide. What this does not do is go beyond sort of the reach of the statute and require Medicaid and CHIP enrollees in fee-for-service to have parity. There's no required changes to the state plans. This does apply just to folks enrolled in managed care. And CMS has included, as it would with any proposed rule, some estimates of the burden and the number of people affected and so on. It's not expected to -- you could say that $157 million is a lot of money, but in the scheme of things, it's a very small fraction of overall Medicaid spending.

So CMS notes in the preamble to the proposed rule that the current policies don't create an affirmative obligation for states to ensure that managed care enrollees receive state plan benefits in a way that fully complies with the parity laws. Because the parity law doesn't apply

to fee-for-service, states and health plans have not had to coordinate to ensure parity when medical and mental health benefits are provided in different delivery systems, which is the case in quite a number of states.

CMS is concerned that this doesn't really satisfy the congressional intent, and it structured the new rule to ensure that managed care enrollees receive their benefits in a manner that complies with the MHPAEA. So, specifically, it changes -- instead of applying just to managed care plans, it applies to anyone enrolled in managed care. If you are in a managed care plan, whether or not that plan is responsible for delivering both medical and mental health benefits, you are entitled to parity. And the state needs to find ways to make sure that you receive benefits in a way that has parity, even if you're receiving them between a managed care plan, a specialty behavioral health plan, fee-for-service, or whatever combination of systems.

CMS considers -- they stated in the preamble that they considered requiring -- as a different way to satisfy the congressional intent, they considered requiring that states either have to be all in or all out, that if you're

going to have managed care, then you have to include mental health in that to make sure that it works, or that you don't have managed care or that you don't provide mental health and substance use disorder benefits in your state plan, and decided that in the interest of supporting continued state flexibility to implement the delivery systems that work for that state, they would prefer to come up with a solution that requires the state to find a way to make sure that they have compliance with the rule while not dictating a delivery system through which the benefits would be provided. So this is obviously going to be complicated to do from an administrative perspective, but it would preserve state flexibility.

As a corollary to this, there are currently rules -- there's federal rules around managed care rate setting that require payments to managed care plans to be actuarially sound, but to be based solely on the cost to provide services under the contract. Because part of what CMS envisions states may need to do if behavioral health is carved out is require managed care plans to provide additional services to managed care enrollees to ensure that there is parity, they need to revise the proposed --

they need to revise the rules around rate setting to specify that actuarially sound rates can take into account the cost of services necessary to comply with the parity rules.

Again, this is complicated. I think there's -- you can see that there's some uncertainty. They have some questions and are looking for comment on how states can comply with this, and that this creates a risk once you sort of open up the rate-setting rule. Is it possible that states could try and include services that are not strictly necessary to comply with parity? So they've asked for comments on that. But, again, this is trying to give states a way to operationalize parity even if you have multiple delivery systems.

Another sort of significant change from the sub-regulatory guidance that is, I think, not a huge change from the way things actually operate in Medicaid right now, the proposed rule will require plans subject to parity requirements -- and this includes both comprehensive managed care plans and the carveout specialty behavioral health plans -- to make their medical necessity criteria available upon request to their enrollees, to beneficiaries

who are not yet enrolled in a managed care plan, and to providers. Plans must also provide enrollees with the reason for denial of payment for mental health or substance use disorder services.

CMS again notes that existing protections for managed care enrollees already largely cover these requirements. Managed care plans and specialty health plans already have to provide their practice guidelines, which would include medical necessity criteria. And managed care plans already have to give written notice of any service denial request. So because the new requirements are not substantially different from existing rules, you know, CMS does not anticipate that the burden of compliance is going to be significant. But, again, it has asked for comment, and I think what CMS is asking for comment on is, Does spelling it out in this rule help further the states' ability to comply with the congressional intent around parity?

So a few areas that we thought the Commission -- of the many areas that CMS asked for comment on, there's sort of the threshold question and then some of these technical areas. The threshold question is: Should CMS

require -- I mean, they've asked -- they've proposed that they're not going to require this sort of all-in approach, but they're asking for comment. Should CMS require states that use managed care to include all behavioral health benefits in the MCO contract? Or should states continue to be allowed to use multiple delivery systems?

Then they also ask, again, Does the proposed change to the actuarial soundness rules create a risk that inappropriate services and costs could be included in the rates? And if so, how could that be mitigated? And are other provisions around the availability of plan information or notice of adverse determinations necessary to facilitate compliance with the spirit of the law?

If the Commission decides to provide formal comments, you know, we can provide a draft comment letter for your review, and comments are due 60 days after the notice was published, which will be June 9th.

COMMISSIONER COHEN: Can I just ask a clarifying question? When you say multiple delivery systems, I was confused in the reading a little bit, and I still am. What do you mean by multiple delivery systems? Do you mean a carveout?

MS. FORBES: A carveout, yes.

COMMISSIONER COHEN: So it's not really -- so it's really the financing, not the delivery system. What do you -- sorry. Just clarify what you mean.

MS. FORBES: Sure. So currently the state health official letters that have gone out have required states to implement this law if they contract with a managed care plan for both medical and mental health benefits. What this would change is to require a state to find a way to comply if you keep behavioral health in fee-for-service or if you contract with a specialty behavioral health plan. And so that's going to be technically complicated because now you'll have to look at -- and they describe in the rule a process by which states are going to have to look at the utilization management criteria and the coverage rules for both the managed care plan or multiple managed care plans and fee-for-service or your specialty vendor, find out where they don't align, and then decide are you going to change your fee-for-service program or are you going to change the MCO contract? You have to redo the rates. There's going to be a whole process that every state will need to go through to demonstrate how they are complying.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah, I just wanted to make a clarifying comment about the actions that the Commission might choose to take to help guide your discussion a little bit.

As everybody remembers, or you may have already forgotten, we are having a chapter on behavioral health in the Medicaid program in the June report. It has been awhile since you've seen it, but it is coming out. One of the issues over the course of the months that we talked about that chapter, mental health parity was one of the issues that was raised. The fact that this proposed rule came out provides an opportunity and sort of a moment for the Commission to comment or not, and either of them is fine. This is an important issue. It's a fairly technical issue, but it also provides an opportunity for you to say what you think in the context of these decisions that are being made now, what the Commission's own agenda, analytic work on mental health parity could be.

So I just want to provide that as some context because, as Moira said, the Commission is not required to comment. If there is something that you find compelling here and you think you should, we will follow up on that.

And if you find this useful background to be thinking about other topics on the issue of mental health parity and the role of mental health and substance use in Medicaid, that's cool, too.

So we will take either type of comment, and do not feel compelled to go deep in the weeds if that is where you -- not your comfort zone or the place where you don't think is the right place for MACPAC to be.

CHAIR ROWLAND: Okay.

COMMISSIONER HOYT: I guess just speaking for myself, I think trying to force the states to put all the MH/SUD benefits in MCO contracts just isn't a viable idea. I get that there's some element of parity to that, but it seems like the parity ought to be in the benefits themselves, not in how they're delivered. And having traipsed around a number of states, there are definitely states where a full-risk contract makes sense and would work for the acute-care benefits, but it's next to impossible for behavioral health. I've been in states where mental health is sort of one area, substance abuse could be someplace else; there could be chemical dependency; there could be methadone. A lot of just little

kind of narrow slivers, and to try and just say put all that in a managed care contract just doesn't make sense just to do it for the principle of it.

I guess with regard to the actuarial soundness rate-setting piece, I think what an actuary's preference would be is that somebody sit down and write out what is it that's going to change to comply with the parity rules. You know, what is that specifically? And then the actuary could put a price on that, and that ought to mitigate the chance for putting in -- just being unclear about exactly what it is we're pricing. It's always better to have somebody write down exactly now what does this change mean so this is what we're going to do, and then you can talk about what it costs.

CHAIR ROWLAND: Thank you from our actuary.

COMMISSIONER MILLIGAN: So I guess I need to ask a clarifying question first, and then I think that will drive my comments.

Your last comments, Moira, you talked about the operational issues of the MCO's obligations, and so my question is: Is the implication that if a state has a capitated managed care program but some of the behavioral

health services are carved out, they remain in fee-for-service or an ASO-type arrangement, the parity requirements would in effect in the fee-for-service part of the Medicaid program kind of get boot-strapped into the managed care rules by obligating the MCOs to make sure it happens? I'm trying to figure out the implications in the fee-for-service side of the rules if the duty is somehow imposed on the MCOs and the extent to which this rule is a way of getting around the fee-for-service parity gap by boot-strapping it into a managed care rule.

MS. FORBES: It seems to envision that while they're not -- it doesn't -- it leaves states the flexibility to figure out the solution that works. It seems to envision a solution in which managed care plans would pick up the gap rather than fee-for-service picking up the gap, which is why they address the change in rate setting.

COMMISSIONER MILLIGAN: So if -- I think there's a different implication on rate setting I want to get to in a second. So if the state plan doesn't include benefits with parity, the MCOs would need to effectively provide that as a wrap-around because of the state plan omission of

benefits on the behavioral health side that comply with parity.

MS. FORBES: So the health plans do not need to cover -- generally do not need to cover a benefit that the state does not cover. But in a category of services, if there are limits that are predominantly applied -- you know, substantially applied to predominantly all services, then they would -- it's what's around the edges more, not in terms of coverage of entire benefits.

COMMISSIONER MILLIGAN: That's helpful. I want to get to my other kind of rate-setting issue. You know, it's really interesting to see this because the last time that the managed care rule was really updated and the actuarial soundness notion was created, a lot of the concern was that states were going to start Medicaid-izing behavioral health benefits by putting it into a managed care contract, things that had previously been state-only funded programs, and OMB in particular was very concerned about building into managed care rate setting federal match for services that were, arguably, not Medicaid services, and that it was a state maximization arrangement.

So it's going to be interesting to see how that

part of this plays out, because I think that that's -- it leaves open the door, and I think CMS is inviting comments about the financial risk to the federal government of Medicaid-izing more services by boot-strapping them in through a managed care rule that were previously not necessarily part of Medicaid.

So I think there are some defects with the rule the way you've outlined -- I haven't read it, but I do -- I guess I want to come back to the original question about whether the Commission should comment. I would be very supportive of some kind of comment that would reaffirm from the access part of the MACPAC name, just the real importance of there being robust behavioral health benefits in Medicaid and that parity is a high value and access to care from the point of view of mental illness and addiction is a part of treating the whole person, but that maybe this rule has issues that are problematic. But I would not want to -- I think we've been given an opportunity to talk about the importance of access to behavioral health, and I think we should take that opportunity without fully endorsing the rule.

COMMISSIONER ROSENBAUM: I was actually raising a

-- when I think about mental health parity, I think about the IMD exclusion, which these rules don't address, but -- I thought I was. I think about the IMD exclusion and parity. Can you speak to that? The rules clearly don't address that.

MS. FORBES: So we asked -- we wanted to make sure we weren't missing something, because the rule doesn't -- they don't talk about it, but they do talk about this -- is there something we're not thinking? And so we actually asked CMS, Are you concerned about this somehow being a back door to get on the IMD exclusion? And they responded and did not say that that was a particular concern of theirs.

So we actually sat down and tried to think about a way in which this creates a problem, and we were unable to see that it did that, which doesn't mean we didn't miss something, but I don't think that this is a way to get around the IMD exclusion, or it's not clearly --

COMMISSIONER RILEY: I mean, it's just a statutory limitation on what they can do on parity, period. And so it takes -- I mean, the concept of parity here is such a vital concept for Medicaid beneficiaries, and it's

such an ill fit because of the structure of the statute. Frankly, I think the only population where there's a shot at this is individuals under 21 where there actually is a requirement. I don't think the slide was correct. I think our position is that actually all medically necessary services that are recognized as medical assistance under the plan are a requirement for individuals under 21. For adults -- well, you said that mental health and substance use disorder services were not a requirement. For adults, that's true. For children, I think it is not true. I think that the full scope of medical assistance, broadly defined, is a requirement. And one of the things we might do, you know, depending on how far into this we want to get, is think about this concept in the context of the under-21 population where you don't -- you really don't run -- I mean, it's a different set of problems, but everything's covered. So the question is: Is it covered inside an organized system or not? Versus the over-21 population, where there will be things that simply are not covered, even for children, the IMD exclusion is tempered, and so -- because inpatient psych can be covered.

So I mean, this is the problem I saw right away

with the parity rule, and I think there are two different sets of challenges for states depending on which population we're talking about.

CHAIR ROWLAND: The parity rule doesn't require states to cover anything, so if it's not covered by the state, then it's not -- okay. I have Donna next, and Sara kind of jumped the queue.

COMMISSIONER CHECKETT: My concern is -- and it's a very interesting discussion. I'm just very, very concerned about having one set of benefits for states that have MCOs and another set of benefits. There are states where we don't even have MCOs statewide. So you're going to have -- and you're going to have -- or this only applies to certain populations within a region. I just -- it's like going backwards to me in terms of parity. I'm all for parity. I'm all for these things. But this rule does not seem to be the way to do it. That's just my initial reaction, and I certainly really want to hear from the other Commissioners. But that concerns me.

COMMISSIONER ROSENBAUM: I'm sorry. I didn't mean to do that, and my comment was going to be that I think the analysis is different depending on whether we're

talking about a Medicaid statute that actually requires a tremendous amount of coverage regardless of the delivery system you're in versus a statute that gives states the authority, however much we may not like it, to limit services and then, you know, how do you apply parity to that.

I mean, I think there's one response when you have adults in a general managed care arrangement and then a behavioral managed care arrangement. The problem is when you have adults in a general managed care arrangement -- we found this for SAMHSA 20 years ago. General managed care arrangements, specialized managed care arrangements, and then stuff still in the fee-for-service system or not. So I am mostly confused about how it would work for adults.

COMMISSIONER MILLIGAN: And I'm sorry to grab a second bite at the apple. I think to some of these other comments, I think one of the unintended consequences if this rule were to be finalized is that it would accelerate the capitation of the behavioral health system in order to create an organized way of the MCOs being accountable for it.

I will tell you that one of the last big pieces

of things I did in Maryland as the Medicaid director is we -- mental health had been a carveout for always under an ASO arrangement as a single point of contact with education system, homelessness, criminal justice system, schools and so on for the population that needed a lot of help with mental illness. Substance use disorders have been carved in, and then it was recently carved out to integrate it with mental health, and so it's now under an ASO arrangement.

I think that the tendency, if this rule were to become finalized, is everything would get pulled into capitation or there would be pressure to do so to have alignment and accountability, and I think that that -- I think CMS is going to hear in the comments they receive that that is having too much of a thumb on the scale of how states organize their behavioral health system.

VICE CHAIR GOLD: Yeah, two things. One, Donna, I thought you'd bring this up, but everything I heard over the years from managed care plans, which I think makes sense, is they don't like being accountable for something they can't control. And it seems that putting -- we can't even define here what's the gap between what's covered now

and parity and sticking it in there. To me, it's understandable because CMS is trying to deal with the restrictions it has in the law. But I'm not sure it makes a lot of sense.

The other is I do have some concern. I mean, it may be there's reasons for not having comparable benefits in the managed care sector and the other sector if you're trying to get people in or give them positive -- like transportation. But generally it seems like Medicaid is a uniform program, and it's sort of the very level to vary the benefits by what sector you're in or what sector is feasible in your state.

CHAIR ROWLAND: But let's be clear here. Are we commenting on the problems of the law or the problems of the regulation? Because the regulation is obviously just trying to implement the law. What is it we would be saying in response to the -- if we commented on this reg, would we be saying this is the best you can do with this exception given the law, but the law ought to be changed?

COMMISSIONER ROSENBAUM: That's not a comment really to CMS. I mean, it's nice advice to CMS, you might go ask for a change in the law. I think we need to comment

within the parameters of the rule, which is why I think the question of workability -- I mean, the issue is: Is this an operationalizable system? CMS I think has tried very hard to cope with the limits imposed on it by the statute, and they've come up with an approach that because the underlying law is different for the under-21 versus over-21 population, might work for one group and no another, but then the question is: Do you end up with a rule that's -- you know, generally speaking, we don't have children's managed care. We have managed care.

And so I think what they've tried to do valiantly here is to fix a statutory problem using parity to do it, which is incredibly commendable, and the only question is whether they've exceeded the limits of what they can do with a rule or whether what they've set up is really not workable.

COMMISSIONER CARTE: I was just wondering, in order to really consider all this, don't we need to know what the minimum mental health/substance abuse benefit is in each state, in each Medicaid program? What's the baseline across all the states? Many states have a state mental health parity now.

MS. FORBES: So CMS in the rule itself has done some -- they've collected some information. Part of what the -- an actual component of this rule is every state would have to do a detailed analysis of its own benefits. CMS has done a little bit of that in the rule. They have looked at how many states cover things through different delivery systems, how many states cover specific benefits, particularly like substance use disorder benefits and things like that. And they have looked at the experience of states that have their own, as you said, state parity laws to see what effect -- that's where they got some of their cost estimates. So they've done some of that, but it's not complete, and doing that work would be part of implementing the rule.

COMMISSIONER CHECKETT: Okay. Now I am getting confused, so could I please -- I really want to get some clarity on this. So if the Medicaid MCO does not provide mental health and substance abuse services now, then they don't ever -- they don't have to provide them even under this rule. Or they do?

MS. FORBES: The state would need to look at the limitations, including both the quantitative and non-

quantitative mechanisms used in both the behavioral health delivery system, which could be fee-for-service or specialty, and in the MCO. And if there are differences, the MCO could be required to make up those differences. It's difficult to envision how that would happen, particularly for the non-quantitative limitations like a difference in how medical necessity is determined. It's hard to envision how that would be operationalized.

COMMISSIONER CHECKETT: But if the MCO doesn't have to cover -- doesn't cover those services at all now, they still don't cover those services.

MS. FORBES: Their contract would have to be amended to require them to provide the services necessary to ensure parity, and the rates would be -- would include some amount to cover that.

COMMISSIONER CHECKETT: Okay. So what it's actually doing -- and I apologize to be thinking out loud here, but what it's actually doing is it's actually carving in services that certain groups have fought for years to keep carved out. Am I correct?

MS. FORBES: You could say that.

COMMISSIONER CHECKETT: I like this rule more

than I thought. I don't know. I'm still concerned about the parity issue, but I appreciate the clarification that we have to really be focused on not the problems with the statute but what the rule is actually proposing and trying to fix.

COMMISSIONER HOYT: Did CMS provide any additional explanation for how they came up with the estimated cost impact? It seems confusing to me that they would -- if you read this 0.03 percent comment, to a normal actuary or anybody, I would think, that's like these changes are immaterial, they basically have no impact whatsoever. And then they come back and say, well, what about actuarial soundness? Do we need to evaluate rate setting or something like that? It seems inconsistent to me.

MS. FORBES: They do build it up, and I think part of it is the differences would impact some states more than others. Some states already -- their underlying rules are already very close to being at parity or may be at parity. So in some states there would be really almost no change, and some states might have a significant change. So it's a small amount overall, but it might be more

significant on a localized basis.

COMMISSIONER MILLIGAN: So I'm not sure how we're going to pull off closing this topic on time, but I do want to reiterate that I think -- and I'm mindful, Diane, of your comment. I think that we could say something in support of parity, and we could reference the fact that the essential health benefits on the exchange and QHPs have -- that that is the most recent version of evaluating what an appropriate minimum essential benefit is, and that Medicaid itself often lacks that.

And I think we can contextualize it by saying that this rule is not necessarily the appropriate approach to provide access to behavioral health benefits and parity with somatic benefits. But I guess my own view is that it's -- that we should not be silent about this.

CHAIR ROWLAND: But we're not commenting -- we would not comment on changing the rule. We would just comment on how we don't like the fact that this rule has to be there because it's not the way we think one should deal with parity.

COMMISSIONER MILLIGAN: Just speaking for myself, I think we could -- if we submitted something in support,

conceptual support of parity, we could, you know, parse item by item in the reg with our concerns. But I think it's going to be very hard to pull that off in terms of a Commission --

CHAIR ROWLAND: I mean, I think we could certainly address the broad issue of parity and that there needs to be a broader look at parity within the Medicaid program than what the statute currently permits, and that given that set of issues, though, on this particular reg, we understand that it's basically codifying previous issuance, but we have some concerns about A, B, and C.

COMMISSIONER MILLIGAN: Yeah, I support that and that we have particular concerns about where the proposed rule might extend beyond previous regulatory guidance, or some version of that. And I'll --

CHAIR ROWLAND: But a very general letter as opposed to a point-by-point critique.

COMMISSIONER MILLIGAN: That would be my preference, just speaking for myself.

COMMISSIONER CHECKETT: So I have another to me really critical point, and so I wanted to make sure, Moira, that what you wrote here was actually what the rule says.

So under changes to rate-setting rules, your second bullet is that the proposed rule would revise this on actuarial soundness that the rates could take into account. So for me, it, like, must take into account, not could take it into account. And so that would be really an important distinction to me and what I thought about a comment, because it is -- it's just an ongoing problem, when something -- when these services are rolled into a rate and there's no compensation, there's no recognition of that in the capitation rate.

MS. FORBES: I can look at the language. My guess is that it says that because not all states will be required to make a change, and so it's more like it could, like if necessary, it can, but -- yeah. I can look.

COMMISSIONER CHECKETT: Great. Thank you.

COMMISSIONER ROSENBAUM: Yes, just to follow on Chuck's comments, I think CMS should be commended for, via this regulation, illuminating what is a fundamental issue for traditional Medicaid beneficiaries over the age of 21, which is that there is no certainty that they're going to have coverage for behavioral health conditions that is equitable compared to the coverage they have for physical

health conditions, and that, you know, this is a particularly acute problem, and here we can, I think, offer the data that we've amassed because of the prevalence of the problems among Medicaid beneficiaries; and that CMS here has attempted to deal with one of the most compelling issues in Medicaid. I mean, it's ironic because we have these letters from, you know, both the Senate and the House asking us to sort of illuminate a path forward for Medicaid. And so I think we can make the point that this is one of the most pressing issues in Medicaid, and then go on with some observations about whether it's feasible to address certain issues that would need to be addressed and whether in doing so CMS has come up with an approach that is operationalizable for states and for plans and raise just some questions and concerns so that there's no mistake about the fact that we see this and we understand -- we see this as one of the great issues in Medicaid, and we really understand deeply, as your slide suggests, you know, and the memo suggests where CMS is trying to go as much as it can. But the question is: Can we get there in a rule? And insofar as the rule has been promulgated, are there aspects of the rule that will be very difficult not only to

operationalize but, you know, going back to what the Supreme Court has raised in Medicaid, can CMS provide adequate oversight? I mean, you know, there's no point in setting standards if the rule is so obscure that it would be very difficult for a state to know or a plan to know if it's even in compliance. And I think that's an issue as well here.

COMMISSIONER COHEN: I would just say that I'm not sure I would support doing a letter on this, just because I am just not sure that we have -- it is a totally important issue. We say those things here. We all know it. We haven't gotten to a point of having -- of sort of -- we haven't gotten deep into our sort of analysis on this issue. I don't think it is appropriate for us to write letters sort of stating a position of priority if we don't have something more specific to add, and I personally don't feel like I know enough, like, I don't feel that comfortable yet. But, I mean, I defer to a group decision that we can all think about, but I would say at this point, I would lean against a letter.

CHAIR ROWLAND: Does anyone -- Chuck, want to make the case for doing a letter, or we can clearly

transmit to CMS without officially writing a letter based on this discussion, some of our views, but do it in a more informal way than officially commenting on the letter.

COMMISSIONER MILLIGAN: So, I think it's useful and I think we could do it in sort of the framework Sara mentioned and to include some of the data that MACPAC staff have wonderfully put together about the prevalence rates, the importance of the service.

I'm not trying to make a hard sell here, though. I just -- I lean in support of doing it very much along the lines that Sara mentioned, and I do -- I personally feel like I have enough information from just the prevalence rates and the importance of behavioral health to many dimensions of physical health and compliance and ED visits and comorbidity and so on, I feel comfortable with that more general version. But, I'm not -- I'm comfortable if we don't go that way, too.

CHAIR ROWLAND: Okay. Well, I think what we're going to do, then, is we're going to see what kind of a draft letter might be constructed, and we'll circulate that to all of you and you can indicate, when we looked at it in writing, it doesn't work for us, so we won't do it. When

we looked at it in writing, it seems like it's the right thing with this tweak or that, whatever. So, I think, clearly, we want to make sure that everyone knows we think this is a very important issue, that this is a central issue in the Medicaid program because of the need for behavioral health services for the population that this program serves, and our perspective is that we ought to make sure that the beneficiaries are getting the care they need in the plans that they have or in the fee-for-service sector.

And, I think, maybe Sara really pointing out the gap between how the under-21 versus the adults are. And, we're going to have this issue around a lot of other pieces, like even the preventive services benefits that Congress gave under the Affordable Care Act to the newly entitled people, but that they're not part of the required preventive services for the adults who were on the program before, even though they are for kids because -- so, I think we really can use this as an opportunity to point out where there are needed changes that will affect the Medicaid population.

So, we'll expect that Anne and Moira will try and

figure out how to put together a letter, and then we'll all look at it and we will make a decision about whether that works for our comfort level and our intent. Thank you.

[Pause.]

CHAIR ROWLAND: As we know, there's a great deal of interest about the federal and the state level, not only in what Medicaid covers, but in what Medicaid spends and its impact on both the federal and the state budgets. And, we know that its impact is counted in different ways and has been counted differently over time. So, April is going to present to you some trend analysis that has been put together. The intent is probably to issue this as a fact sheet or issue brief, making it available on our website, as well.

So, let's hear the presentation, and then I'd like your thoughts on whether there are other caveats, explanations, other kinds of analysis around these issues that would be helpful to the Commission as it responds to the request for keeping an eye on spending and on the contributors to the spending.

April.

Session 6: Update on Trends in Medicaid Spending and

State Budgets

* MS. GRADY: Thank you, Diane.

I'm going to open up the presentation with a little bit of context for Medicaid spending, then turn it over to Nick to describe Medicaid's share of state budgets, and then I'll wrap up with some of the recent changes we've seen in 2014 and what's expected in the future.

I don't have to tell you, you're very well aware, that growth in Medicaid spending has led the program to account for an increasing share of national health expenditures, of the national economy, and state and federal budgets. Despite the historical and projected growth in Medicaid, though, things in the future are expected to stabilize a bit, and we'll get to those statistics.

Setting aside growth in the number of people on the program, we're also going to look at recent growth in Medicaid spending per enrollee, which has generally been moderate compared to other benchmarks, at least since the early 1990s.

Two things I want to point out here in terms of Medicaid's share of U.S. health care spending. The first

is that even though the program has grown quite a bit over time -- it currently accounts for about 15 percent of U.S. health care spending -- it's still lower than both Medicare and private insurance in terms of our national health care spending.

The second point is that although Medicaid's share of national health expenditures is expected to jump to 18 percent in 2017, that's mainly the result of the short-run influx of new adults on the program over the next few years. And when that enrollment stabilizes over the next few years, so will Medicaid's share of national health expenditures. And, during that same period, Medicare is projected to grow slowly throughout and the share of national spending on private insurance is actually projected to fall a little bit, but remain at about one-third of overall health care spending.

Here, the point we want to make is that, as with U.S. health care spending overall, Medicaid is growing as a share of the U.S. economy, and here on this slide we're measuring the economy in terms of gross domestic product, or GDP. Whether that's a good, bad, or neutral thing depends on your perspective. But, in any case, it's clear

that policies that affect Medicaid and other types of health care spending have important economic implications that we could spend an entire session on separately from this.

In terms of the federal budget, both Medicare and Medicaid clearly account for an increasing share of spending. I want to point out that this topic also could fill an entire meeting session on its own, but we're focusing today on state budgets in particular, and we can come back to you in the future with more information on federal spending on Medicaid.

On that front, you're going to hear from Nick in just a minute regarding the many ways in which Medicaid's share of state budgets can be measured, but I'll just put that thought on hold for the moment and wrap up our discussion of Medicaid spending in context with some information on Medicaid spending per enrollee and how it compares to some benchmarks that you see on this slide here.

The main point -- there's a lot of numbers here, but the main point here is that Medicaid growth has been comparable to or lower than these benchmarks since the

early 1990s. There's a lot going on, so I just want to walk you through what we're looking at.

Here in the top portion, we show spending per enrollee by coverage type, and that's Medicare -- I'm sorry, Medicaid, Medicare, and private insurance. The one thing I want to point out is that the growth rates can be very sensitive to the start and ending years that you choose. So, the time periods that were selected here were chosen by grouping to the maximum extent possible, years when Medicaid spending and growth rates were roughly similar so that we were giving a fair comparison here in terms of the Medicaid growth rates.

Continuing our walk through the table here, at the bottom, you see average annual growth in medical prices as measured by the medical care component of the Consumer Price Index. That's that CPI-U MC line you see at the bottom there.

And this brings me to the final point I want to make before I focus on some of the specific numbers in this table, and that's that there are three main factors that influence growth in spending per enrollee for any given time period. The first is prices, and that's that bottom

line that you see there. Even without any other changes in the program, you might expect an increase in spending per enrollee simply because of price inflation.

The second factor influencing per enrollee spending is the composition of the population. So, in years when you are adding relatively inexpensive people to the program, spending per enrollee might be expected to be -- you might expect spending per enrollee to be pretty low. In years when you're adding very expensive people to the program, you might expect spending per enrollee to go up a bit.

The third factor that influences spending per enrollee is sort of everything else, and that's the changes in the breadth of the benefit package, changes in service use or intensity for a variety of reasons, perhaps related to medical practice, changes in payment rates that are perhaps above and beyond what price inflation might otherwise indicate, so sort of everything else.

And, now, I want to walk you through three examples in this table of periods where each of those things were more or less important to the per enrollee growth that we see.

So, from 1987 to 1991, which is the first column in the table here, if you look at the bottom, you can see that the average annual growth in medical prices was pretty high. It was eight percent per year, and that's reflected in both the Medicaid, Medicare, and private insurance growth rates that are seen here. So, even if nothing else was changing, we would have expected growth in the per enrollee numbers to be relatively high, just because of price inflation.

Moving across to the 2005-2006 period in the middle of the table, this is an example where a change in the breadth of the benefit package had a really big impact on Medicaid and Medicare spending per enrollee. And, of course, in 2006, the Part D Medicare drug benefit was implemented. So, that had two effects. One was to shift a fair amount of spending from Medicaid to Medicare, because drug costs for dually eligible beneficiaries that were previously covered by the Medicaid program were shifted to Medicare. So, we have a decrease in Medicaid spending per enrollee in that year. Medicare picked up those costs, and it also picked up the costs of drug spending for non-dually eligible beneficiaries. So, that's why we see such a big

increase in the Medicare spending per enrollee.

And, then, I will focus on the 2013-2014 and the current year change. What you see here is a decrease in Medicaid spending per enrollee of a little bit under one percent, and a lot of that is because we added a lot of new adults to the program who are relatively inexpensive and they've brought down the average spending per enrollee in the program.

In terms of the future projections, for 2014 to 2022, which is the column all the way on the right side, Medicaid, Medicare, and private insurance are expected to grow about on par with each other over that period, and we can talk more about that, if you'd like, during the question and answer session.

Now, I'm going to turn it over to Nick, who's going to talk about Medicaid's share of state budgets.

* MR. ELAN: Thank you, April. I'm going to go over some of the details of Medicaid's share of state budgets.

As April mentioned, there are multiple ways of measuring Medicaid's share of state budgets, but we looked at two main ways. The first way is to consider Medicaid

spending from combined state and federal sources out of overall state and federally sourced expenditures. Using this measure, we found that Medicaid accounted for 24.5 percent of spending in state fiscal year 2013.

The second way of measuring Medicaid spending is to consider only the state-funded portion of state budgets, excluding all federal money. Using this measure, we found that Medicaid accounted for 18.9 percent of spending from state general funds and 15.1 percent of spending from all state funds, which include bonds and other state funds.

I should note that, typically, MACPAC considers all state funds rather than just general funds, because non-general state funds include provider tax revenue and local funds that flow through the state budget.

Now, these two charts show the distribution of state budgets, including and excluding federally sourced expenditures. The chart on the left covers total state budgets. The dotted portions show the federal portion of each category, and in the Medicaid category, which is colored blue, the dotted portion reflects the majority of Medicaid spending that comes from federal funds.

Looking at the chart on the right, which breaks

down only the state-funded portion of state budgets, we can see that because Medicaid accounts for a 15 percent share of the budgets instead of 25 percent, a greater portion of the budgets is left for elementary and secondary education, higher education, and other spending.

Another factor to consider is local government spending. We would do that because Medicaid and education spending are often compared to each other, but elementary and secondary education is substantially funded at the local level. Considering just state government spending, including federal dollars, Medicaid's share was about 25 percent in state fiscal year 2013, compared to a 30 percent share for education. But, in a preliminary analysis, when considering state and local government spending together, we found that Medicaid's share was reduced to about 17 percent or less in fiscal year 2012 while education's share stayed about the same, at 28 percent.

Now, we also looked at Medicaid's share of state budgets over a longer time period, going back to state fiscal year 1987. Regardless of how we measured Medicaid's share, we observed the same basic trend, which is a trend of general growth, over the period. The one exception to

this was in 2009-2010, when the share of total state budgets continued to increase while the share of state-funded budgets either stayed the same or decreased. This decoupling can be attributed to the stimulus bill, which temporarily increased the federal medical assistance percentage, or FMAP, for all states, allowing for a lower state contribution. When the temporary FMAP increase expired, this decoupling ended, and by 2011, the previous trend resumed.

And here is an illustration of the trends I just mentioned from fiscal year 1997 to 2013. The top line here is for the measure that includes all federal and state funds. The middle line is for state general funds only. And, the bottom line is for all state funds. And, recall, as I mentioned earlier, the bottom line is typically what MACPAC reports for state spending as opposed to general fund spending, because it includes spending from provider tax revenues.

Finally, I have one last exciting chart to share with you.

[Laughter.]

MR. ELAN: This shows the state variation in

Medicaid's share of state-funded budgets, excluding federal funds, from fiscal years 1998 to 2013. There's a lot going on here, but the highlighted lines show the trends in aggregate and median state shares for Medicaid, while the gray lines in the background show each state individually, which gives us a glimpse of the variation among the states.

But, there are three things to point out in this chart. Some of the variation, especially at the higher levels, can be explained by unusual state accounting practices. But, as you can see, most states are clustered around the median.

We can see that -- the second thing -- we can see that the median state share is lower than the aggregate. An aggregate is the sum of Medicaid spending for all states divided by the sum of total expenditures for all states, which would have the effect of giving greater weight to larger states with larger budgets. On the other hand, median means half of the states are above and half of the states are below that level, which would give an equal weight to each state regardless of size.

The third point I would like to make is that this chart appears to show a less steep trend than the previous

graph, even though the numbers are the same. This chart covers a shorter time period and is wider, and that shows how the manner of display can affect the appearance of the trend.

And, now, I'm going to turn it back over to April.

CHAIR ROWLAND: That is a great point.

[Laughter.]

MS. GRADY: I don't know if I can follow that exciting chart now. I'll try.

[Laughter.]

MS. GRADY: So, I'll tell you a little bit about changes that we saw last year, fiscal year 2014, and what we might expect in the future.

CHAIR ROWLAND: You know, it does also point out that, now that you're going to go to the expansion and the new federal funds, that it's going to be very hard to extend this beyond 2013, because it's going to be influenced very differently by what happens in the expansion states versus the non-expansion states. So, to 2014.

MS. GRADY: So, in 2014, what we saw in terms of

overall Medicaid spending was eight percent growth. Total Medicaid increased from about $460 billion in fiscal year 2013 to nearly $500 billion in fiscal year 2014. However, the growth in Medicaid spending was heavily tilted towards the federal side of the house. There was about a 13 percent increase in federal spending and only one percent increase in state Medicaid spending.

Of course, the increase in federal spending was driven, in part, by the availability of the 100 percent federal match for many of the new adult enrollees in Medicaid, which had the effect of increasing the share of Medicaid's benefit spending to 60 percent from its historical average of 57 percent.

Moving from the federal spending picture to focus on what happened with state Medicaid spending in fiscal year 2014, first, I want to point out that growth in state spending was generally lower in expansion states, which are shown on the left side of the chart here. So, again, this is just state spending, excluding federal dollars, for Medicaid. So, as you can see, the median growth rate for expansion states was 1.4 percent, and actually, if you look at all of their spending in those states, it actually

decreased by two percentage points, and the difference there is that the overall number is heavily weighted, as Nick explained, by some of the larger states, including California and New York that you see at the top there, who had, actually, seven percent decreases in their state Medicaid spending.

The right side of the chart shows growth in state spending in non-expansion states, and as you can see, median growth rate was higher. It was 4.2 percent. And, instead of there being a decrease in state spending, there was a healthy seven percent increase in state spending in non-expansion states.

The second point that I want to make, in addition to this variation, is that the slide only shows state Medicaid spending, and as I'll discuss on this next slide here, even expansion states with an increase in their state Medicaid spending may still be seeing savings in their overall state budgets for a variety of reasons.

To date, we've seen information from nine states that indicates that the savings they're experiencing from expansion offset any increased cost they may have from increased participation among previously eligible but

unenrolled individuals who would be coming on to the program with regular FMAP.

In terms of some of the effects on state budgets in expansion states, the savings are a result of three factors. The first is increased federal Medicaid funding, or the availability of federal Medicaid funding for activities and populations that were previously funded with state-only dollars, including things like programs for the uninsured. Because the people served by those programs are now eligible for the Medicaid program, effectively, the state is able to free up state dollars and replace them with federal spending, and they may choose to use those state savings in any way they see fit.

The second reason that states are seeing savings is that they are receiving an enhanced FMAP for some new adult enrollees who otherwise would have qualified under regular FMAP pathways. I will not get into all the reasons for this. We are going to be looking at this in the near future and coming back to you with a more complete discussion of some of the eligibility and FMAP claiming issues that are at play here.

The third factor is increased revenues from taxes

on providers and health plans who are seeing increases in their own revenues from the results of the coverage expansions in these states.

In terms of the next steps that we're planning, as Diane mentioned, we are going to be using the information in this presentation as the basis for an issue brief that will be posted on MACPAC's website.

And, I'm not going to read all of these issues, but we are going to continue to monitor relevant topics. And, a few that I'll call out today because we didn't really talk about them here- One is the federal budget perspective, of course, including projections of growth in Medicaid along with other major entitlement programs, like Medicare and Social Security; and the implications for the future. We'll also be, as I mentioned, coming back to you with issues surrounding the enrollment process for the new adult group and the newly eligible FMAP claiming for individuals coming into the program through this pathway.

Thank you.

CHAIR ROWLAND: Thank you both.

You know, I think it's very important that you do the per enrollee cost growth as well as the overall cost

growth because that really tells a very different story, and much of what's driving, obviously, the increases in spending is because of the enrollment increases, both during the recessionary times and now during the expansion times. So, I think this is a great start, but, I think, to add in the picture of what's driving these spending increases is very important, just to get that context, and especially to keep a focus on the per enrollee versus the overall growth.

Okay. Mark, Trish, Chuck, Yvette.

COMMISSIONER HOYT: A couple of comments based on, I guess, my own war stories. First off, definitely exciting charts. I'm glad you --

[Laughter.]

COMMISSIONER HOYT: It gives an actuary chills, just looking at it.

[Laughter.]

COMMISSIONER HOYT: I'm glad you guys are doing this.

I think we're all aware of this, but I don't think you can overstate or state often enough, the bane of a state treasurer's existence is having to balance the

budget every year. So, just think about where that would fit. I'm thinking particularly on Slide 13. I believe it's a fact that Medicaid expenditures vary much more widely than tax revenues do, and in particular -- I mean, we're generalizing, but they tend to be countercyclical, so that when things are good, they're really good, and when they're bad, they're awful. So, when the economy goes down, you have more people eligible for Medicaid, higher expenditures, and then tax revenues decrease.

I don't know that you can tease this out from data, but I had a very memorable meeting with a guy who got his finger right in my face, the treasurer, notifying us that we were the biggest problem they had because in a good year, he said, his tax revenue would go up about two percent -- that's what it was this year -- and, he said, and you want all of it. So, the percentage of the new money that Medicaid takes from state revenues sometimes causes a huge amount of consternation in budget negotiations and everything else.

So, it's a little different than what you've got here, and all this stuff is good, but, boy, that's a flashpoint sometimes when they're looking at how much the

tax revenue may go up, and then because of all the factors we're aware of, Medicaid wants half of it or something, and it makes --

CHAIR ROWLAND: You know, we often talk about tax revenues going down, or revenues going down because of recessions, but they also go down because of tax policy and tax cuts, and I think tracking some of those is also important, because that puts a different kind of pressure on the budget than Medicaid.

COMMISSIONER RILEY: Well, this is terrific, and I think it is especially great that you've made an apples-to-apples comparison with the state and local. It's terrific, though I think our audience is very mixed, because there are those who suggest that spending growth is just too high, no matter what.

I think Chart 18 may need a footnote and some description in the policy brief because I think it misrepresents and makes the median growth rate for the non-expansion states actually lower, because Maine's growth rate was lowered in 2014 because they cut eligibility for everybody who had been expanded, the adults to all the levels of the ACA, and they cuts lots and lots of people

off coverage. So, that seems to me to skew the results and is worthy of at least a footnote.

MS. GRADY: I will point out, with Maine in particular, too, it appears that one of the reasons for the big decrease in fiscal year 2014 is because there was an abnormal increase in 2013 associated with some sort of hospital settlement. So, this also just goes to show if you take any two points in time, there's a lot of things going on and there will always be anomalies of some sort.

CHAIR ROWLAND: Chuck.

COMMISSIONER MILLIGAN: So, this is always a fun and interesting topic and I commend you on your work here, and Slide 15 reminded me I needed to get the windshield on my car fixed.

[Laughter.]

COMMISSIONER MILLIGAN: So, I have two comments I want to make here. The first is really sort of the Slide 14 kind of related data, and I just -- I don't know that you need to add this to the issue brief, but I want to provide a little bit of context. There are times in which the state general fund contribution to Medicaid went up as a deliberate state strategy to Medicaid-ize otherwise 100

percent state-funded services.

So, you would see a lot -- and legitimately, fairly, appropriately -- IEP programs for kids in school, and foster care-related costs and other things. But, some of this growth was the substitution of Medicaid match for something that would otherwise be 100 percent state funded. And, so, some of this growth -- and some of the fact that Medicaid is eating more state budgets was a deliberate strategy to mitigate budget pressure at the state level. So, I think that that color commentary, which applies to a lot of services over the years where the feds have gotten concerned about maximization, but there is legitimacy to a lot of it, that's part of the story, going back to 1987.

The second comment I want to make, and I want to, I guess, follow up on Diane's comment about the per enrollee spending, I think that per enrollee spending can also be -- can confuse and somewhat distort the picture -- and there's really great data out of SHADAC. They do their biennial review of insurance coverage rates by payer. And, what -- so, I'm drawing attention to Slide 8 here.

Over the course of a lot of the years from maybe the late 1990s through recently, is there has been a fairly

seismic shift in the under-65-year-old population out of employer-sponsored insurance and into Medicaid and CHIP, and a lot of that was in response to not only people losing their jobs and losing access to ESI, but employers raising their premium contribution levels, therefore, employees dropping coverage, as well as the shifts in employer-sponsored insurance.

And, the effect of that is -- and there's really good data from SHADAC -- is you see a lot of dependent coverage, like kids, in particular, coming out of employer-sponsored insurance where they were picked up by the employee as a dependent, dropping their family dependent coverage and the kids then coming into Medicaid and CHIP because it was available and was a way for a family to manage a family budget, and there is very significant, like millions of kids, I think, in the data from SHADAC, over the course of late 1990s to last year, substituting Medicaid and CHIP for dependent coverage in ESI.

And, what that means for a per enrollee is that Medicaid's population mix was changing quite a bit to a generally healthier, generally more affluent population of kids, often. And, so, I think that we have to be really

careful about how we measure spending per enrollee to make sure we are not just reflecting a change in the mix of who has insurance over time.

CHAIR ROWLAND: April, this is Medicaid spending exclusive of CHIP?

MS. GRADY: Yes. It is just Medicaid spending. That's correct.

COMMISSIONER MILLIGAN: Well, in Maryland, that would include kids up to 300 percent of poverty --

COMMISSIONER ROSENBAUM: I was going to say, in a lot of states, there is no separate CHIP, or the threshold --

COMMISSIONER MILLIGAN: It's a Medicaid expansion.

COMMISSIONER ROSENBAUM: Right.

COMMISSIONER MILLIGAN: And, there was no crowd-out prohibitions if you did a Medicaid expansion, and so I think that -- I think that we have to be really careful that we're not reflecting -- because it's not a constant population over time and we're measuring just premium costs. It's --

CHAIR ROWLAND: But, the other analysis that can

go underneath that is if you look at by beneficiary type, the per enrollee spending is still very low, even for those in --

COMMISSIONER MILLIGAN: No, I want to make sure that we accurately depict the data and that it doesn't look like we're -- I agree with you completely, Diane. I want to make sure that we don't have a roll-up number that is revealing the data in a way that looks like there's a bias. I want to be just very careful about that.

CHAIR ROWLAND: Of course. When most people see the low per enrollee spending under Medicaid, they say that's because Medicaid doesn't pay enough for services and that it's a fact that the price of care under Medicare and private insurance is going up at a rate that Medicaid is not matching --

COMMISSIONER MILLIGAN: People tend to see what they're looking for, yes.

CHAIR ROWLAND: Okay. I have Yvette, and then I have Peter and I have Sharon.

COMMISSIONER LONG: This is very important data that you guys had presented to us. I support MACPAC in making it public because there's a lot of misinformation

out there, and to have these charts just to see how things are, you know, spending on the budget level.

Well, two things I just want to say is explaining now -- I'm trying to read my own notes here -- explaining that Medicaid spending increased just like health care increases, and Medicaid spends less per person -- spend less on -- spend less per person than the private coverage. What these charts tell me is that--from what I gather here--is that I read something totally different, and I don't know where I got the information from, and I was prepared with two pages here to talk today, but apparently we're not talking about spending caps or what not. Do we have any information on that? Is that what they're proposing or want us to begin to look at or something? I'm just asking.

MS. GRADY: There are a variety of proposals that have been introduced in Congress and discussed elsewhere, and that is something that we're going to be looking at in the future.

COMMISSIONER LONG: It is? Okay. Thank you.

CHAIR ROWLAND: Yvette, that was in the letter that came to us from the Congress as an area for us to consider exploring further.

COMMISSIONER LONG: Hang on to that sheet.

CHAIR ROWLAND: So, hang on to your sheet.

Okay. Peter.

COMMISSIONER LONG: I was prepared for all that, so --

[Laughter.]

COMMISSIONER SZILAGYI: You'll get your time.

CHAIR ROWLAND: You'll need it someday.

[Laughter.]

COMMISSIONER SZILAGYI: I just had a question for Chuck. Were you talking about crowd-out, because I don't know the evidence as well for Medicaid, but I know it very well for CHIP, and crowd-out is extremely low for CHIP, true substitution -- that the reason -- I just don't want there to be misunderstanding in what you said. The reason that most people -- that many children enrolled in CHIP and went from commercial to uninsured to CHIP is not crowd-out. It's because they lost their jobs and their income went down. The latest CHIP evaluation by Mathematica found a crowd-out rate of four percent only.

So, I'm not sure whether you were really talking about -- or a substitution rate of four percent. I'm

worried that the misunderstanding of what you might say -- of what you said might be that families are purposefully dropping commercial insurance to enroll in Medicaid and CHIP, and the data in CHIP is not showing that at all.

COMMISSIONER MILLIGAN: Umm --

COMMISSIONER SZILAGYI: Across the country. I don't know about Maryland, but across the country.

COMMISSIONER MILLIGAN: No, no, I was speaking at a national level, and I was not trying to offer a hypothesis of what was happening. I was trying to reflect the fact that if you look at the data in these biennial SHADAC studies, and they're very well researched, that through the course of time, there is a high correlation between employer premiums going up and kids moving into Medicaid, into -- how SHADAC puts it is public insurance that includes Medicaid and CHIP. It doesn't differentiate the two.

And, it is a very -- if you look at the under-65 population, there's a very stark shift from about 68 percent of all of those individuals getting coverage through ESI in the late 1990s to about in the high 50 percents now, and Medicaid -- the public insurance picking

up a lot of that, and it doesn't tie to -- it doesn't neatly tie to recessions, to the ACA. But there has been, somewhat outside of the radar of a lot of policy, a lot of growth through the course of -- so, I mean, substitution in a different sense, which is people who once had coverage through ESI now having coverage through public programs, not families making a deliberate decision --

COMMISSIONER SZILAGYI: Right.

COMMISSIONER MILLIGAN: So, if I overstated it, I'm glad you gave me the chance to --

COMMISSIONER SZILAGYI: The reason is that they dropped into poverty.

CHAIR ROWLAND: Well, there's also been a tremendous change in where the jobs are and whether health insurance comes with the jobs. It's not just premiums, but it's also the change in our manufacturing base.

COMMISSIONER MILLIGAN: It's multivariate, and I guess the main point I'm trying to make, which I think is a fair point, is spending per enrollee can confound whether we're watching a population mix change over time. That's the key point.

COMMISSIONER SZILAGYI: Oh, yeah. No, I agree

with that. I agreed with that, and the population that went from ESI to uninsured to Medicaid or CHIP is probably a lower-cost population than populations that were long-term in Medicaid, and so that -- but, I just wanted to make sure that people don't kind of over-interpret what you said.

COMMISSIONER ROSENBAUM: To Chuck's point, regardless of whether it's causal or just it happened, that one form of coverage of dependents has sort of disappeared and another form of coverage has appeared, the children who essentially disappeared from one side and reappeared on the other side are potentially quite different in terms of their overall health status from classic children on Medicaid who were desperately poor. This group is low-income, but not the same.

CHAIR ROWLAND: But, this is also the result of a deliberate policy choice, as it expanded Medicaid eligibility. So, what we're really looking at is the policy impact of adding millions of children to Medicaid, and pregnant women, as well.

EXECUTIVE DIRECTOR SCHWARTZ: I think this went from an issue brief to an issue long.

[Laughter.]

COMMISSIONER MILLIGAN: Well, we just need to be careful to say that Medicaid wasn't so awesome at containing costs, that it's so much better than other insurance, if we will then -- we're inviting a comment that we're not adequately accounting for the mix change over time, unless we just reflect that somehow. A footnote would make me just ecstatic. That's --

[Laughter.]

COMMISSIONER MILLIGAN: I just want to make sure that we're not saying Medicaid is just the best at managing costs, because it may be a mixed change.

CHAIR ROWLAND: Marsha.

VICE CHAIR GOLD: I have a really dorky comment. I assume -- I wanted to pick up on your comment that there's a lot of ways to show these charts and they look different. I hope -- I assume when you play around with this as you're doing the issue brief you'll refine things. But, on Chart 11, I think, you know, where you have the two pie charts, I think you might play with making them two bars that are different sizes, because that may help make it clearer what's going on. So, I encourage you to

experiment with different ways of showing things and see which ones you like.

MR. ELAN: So, I'm actually working on something just like that, and so --

[Laughter.]

CHAIR ROWLAND: And I'm glad we have a graphic designer.

EXECUTIVE DIRECTOR SCHWARTZ: Now, we can now make donuts without even graphic design help.

[Laughter.]

CHAIR ROWLAND: Sharon.

COMMISSIONER CARTE: I think I'm going to pass. I think there was enough comment. I was going to ask Chuck for a little bit more clarification, but I can get that later.

CHAIR ROWLAND: We've gone around that pie, and we still have a hole in the middle.

[Laughter.]

CHAIR ROWLAND: Okay. Thank you both.

So, now we've gone an issue long, as Anne put it. And, finally, we're going to go back to another proposed rule, on the extension of the 90/10 matching rate for

eligibility and enrollment systems. So, Martha and April.

Session 7: Proposed Rule for Extension of the 90/10 Matching Rate for Eligibility and Enrollment Systems

* MS. HEBERLEIN: Okay. So, on April 16, CMS issued a proposed rule to permanently extend the enhanced matching rate for eligibility and enrollment systems. The comment period goes to June 15, and we thought you might want to weigh in, so we wanted to bring some information to you about the proposed rule.

So, I'll start today with a brief background on the need for the new systems, a little background on the prior regulations and guidance that CMS issued back in 2011, as well as states' use of the 90/10 match, and then I'll turn it over to April to talk about the current proposed rule as well as any possible areas for comment.

So, prior to the ACA, a number of states were relying on legacy mainframe eligibility systems that were decades old. More than ten years -- sorry. Roughly half the states reported having systems that were more than ten years old, and 12 of them were between 20 and 40 years old. So, the eligibility systems that they were relying on were just not cut out to accommodate the ACA changes to the

eligibility rules and processes.

So, for some of these, as you know, it's the use of the modified adjusted gross income. They needed to have new income rules that they needed to implement, as well as share information with the federal exchange and rely on electronic data for both eligibility verification at application and conducting administrative renewals.

In large part because these systems were so old, they just lacked the technical capacity to institute these reforms and so the states really needed to upgrade or build new systems in order to do that.

So, in recognition of these changes in the ACA, CMS issued a 2011 rule that allowed for the temporary, until December 2015, matching rate of 90 percent for eligibility and enrollment systems. So, while most administrative activities in Medicaid can be matched at 50 percent, Congress had allowed states to receive an enhanced 90 percent match for the design and development and 75 percent match for the ongoing operations of MMIS systems.

However, because the eligibility and enrollment systems were typically run out of welfare and social services agencies, the eligibility and enrollment systems

were exempt from this enhanced match. So, the 2011 rule changed that policy and allowed states to receive the enhanced match for the design and development of new eligibility systems.

As I said, the 90 percent match was time limited. They limited it, thinking that as of the end of this year, that states would have made the changes necessary to implement the ACA.

At the same time, CMS, along with the ACF and USDA, provided guidance to states that provided a time limited cost allocation waiver, where states normally would have to -- or programs within the state would normally have to share with Medicaid the cost of upgrading the systems, this allowed states to upgrade their TANF and SNAP systems at the same time without having to cost allocate those. It was seen as a way to allow other human services to benefit from the changes that were coming in Medicaid as well as to encourage just some integration. Prior to the ACA, the vast majority -- 45 states -- had integrated eligibility systems, so the idea was to encourage states to reintegrate as they went forward.

So, as of the end of the last fiscal year, all 50

states and D.C. had taken advantage of this higher matching rate. Their reported spending totaled about $1.8 billion, with the federal government spending about $1.6. The degree of the spending varied, as based upon how much of an upgrade the states needed. About two-thirds had to build fully new replacement systems, whereas 17 upgraded existing systems, and it was typically states with newer systems that only had to do upgrades, whereas the older systems needed to start more from scratch. Those states that were modifying their existing systems spent about half as much, on average, than those that were doing full system replacements.

As of now, not all system improvements have been completed, despite the interest in states and the ongoing work. There are a number of things that remain to be done. The non-MAGI groups still remain in the legacy systems in most states, so states are working to move those over. They're also working to reintegrate with the other human service programs, such as SNAP and TANF.

So, with that, I will pass it over to April, who will talk a little bit about the proposed rule.

* MS. GRADY: Thanks, Martha.

As Martha mentioned earlier, the proposed rule was issued last month and it would permanently extend enhanced funding for the Medicaid eligibility systems. CMS also announced an extension of the cost allocation waiver through 2018, which would continue to allow the other programs to benefit from the 90 percent match for the Medicaid integrated systems upgrades.

CMS extended the rule, you know, in part saying that the operation of these systems is really an integral part of administering the program, and in terms of program management, very important. It also recognizes that more time was needed. As Martha said, states are not -- not all states are going to be able to complete their work by 2015, and even if they were, there is a recognition that future policy changes and considerations may require additional upgrades beyond this year.

CMS has proposed tying some new conditions to this match to increase the accountability for federal dollars that are being provided. One example is that states are going to have to identify key personnel who are going to be working on these systems upgrades, including the amount of time that these folks are dedicating, so some

pretty detailed information about how these projects are going to unfold.

They're also required to develop mitigation plans. In the case that an upgrade fails, doesn't meet the milestones that it set out to achieve, the state needs to describe how it's going to mitigate the potential effects of that failure. So, we want to avoid a situation where there are application backlogs and other problems to address.

Another requirement is to provide clear documentation of the system and its operations so that the state is not beholden to a small group of staff or a single outside contractor. The idea here is to have a number of people have access and understanding of how the system works.

There are other changes proposed, and that includes a 75 percent matching rate available as portions of the system are upgraded. As the rule currently stands, the entire system has to be finished before you can get the 75 percent match for the operation of the approved system. CMS is proposing to move to a more modular approach so that states can take the money and accomplish things along the

way. It doesn't have to be a huge overhaul. Progress can continue to be made with enhanced match. As I mentioned, the cost allocation waiver has been extended.

We offered three possible areas for comment in the background materials that you have and are looking for your comments on these and other potential areas.

The first is eligibility process improvement. Of course, we know that these upgrades are needed for both administrative efficiency purposes and to improve the beneficiary experience. States are still upgrading their systems to be able to have the functionality to do administrative renewals, for example, so that they don't have to go back to enrollees to ask for additional information. They can use data that's been pulled from existing electronic systems outside of the Medicaid agency. They're also bringing new populations into the eligibility system, so they've migrated a lot of the MAGI-based populations, but now other folks, people with disabilities, elderly enrollees can also be brought into the system. And the other programs, the other human services programs, TANF cash assistance and SNAP food assistance can also be brought into the fold. So, there are both administrative

and beneficiary improvements that could be had here.

The second possible area for comment is with regard to enhanced data collection and reporting. I feel like we're beating a dead horse, but the Commission has discussed on many, many occasions the need for good information, and if we want good information at the federal level, we're going to have to invest in the state systems that produce the data that gets sent to the federal government. The Commission has previously commented on this issue in its March 2011 report and its June 2013 report to Congress. And in that most recent report, you expressed strong support for increased staffing and resources and investments in these systems. So, a comment supporting this 90 percent match would be consistent with the previous statements the Commission has made on this front.

The third possible area for comment is its potential for extending administrative capacity. Last year, in the June report, you had a variety of discussions of state administrative capacity and the need for approaches to better manage these programs, to allow for better staffing, more resources to be put into developing

efficient and economical programs. And, one of the things that was discussed is the potential for using targeted enhanced federal match for purposes of extending administrative capacity. The current rule provides that sort of enhanced match but also ties it to some outcomes and standards, and you may want to comment on that serving as a potential model for additional enhanced matches to be provided in the future for other administrative purposes.

That's all we have and welcome your comments.

CHAIR ROWLAND: Thank you, April.

It appears to me that this reg, rule, would do much of what we have tried to say should happen in this program, that it leads toward trying to get modernization of the data systems, simplicity and streamlining, especially across programs. I think it's very important to recognize that you can't run a program without good data, and there clearly is an emphasis now. You can try. But, I think it also does reinforce our earlier comments that we should invest in making sure that some of these changes happen by increasing match rates, when possible.

So, I think this is an area where our previous comments would lend us to lend support to this, but I'll

take any comments from the Commission members. Trish.

COMMISSIONER RILEY: I think it's great. I don't know if we want to speak to -- I think the fact that it helps the legacy systems get upgraded, because the fact of the dual systems is really confounding and I think that's very important.

It also -- I don't know how much we want to talk about this, but the fact that -- you mention the exchanges, and both the FFM and the state exchanges. This is an important part of ending the cliff and meeting the ACA's promise of ending the cliff of eligibility so that there's a seamless eligibility process for both the tax credits and Medicaid, and I think this can only help.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: Yeah. And, the other thing I really liked about the proposal was that it also speaks to human capital, in other words, that you don't just upgrade the system. You make sure that you've got human capacity inside your Medicaid program, you know, that it's not just held at the vendor level, that you really are using this to strengthen your human operational capacity, as well.

CHAIR ROWLAND: I also like the fact that it recognizes that these systems don't always work properly and that you need a strategy for what you do when it doesn't work, which, I guess, is a lesson that everyone learned with the implementation of the ACA.

Okay? All right. So, we will send in a letter reinforcing those points, and we will then take any public comment that anyone would like to offer before we adjourn for the day.

[Pause.]

CHAIR ROWLAND: There's a mic if anyone -- is there anyone who would like to come forward? Please do so now.

Public Comment

* [No response.]

CHAIR ROWLAND: Seeing and hearing no one, we will adjourn for the day and reconvene tomorrow. Thank you all for your participation.

[Whereupon, at 4:38 p.m., the meeting was recessed, to reconvene at 10:00 a.m. on Friday, May 15, 2015.]

PUBLIC MEETING

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

Friday, May 15, 2015
10:05 a.m.

COMMISSIONERS PRESENT:

DIANE ROWLAND, ScD, Chair
MARSHA GOLD, ScD, Vice Chair
SHARON L. CARTE, MHS
DONNA CHECKETT, MPA, MSW
ANDREA COHEN, JD
GUSTAVO CRUZ, DMD, MPH
HERMAN GRAY, MD, MBA
MARK HOYT, FSA, MAAA
NORMA MARTÍNEZ ROGERS, PhD, RN, FAAN
CHARLES MILLIGAN, JD, MPH
PATRICIA RILEY, MS
PETER SZILAGYI, MD, MPH
STEVEN WALDREN, MD, MS

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[10:05 a.m.]

CHAIR ROWLAND: Good morning. It's a pleasure to begin today to review what evidence we have on some of the impacts of cost sharing and other provisions on children's access to care and on their ability to afford the care that their families try and purchase or obtain for them. This really is beginning to lay the groundwork for the next iteration of our recommendations on the future of children's coverage in the CHIP program.

We're glad that the CHIP program has been extended for 2 years, but 2 years is a very short time frame to resolve many of the issues that were raised around the need for the extension. And so Veronica and Joanne are going to really lay out for us the first part of our consideration of some of the key factors we need to take into account as we move forward to develop better policy for children.

Session 8: Design Considerations for the Future of Children's Coverage

* MS. JEE: Good morning. With the CHIP funding extended for 2 years, through fiscal year 2017, the

Commission has an opportunity to have a more deliberative discussion about children's coverage more broadly.

To begin that conversation today, we're going to provide a brief update on where the Commission is with its work on children's coverage. Then we're going to share with you some information that you all had previously requested of staff.

Veronica will share findings from a review of the literature on the effects of premiums and cost sharing, on access to coverage and use of services and outcomes for children, and after that I will provide a brief summary on what we've learned regarding how income and subsidies are related to one another in other federal programs.

Commissioners, we're providing you this information as background, and we hope that it will inform future analysis that you all will undertake. We expect to bring these pieces back to you again in the fall and possibly beyond that in support of your deliberations on approaches to children's coverage, including affordability.

So to just provide a very brief update, the Commission's March 2015 report has been issued, and it includes several chapters regarding CHIP and children's

coverage, including sources of coverage if CHIP funding were not extended, affordability of coverage, adequacy of benefits, and provider networks. And, of course, at the time of publication, the CHIP funding had not yet been extended. So while the funding question is no longer front and center, the issues in the March report certainly remain pertinent.

So with that, I'll go ahead and just turn it over to Veronica to share her overview.

The Impact of Cost Sharing on Access and Use of Services

* MS. DAHER: Thank you. I'm going to be giving an overview of the literature on how premiums and cost sharing affect access and outcomes.

The Commission now has the opportunity to begin to articulate its vision for children's coverage in the long term. One of the key issues will be determining an appropriate amount of cost sharing for low- and moderate-income families. So to answer this question, it's important to consider how premiums and cost sharing affect these families.

Premiums and cost sharing are a feature of

virtually all insurance, but Medicaid and CHIP have historically imposed low or no out-of-pocket costs because they serve a low- and moderate-income population.

While there is some authority to charge small premiums in Medicaid, federal law generally prohibits premiums for children and for people below 150 percent FPL. Separate CHIP programs permit more cost sharing than Medicaid, but combined expenses for premiums and cost sharing may not exceed 5 percent of a family's income.

It's important to distinguish premiums from other types of cost sharing. Premiums are likely to affect the decision to enroll in or disenroll from coverage. Other cost sharing, such as co-insurance, co-pays, and deductibles, is more like to affect a person's decision to seek out treatment once they have insurance.

So this review looks at studies of the effects of out-of-pocket costs on children's access to care and health outcomes. On issues where there was limited evidence regarding children, we looked at studies of adults.

There are some methodological limitations in many of these studies, both in terms of study design and how changes are measured. But this is described in more detail

in your paper.

So cost sharing includes deductibles, co-payments, or co-insurance at the point of service. However, those who are insured may face barriers to care if they can't afford these costs.

Virtually all employer-sponsored insurance plans, Medicare, and exchange plans charge some premiums and cost sharing, and there are several reasons that they do this. Cost sharing may reduce use of unnecessary services. It can also steer enrollees to more cost-effective or preferred services. And premiums and cost sharing may shift some of the costs of health care from plans to enrollees. And, finally, another rationale for both is to encourage personal responsibility in health care purchasing decisions. However, the literature shows that there are also other consequences to premiums and cost sharing as well.

So studies have found that increasing public insurance premiums leads to significant decreases in enrollment for low-income children. For example, in one study, increased CHIP premiums led to fewer new enrollments in Kansas and New Hampshire and faster disenrollments in

Kentucky and New Hampshire. And this effect was greater for children who were lower on the income scale.

Another study found that $10 per month premium increases for children eligible for Medicaid or CHIP were linked to decreased enrollment for all children, but more so for lower-income children between 101 and 150 percent FPL. Children above 150 percent FPL experienced a reduction in public coverage, but it was nearly offset by an increase in private coverage. These findings were part of the evidence that led to the March 2014 Commission recommendation that states eliminate separate CHIP premiums for those under 150 percent FPL. And, in fact, even a $5 per month increase has been shown to decrease child enrollment, with the greatest effects, again, on children between 101 and 150 percent FPL.

However, children with chronic illnesses in general are less likely to disenroll from CHIP than healthy children, and some studies have found that they are also less sensitive to those premium increases than healthy children.

Cost sharing at the point of service can also affect access to care and increase financial distress. For

example, a study of Alabama's CHIP program found that after co-payment increases of $3 to $5 per service, use declined significantly. In a study of low-income children with asthma, cost sharing was associated with delays in care and financial distress. Parents below 250 percent FPL with lower cost-sharing levels were less likely to delay office visits or emergency department visits for their children, as were parents of children enrolled in Medicaid or CHIP compared to commercially insured children in the same income group who had higher cost-sharing levels.

Parents and families with incomes at or below 250 percent FPL with higher cost-sharing levels were more likely to report borrowing money to pay for a child's asthma care than those in the same income group who had lower cost sharing.

Notably, in response to cost sharing, poor children as well as adults in all income groups have been shown to reduce the use of highly effective services as much as rarely effective services. The seminal RAND Health Insurance Experiment found that enrollment in any cost-sharing plan was linked to a reduction in the use of health care when compared to those assigned to the free care plan.

However, for most participants, using fewer services did not adversely affect health. For low-income, high-risk participants, enrollment in the free care plan versus the cost-sharing plans produced a statistically significant difference in the risk of dying score at exit, which researchers based on smoking habits, cholesterol level, and blood pressure.

And also in the RAND experiment, while children on cost-sharing plans did use fewer medical services, there was no significant difference in health outcomes between the free and cost-sharing plans. However, the children did have better dental health outcomes when care was free, including fewer decayed teeth and also better periodontal health at the end of the experiment.

So, in conclusion, the literature has shown that even small increases in cost sharing and premiums can significantly affect low- and moderate-income families. As the Commission considers policy options for children's coverage going forward, it's important to consider what level of premiums and cost sharing may encourage appropriate use of services without impeding access to necessary care.

And now we'll hear from Joanne.

CHAIR ROWLAND: Are there any quick questions? Veronica, before we move on.

COMMISSIONER CRUZ: I just have a very quick note of caution. When I was reading the paper on the dental outcomes, the measure that you used was the number of fillings, and that is not really a measure of better oral health. It may be a measure of overuse of services. So it's better to use -- if you find the unmet need, the number of decayed teeth, instead of the number of fillings.

COMMISSIONER CARTE: It's helpful to me to know that the co-payments can adversely affect -- whether it's less effective or more effective care, that's -- and our CHIP program, where we had co-payments, we always tried to provide an alternative where there would be none. For example, we might have a co-payment on a sickness visit to a physician's office, but if the family had selected a medical home, that co-payment could be removed. Similarly, if there was a co-payment on a drug, the co-payment could be removed if there was a selection of a generic. So that's one approach.

The other thing, even though I think it's really

helpful to know this, I'd note that a lot of these studies are older, go back to the 1990s, and I think it might be helpful to see -- yeah, there are some '80s and '90s, at a time when the whole uninsurance question could have been entirely different. I would find it helpful to see just some survey data now, you know, that might look at just that particular question. But other than that, this is very helpful information, and thanks for your work.

COMMISSIONER SZILAGYI: This is a very good summary of the literature, and I agree that there is a dearth of recent literature on cost sharing.

Just a couple thoughts. In terms of the context regarding the lack of a relationship to many of the outcomes, many measures of -- much of children's health results in the long-term outcomes and not short-term outcomes. So one would not be surprised that short-term outcomes weren't as well linked with cost sharing.

The second point is in terms of the dearth of literature -- and I think you're right in looking at the adult literature where you didn't find children's literature -- there is a whole other literature that you may not have looked at, and it's not exactly analogous, but

it's the high-deductible plan. There's some literature, there's some recent literature on the effect of cost sharing or high deductibles on children's health care recently. So that would be data in the last 10 years.

COMMISSIONER MILLIGAN: So I'm going to make a comment, but I'm not asking you to do more work about it. I just want to make sure that it's one the frame in case we come back to this topic. It's the relationship between the co-insurance, co-payment side of things and provider satisfaction, provider participation. I think from the Medicaid agency point of view, if you impose cost sharing, the provider perceives it as a fee reduction because they're going to have a hard time collecting that co-payment, and that can generate provider dissatisfaction, and that can generate provider disenrollment from the program. So there's an access issue that gets attention from the provider network angle, not just the access issue of providing the co-payment. So I just want to make sure we don't lose sight of the effect on providers of imposing co-insurance and co-payments.

CHAIR ROWLAND: Which we saw in the work we did on the duals cost-sharing issues as well.

COMMISSIONER COHEN: Great work, and thank you. I think this is such a contribution. I really do, just to sort of put this all down in one place for our thinking, it's so critical to sort of the decisions that everyone is going to have to make about CHIP and its future.

I wanted to just highlight one piece that I've always struggled with a little bit, which is in terms of the outcomes on the cost sharing in general, one of the bullets says, you know, cost sharing at the point of service can impede low-income children's access to care and increase financial distress. So it is the financial distress part that I urge us to be a little bit more sort of analytical and granular about, because I find that that piece of the analysis sometimes feels very circular and isn't sort of made as strongly as it could be, where obviously an organization that is focused on people's, you know, health and the performance of a health program, there's clearly -- there is literature, I know, that documents real relationships between health care and financial distress, and financial distress and health. But I think it can sometimes be circular to say that paying for something causes financial distress. It does. I mean,

everything we pay for, it means you're not -- you know, for most people it means you are choosing not to pay for something else. And so I think being a little bit more rigorous -- and maybe the literature is not there to be so, but then we at least should sort of point that out. I think it is -- it's something that, you know, people can both ignore if it's not explained in some more depth, or treat like it is a really significant finding on its own to just sort of say that, you know, premiums and cost sharing can cause financial distress. I really think to sort of make something of those we have to go a little bit deeper and sort of understand or analyze is this a financial distress that is something that rises to a level that, you know, Congress and policymakers might decide that it is the financial distress, you know, itself that they are kind of reacting to, or whether this is a more sort of circular and generic point around everything you pay for means you're probably not paying for something -- you know, it's a choice.

So I'm not trying to minimize the point of financial distress at all. It can be really significant. But I have just often found that in sort of reports and

literature it's treated like if you have to pay something that is in itself a harm because it's meaning you're not paying for something else or are not able to pay for something else, then the question of for whom and what, and does that mean food or does that mean a nicer car is a really significant difference that sometimes just gets really blurred. So I think the points can be made more sort of like in a tighter way. And, again, I'm sure some literature will support that and probably some will not at all, but I think it's a point worth clarifying.

CHAIR ROWLAND: I think it's also important that in much of the literature we're looking at a one-on-one relationship, and many of these families have more than one child. So if it's $5 for one child, it might not be a burden, but the same family might be bringing in three children, and if each of them has a $5 co-pay, then you're talking about a different level. So I think we just need to be clear about how things are counted for families.

Joanne, that was a good transition to you to talk about how other low-income programs handle these issues.

Eligibility under Federal Low-Income Assistance Programs

* MS. JEE: We spent much time over the last several months thinking about how low- and moderate-income families are affected by the differences in financial requirements and subsidies in Medicaid, CHIP, and exchange coverage. You asked us to look at how other federal programs structure subsidies relative to income, so that you could consider some possible approaches for making increases in family financial requirements, resulting from increased income more gradual when purchasing children's coverage.

So we looked at eight federal programs, which are listed on the slide that you see here. The five on the left-hand column generally structure subsidies so that they are reduced gradually as income increases. Whereas, the three on the right have more of a tiered structure in which there are less gradual changes to the amount of subsidy and, thus, cost to individuals or families.

The programs, of course, have their own program rules related to eligibility and the subsidies, of course, and those are described a little bit in Tab 8 of your meeting materials. And I won't talk about those things specifically this morning. Rather, I just wanted to talk

generally with you about how these programs structure their subsidies.

So this is an example of a program with a subsidy that is gradually reduced. Programs that do this generally provide a subsidy to some set maximum level, which can be established in statute or in program rules. Subsidy amounts are determined then by subtracting income or some required contribution by the individual or family from that maximum subsidy level.

This slide here illustrates generally how this work using SNAP as an example for a family of four in fiscal year 2015. So in this example, the maximum SNAP benefit limit is $649, which is the blue horizontal line up towards the top of the graph. In SNAP, families are expected to contribute 30 percent of household net monthly income toward the cost of food. So to calculate the amount of the SNAP benefit a family can receive, you subtract 30 percent of the household net monthly income from the maximum benefit level, again, which is $649 in this example.

So you see as income increases, the family contribution increases, and, thus, the amount of the

benefit decreases. And this is similar, generally, to how premium tax credits are determined.

CHAIR ROWLAND: Joanne, would you remind people what 100 percent of poverty is for a family of four?

MS. JEE: I believe it's about $32,000.

CHAIR ROWLAND: Four. Three is at 20-something, 22. I think it's important.

MS. JEE: I think that's high.

CHAIR ROWLAND: Is that high? Sorry.

I think it's always important when you're using that to also put at least one benchmark number on there. Thank you.

MS. JEE: So in this next example, which is based on the earned income tax credit program, there's a slightly different approach for determining the subsidy level. This example is for a married tax filer with two children in tax year 2014.

The blue line on this graph represents the value of the tax credit. The tax credit equals a set percentage of income until the tax credit reaches the maximum tax credit level, which is indicated by that first green arrow on the left-hand side, and that's about $5,460.

The tax credit then plateaus and remains at the maximum level until a second income threshold is reached, and that threshold is called the "phase-out threshold." The phase-out threshold is the second green arrow on the right. After that point, the value of the tax credit is reduced as income increases based on a specified phase-out threshold until the tax credit is reduced to zero.

EXECUTIVE DIRECTOR SCHWARTZ: $24,250 in the Lower 48.

MS. JEE: Thanks.

So in this last example, we have illustrated how subsidies and, thus, a family's financial exposure changes in programs with more of a tiered approach. The program shown here is the Medicare Prescription Drug Low-Income Subsidy, or LIS program. In the Low-Income Subsidy program, Medicare Part D enrollees receive different levels of premium subsidy, depending on which income range they fall in. So as income increases, moving Part D enrollees from one income range up to the next, they experience a 25-percentage-point decrease in their premium subsidy.

For example, those with incomes at or below 135 percent of the federal poverty level receive a full premium

subsidy. Whereas, those with incomes between 136 to 140 percent of the federal poverty level receive a 75 premium subsidy, and the subsidy is reduced and so on in that way up until the maximum eligibility level is reached. And that's 150 percent of federal poverty.

Copayments and deductibles are also reduced based on these income brackets, and just to note for you, the exchange cost-sharing subsidies have a similar tiered structure to help families pay for a cost-sharing.

Veronica and I have shared with you some background information pertinent to the broader question of the design of the continuum of children's coverage. With respect to affordability of that coverage, there are some key design questions. These include how to balance what families pay for children's coverage and care, with access to needed services, and whether other federal programs, such as the ones we've talked about today, offer any guidance on how increases to family out-of-pocket costs can be made smoother as income increases.

As I said, we'll bring these back to you, bring these key points and design questions back to you as you continue deliberation on any preferred approaches to

children's coverage, but if you have any questions now, we'd be happy to take them.

CHAIR ROWLAND: Marsha?

VICE CHAIR GOLD: Just a couple of observations. One is I was trying to get to your question of how you balance it. You have shown the effects, but I think one thing that's different about health care from most of the programs you show is that the expenses are skewed. So you have a large number of people with not that many and then a lot with some, and it would be useful -- I think the next step is to sort of sort out how various programs have defined too much or high.

For example, with kids, you'd want to look at family income, not just the individual ones. You get a sense of the multiple kids. Is it a 5 percent limit as something, or what are the choices as to how you design those limits? And then once you do that, then you can worry about the smoothing part, but I guess sort of -- I don't know how you answer the "what's too much" without getting to some benchmarks that have been used or a potential, given the nature of health care expenses that might be appropriate in how one looks at that.

CHAIR ROWLAND: Trish, then Mark.

COMMISSIONER RILEY: It's really interesting. It's an interesting example of federal policy and the complexity of it for families, but it strikes me that we need to sort of take the extra step here and think about this in light of there will not be CHIP in two years, so how does this really relate to the family glitch. I mean, I think this has to be packaged with some work around the family glitch around how insurance works and how you would subsidize in a new world of no CHIP.

EXECUTIVE DIRECTOR SCHWARTZ: Stay tuned.

COMMISSIONER RILEY: Okay.

CHAIR ROWLAND: I also think that we need to make some distinction between premiums and assistance with premiums, which everyone pays, and cost sharing, which hits those with health challenges.

I had Mark next, I think.

COMMISSIONER HOYT: I don't know how common this is between all the states, but at least for a while on some of the CHIP programs, they moved away from monthly premiums because the administrative expense was so high to chase down small dollar amounts. It went to an annual enrollment

fee, which just creates an even higher barrier, even though those amounts might not seem significant to some of us. They come up now with $100 or something to enroll for a year. So I thought you might want to mention that.

Also, if you want to get down to a source where you would quantify the impact on utilization of introducing copays, actuaries have certainly made up factors to account for all that for years. I don't know if you can find that on Society of Actuaries' website under experience studies, but if you knew somebody who worked at a company like Aetna where they'd have a large --

COMMISSIONER CHECKETT: Or United.

[Laughter.]

COMMISSIONER HOYT: -- group experience department, I mean, somewhere they -- like pharmacies have been playing with copays and tiers and all that forever, but somewhere, there's somebody who's got factors who could tell you how utilization is impacted. At least there, it's different income levels and a different environment, but it might be helpful.

COMMISSIONER COHEN: I will just make a quick and restrained comment. I think it is so great that we did the

comparative work with other programs. The answer to Medicaid's problems is not always within Medicaid. I'm not saying we found an answer up here, but I just think it's great that we're looking across other programs, too, for some insight, so like the methodology.

COMMISSIONER SZILAGYI: Just a question. Is there any literature that examined either changes in these programs? I mean, this is kind of a description of what other programs are doing, but I know we haven't really yet looked at whether this type of pattern is good or bad or administratively more of a hassle or less of a hassle if there's sort of a flat the way the earned income tax credit is or a gradual. So I'm having a hard time trying to assess how would one know whether one pattern is better or worse. So is there any literature that's tried to look at whether there's been changes and what is the impact on administrative costs or sort of other things?

And then one other point. It may have little to do with exactly this chapter, but there is good evidence in a totally different literature that the earned income tax credit has taken a significant bite out of child poverty, and there's recent literature that showed that Medicaid had

reduced child poverty by a certain percentage point. And so that might be kind of -- in the context might be helpful in this chapter that there are spillover benefits to some of these programs that aren't directly health benefits but other benefits as well.

COMMISSIONER MILLIGAN: Peter's comments reminded me that one of the anecdotal things that I think can sometimes drive policy is the view that people have a disincentive to earn more money because of the loss of subsidies or the higher out-of-pocket, and I do think that that contextual framework would be helpful to see to what extent is that real or to what extent is that mythology.

CHAIR ROWLAND: I also think the issue of how to administer any of these is also a key question. I mean, it can be a well-designed reduction in subsidies, but if it's totally impossible to administer it, then that's not also a useful recommendation. So any of the -- going back to Peter's points, how are these various programs administered? Do they think they work smoothly? Do people have to -- we know with Medicaid, the changes in reporting of income can be a real challenge. How is income handled here in terms of changes in reporting?

COMMISSIONER SZILAGYI: And the other related point is there's been a lot of discussion in the CHIP literature at least about kind of if you're eligible for one program, automatically being eligible for another, and sort of the overlap between programs, and so the extent that we could summarize that.

Now, some of that, CHIP income is above the income level for some of these programs, but if we're trying to make a more seamless system where eligibility could be eligibility for multiple programs at the same time and there's some state experiments where that has happened, that might be helpful in terms of context, not necessarily to review that data but to put it into context.

COMMISSIONER MILLIGAN: If I could just jump on that, I think in fact the way to tie Peter's comment right there to our conversation late in the day yesterday about eligibility systems and 90/10 matching funds, the vision of the new eligibility systems across these social programs is the family provides this data once, and the adjudication of what programs they are eligible for and what subsidy levels will simplify the family's experience of qualifying for these programs. And so I don't want to think of these

things as separate topics when from the family's experience, providing my income and providing my documentation one time into a system that can adjudicate to me is an argument strongly in favor of some of that 90/10 enhanced match extension.

COMMISSIONER SZILAGYI: That would be a major advance, if we could do that seamlessly for families.

CHAIR ROWLAND: So instead of reviewing what other programs do, we're just asking you to design a subsidy system.

[Laughter.]

CHAIR ROWLAND: I think this is a good example of the fact that there are other experiences and other ways of dealing with it. I think we need to look at how CHIP operates. We know how Medicaid operates and the implications of MAGI, so I think this is the beginning of an exploration as opposed to the answer of how to do subsidy assistance.

Thank you both.

CHAIR ROWLAND: Did you have a comment, Sharon?

COMMISSIONER CARTE: No.

CHAIR ROWLAND: Okay. Thank you.

Now, we're going to go from how you help people afford things to how you take back estates.

[Laughter.]

CHAIR ROWLAND: And, this has become -- it's always been an issue in the Medicaid program with regard to individuals who qualify on the basis of long-term care, but has increasingly been raised in the context now of the Affordable Care Act and about whether people who are getting health insurance coverage are then going to have their estates attached. There's been a lot of newspaper articles on it and now Kristal is going to give us a better insight into what's going on.

Session 9: Medicaid Estate Recovery Policy

* MS. VARDAMAN: Thank you. Good morning. Today, I'll be presenting some details on policies related to Medicaid estate recovery to set up your discussion of this issue. I'll be highlighting, in particular, some concerns about the new adult group in states that have expanded Medicaid and how they interact with this issue in relation to receipt of non-LTSS benefits. I'll also describe briefly some parameters for some future analysis if the Commission is interested in pursuing this issue any

further.

But, first, I'm going to start off with some background. Since Medicaid's inception, states have been allowed to seek recovery for benefits that were received for long-term services and supports from individuals' estates. But, starting in 1993, OBRA began to require that states seek recovery for long-term services and supports, or LTSS, both those received in institutions and in the homes, under certain circumstances, most notably for this discussion when a beneficiary received those services when they were age 55 or older.

Estate recovery ensures that assets that are available to a beneficiary are used to pay for their care while protecting those assets, or some of those assets, during their lifetime, most notably, their home.

In addition to requiring states to pursue recovery for LTSS benefits, OBRA also allowed states to choose whether to pursue recovery for payments for any non-LTSS services. States have flexibility to select which specific non-LTSS services they subject to estate recovery or if they will seek recovery for all of them, and this could include some portion or the entirety of capitated

payments that are made to managed care plans. This optional estate recovery is, again, limited to those that were provided to Medicaid beneficiaries age 55 or older.

And, as of last year, 36 states pursued estate recovery for non-LTSS services and 15 of those states have expanded Medicaid.

CHAIR ROWLAND: And, just to clarify that, if you are 55 or older when you begin the use of services --

MS. VARDAMAN: Yes.

CHAIR ROWLAND: -- but if you are 48 when you begin the use of services --

MS. VARDAMAN: Those services will not count --

CHAIR ROWLAND: Until you're 55?

MS. VARDAMAN: Right. The services that you receive starting at age 55 will count, yes. Exactly.

In addition to kind of delineating which benefits are subject to mandatory recovery, OBRA also established protections for beneficiaries and their survivors. In particular, states must exempt or defer recovery if a beneficiary has a surviving spouse or a child under 21, disabled, or blind. There's also exceptions that are made in circumstances to disallow liens on homes, for example,

when a beneficiary's sibling has occupied the home for a certain amount of time. In addition to those protections, OBRA required states to establish procedures for hardship waivers.

CMS has given states example criteria to consider, such as if it's the sole income-producing asset of survivors, such as might be the case with a family farm, but the agency does not require currently that any of those examples they provide in the Medicaid manual be incorporated by the states, giving them that flexibility.

In fiscal year 2014 -- and this is an updated number from what was in your briefing materials -- states collected $589.2 million from beneficiaries' estates, which is less than one percent of total Medicaid spending. And, CMS is able to provide us this updated number based on the CMS 64, which is where they collect this information.

So, before I go on to discuss some of the policy concerns around the new adult group, I just want to note that there's some more information in your materials on the legislative history and on program administration of estate recovery.

So, now, I'd like to discuss some policy concerns

related to the new adult group as we consider potential analysis in this area. In particular, several recent media anecdotes have suggested that there is awareness of the potential for estate recovery for these non-LTSS benefits for those age 55 and older and that this could be a barrier to enrollment for some eligible individuals. And, this, of course, would -- you know, if they choose not to enroll in Medicaid, would expose them to the health and financial risks of remaining uninsured.

In 2004, CMS said it was exploring available authorities to eliminate recovery for non-LTSS benefits for those new adults, and several states, including Connecticut and Oregon, have already done so themselves, using their own available authority.

Another concern is in regard to how estate recovery for the new adult group coincides with the MAGI criteria for eligibility determination. Individuals in the new adult group are deemed eligible based on the MAGI criteria that do not include assets, and the purpose of eliminating assets tests for all but certain groups was to align determinations of eligibility with exchange subsidies. Therefore, applying estate recovery to these

new adults appears incongruent with the intent of using MAGI for eligibility purposes.

On a related concern, there is concern of whether or not there is an inequity with individuals that are receiving exchange subsidies who are not subject to estate recovery, as opposed to those who are in these states that have expanded Medicaid who could potentially find themselves subject to estate recovery.

So, that concludes some background and some concerns. The concerns about this new adult group is really what prompted us to bring this issue to your attention today, but in terms of next steps, staff could conduct some analysis that either sheds light on policy concerns for just this group or looks at some broader issues related to estate recovery programs.

As noted earlier, CMS collects this data at a high level on the CMS 64, but some of the details and information on administrative costs, average estates recovery, the number of estates that are recovered from that were reported in some of the citations in the briefing materials are over a decade old, and so there is not a lot of current information on how these programs are

administered.

Also, in regards to the hardship waiver criteria, we know they vary, but that information isn't sort of readily available and compiled, nor is any particular size of estate or claim thresholds that states may have in place in their hardship criteria.

With that, that concludes my presentation and I look forward to your discussion and direction on any future steps you'd like to take in this area, and I'm happy to take any questions.

CHAIR ROWLAND: So, this is clearly an example of a place where the Affordable Care Act was moving forward with a wrinkle in the underlying Medicaid statute that they did not anticipate at the time they were drafting the 1,300 pages or whatever of the Affordable Care Act, but it has clearly come up as an inconsistent policy across states, though it is at a state option to do this for the non-long-term care services, and it's required for the long-term care services.

Those of us remember the era was when transferred assets and individuals who were using Medicaid nursing home services had substantial assets and there was concern there

about how to tighten that. But, now, we really need to look back to say, is this really interfering with the non-long-term care services and supports issues in the Medicaid program and people's eligibility for that.

Gustavo.

COMMISSIONER CRUZ: Just a quick question to clarify, because this is new to me. So, if an individual did not receive long-term services, can the state try to recover the non-long-term services, even if they --

CHAIR ROWLAND: Depending on what the state has elected to do, I believe.

MS. VARDAMAN: Right. States have the choice of, let's say, choosing one or a few benefits that are outside of long-term care, or they could pursue for all benefits outside of long-term care. It's really up to their discretion.

CHAIR ROWLAND: Trish, and then Donna.

COMMISSIONER RILEY: It's probably important to point out, one of the other motivators was the notion that people in nursing facilities with 300 percent of FPL and, therefore, they were, quote-unquote, "wealthier," and the spend-down issues that apply. But, it strikes me that any

report we do ought to talk about the administrative burden of this. To net one percent of Medicaid revenues, what's the cost of the states being in the real estate business?

CHAIR ROWLAND: Donna. I mean, it also goes with the earlier states looked at assets and said determination of assets was more of an administrative burden, and if your income is that low, your assets are probably pretty low, too.

Donna.

COMMISSIONER CHECKETT: You know, there have been some interesting stories in the media about this, and one I recall in particular that you've seen variations of, with individuals who applied for the ACA exchange coverage, found out they were Medicaid eligible, because, good news, they were in an expansion state, and then find out their estates are being gone after because someone got coverage, then they died, then the kids thought they were inheriting something, you know, you can figure the story out.

But, I have to say that of all the things on our plate, this just does not strike me as a big priority. There are just so many other things that we're working on, and I fear a lot of it will be anecdotal. I totally agree

with Trish's comment about the cost of what it is just to pursue the whole asset recovery and the administrative burden. But, even more than that, for me, it's just -- I just feel like we have had a very important discussion earlier this morning and throughout the past couple of days where we're talking about all these programs and great issues and mental health parity, et cetera, and I just don't feel like this falls in that bucket. So, that would be my reaction to a suggestion about pursuing further research.

CHAIR ROWLAND: And, it's currently an option for states to do it and not a requirement, so if states wanted to eliminate it, they could.

COMMISSIONER CARTE: Eliminate estate recovery?

CHAIR ROWLAND: What?

COMMISSIONER CARTE: Are you saying it's an option for the state to do --

CHAIR ROWLAND: It's an option to do it outside of long-term services and supports.

COMMISSIONER CARTE: Oh, right. Outside, to Gustavo's question.

I just wanted to add to what Trish and Donna were

saying, that in addition to the administrative burden around this question, that at one point, the look-back period for transfer of assets was only three years. It's now five. I think that's a further protective factor. So, if you added up what the 50 states spend to do this versus that, to Donna's point, it just doesn't rise to a high level.

CHAIR ROWLAND: It's an interesting dilemma within the Medicaid program, because we talk about Medicaid no longer being a welfare-based program, but that really is much more for the health insurance coverage that's being provided to families. And, so, the reason this has come up as a bit of a rub is it's more if all you're getting is really health care coverage, and then there's this estate recovery, it kind of links it back to welfare when it's supposed to be separate.

But, we also know that for long-term services and supports, there are still a lot of statutory requirements and a lot of concern that those be focused very much on people who have either spent down or who are already low-income or who are on SSI. So, it just really kind of points up the continued multiple roles that Medicaid plays

and the fact that it operates quite differently. And, I do think, over time, one of the things that, when we are dealing with the dual-eligible population and others, we're going to have to deal with the differences now in how eligibility is established for individuals who need long-term services and supports as opposed to for low-income families.

Mark.

COMMISSIONER HOYT: It does seem inconsistent to me to exclude the assets at the start and then to include them later, in effect, go chase them down.

Just sort of a ripple effect is, it turns out, I have a really good friend in Phoenix going through this exact thing right now. His brother in Hoboken died, and because of New Jersey does a substantial push to recover like this, and it just means the death of the brother and everything just lingers. You can't finish the tax return. And, so, it just hangs over my friend all the time, and it takes a long time to resolve, then, what the amount is. So, then you have to file, you know, delays with the IRS and all of that. It's just a substantial amount of additional pain beyond the death of the person.

CHAIR ROWLAND: But, it also adds to the image of an unworkable, difficult, challenging program for families, so that your friend, obviously, doesn't particularly think very much of the fact that there's estate recovery in the Medicaid program.

Well, Donna has said that it's in her view that this is not worth pursuing, but I think others should really reflect on kind of is this also yet another glitch in the Medicaid program that's worth pointing out, at least, that it's a problem.

Trish and then Norma.

COMMISSIONER RILEY: I never disagree with Donna, except now. I actually think -- I agree that it's not worthy of a lot of staff time on this, but I think as a policy matter, it's such a flagrant inconsistency in where we're headed in health reform. Even though we're only talking about long-term care, it seems to me it's a least worthy of a paper and some shining of the light, if not any more. You know, to sort of put this -- to add to this some of the administrative burden and the cost to the states and just shine a light on it, at the very least, it seems to me, would be important for us to do.

CHAIR ROWLAND: There's also, I would say, based on the news reports, there's a lot of misinformation out there on what this is and how it's come to be, and a lot of the reporting, I think, has also poorly reflected the fact that this is a provision from 1993 that's still in the statute and it makes it sound like it was a part of the Affordable Care Act.

COMMISSIONER RILEY: And, it does have a chilling effect on broader issues of health reform, because you always get pulled and sucked into this discussion. So, it seems to me, from a policy perspective, it's worthy of review.

COMMISSIONER CHECKETT: [Off microphone.] Do a tiny, tiny, tiny paper --

[Laughter.]

CHAIR ROWLAND: I have Norma, then I have Andy, and then I have chuck.

COMMISSIONER MARTINEZ ROGERS: I agree with Trish. You know, I think that we should make a policy statement. You know, it's indicative of when we think of the number of senior citizens, elderly, that we have, and as we look at the poor and the increasing number of poverty

is that -- my sister was hit with this. You know, she got very sick and she was going to -- and this is a personal story, but we thought we were going to have to place her in a home, nursing home. Well, she wasn't eligible for Medicaid, because in Texas, we have, you know, it's a five-year statute and she owned her house. So, we were in a dilemma. Okay, who's going to pay for her long-term care? What are we going to do? The insurance isn't enough to cover it.

And, it's a dilemma and I think it's a policy issue, and I think it's an issue of how do we take care of those who ultimately end up in long-term care. And, I think that from a humanitarian aspect, we have to address it.

CHAIR ROWLAND: Andy.

COMMISSIONER COHEN: I am betwixt and between my smart colleagues on this one. I wondered if it might be a fruitful effort to think about it this way. I think it's a real problem where the ACA has sort of principles and concepts that are inconsistent with the Medicaid program and where people who have the lowest incomes are at a disadvantage as compared to those with higher incomes.

This issue is a very human issue and it affects people very much. I'm not trying to say it's not an important issue. It's not so much of an analytic issue, though.

I wonder if there might be a project of sort of identifying and documenting those areas where there are real inconsistencies between sort of the principles of the ACA and Medicaid and sort of packaging them a bit, you know, just as a potential opportunity to say, when there is a legislative opportunity to do some sort of clean-up and trying to make things a little bit more consistent, here is a ready-made package of the things that you should be looking at.

So, I think that might be one way to go forward and not -- it's not a tremendous analytic issue. It's a very human issue. But, sort of packaging it together as something that shows, not -- different values are being sort of, like, applied in these different programs might be a good idea.

CHAIR ROWLAND: I also think there's an interesting age issue here, because it's age discrimination, that if you're 55 and you're getting

coverage for your health benefits, you're subject to this. But, if you're 50, you're not, so that it really is only one subset of those who are getting the health insurance coverage that would be affected.

But, I have Chuck and then Gustavo.

COMMISSIONER MILLIGAN: So, thank you for sharing this is. I'm not sure what the "it" is, quite what we're talking about. If we're talking about the ACA piece, I guess I'm closer to Donna than not about it's a state option and states will make their choices.

If we're talking about estate recovery more broadly, where we're sort of visiting the 1993 long-term care piece of it, I just want to contextualize that, to me, part of the Medicaid stigma is that very -- I can't think of any other federal benefits that anybody receives that are subject to estate recovery, Medicare benefits, earned income tax, I mean, some of the stuff that Joanne just presented.

So, I think that if we're talking more broadly about estate recovery, there is a punitive part of this about the receipt of a federal benefit to which people are entitled that doesn't apply to people receiving Medicare

benefits. And, so, to me, that's a tax policy-Medicare intersection. You know, under what circumstances should somebody, as a part of entitlement reform or not, be subject to repaying the government for the use of benefits.

But, if we're talking about the ACA, I don't think -- I think, right now, personally, and maybe, Andy, having a list like that is helpful, but I don't think that it merits a lot of Commission resources in the moment.

CHAIR ROWLAND: Okay. Gustavo.

COMMISSIONER CRUZ: Just a quick comment. I agree with Andy and also with Chuck a little bit. I mean, there's a punitive aspect of this that I think should be addressed, but I think we should look at it under the umbrella of trying to align these programs in a way that makes sense, both for beneficiaries and administrators of these programs. It seems like, you know, families and beneficiaries get lost in all of these regulations between programs and among programs. So, I think under that umbrella, it could be useful.

CHAIR ROWLAND: Okay.

VICE CHAIR GOLD: I really think we need to distinguish the long-term care part of this from the other

part of it. I mean, on the long-term care part, looking -- I mean, these are not trivial amounts. They may be less than one percent, but it's a fair amount of money. And, if you think back, I mean, to -- I mean, it's the default for people who have trouble getting long-term care, and that's important that people be able to use Medicaid. But, I don't think it's so bad, even though, probably, if I look back at my family's history, it might have affected me at one point, or my parents or grandparents. But, transfer of assets doesn't make the most sense in terms of public spending. If people need long-term care, they should get it on Medicaid, but they shouldn't necessarily get it because they've given their money away. And, you want to have people be able to keep their house --

CHAIR ROWLAND: [Off microphone.] But this isn't a transfer of assets.

VICE CHAIR GOLD: No, but it's -- I guess what I'm thinking is, to me, the issue of fairness and of punitiveness really relates to the basic regular acute care insurance program more than the long-term care side of it. Maybe I'm missing something.

CHAIR ROWLAND: Well, there's a whole different,

as Kristal will have to tell us down the road, level of consideration when we're talking about who qualifies for the long-term benefits under Medicaid, and how there's a sift, of course, from just nursing home benefits to more and more in the community. So, long-term services and supports is another bucket that we have that really has a huge amount of complexity to it because of Medicaid's unique role in that field.

VICE CHAIR GOLD: But, I guess what I wouldn't mind seeing is if we know anything about the recovery versus the effort for these other expenses, I mean, it seems like Trish's point on there is really, you know, it's just not worth it and it also is punitive because you're not being taken back for other kinds of insurance. Sort of, it's -- that's a more important issue than the recovery of assets, generally, for long-term care. Okay, I'm getting funny looks, so --

[Laughter.]

CHAIR ROWLAND: Okay. So, clearly, what we're going to do here is at some point engage in a much broader discussion of the eligibility requirements and availability of options for controlling people who either transfer

assets or estate recovery around long-term services and supports. For this issue, I think what would be most helpful is not to do a lot of additional research on it, but to instead put out one of our little short issue briefs that explains the issue and why it comes up, that it's a state option, and that it could have both administrative burden and kind of a paragraph qualifying why it can be an issue, and that's it. No recommendation, just a policy note on our website. And, then, revisit it really in the context of trying to figure out long-term services and supports and down the road.

But, we can get that out just to have it there, because I do think there is so much misinformation on that point, that just to have an explanation of why it's there, who it -- that it's a state option, that it can conflict with the ability of people to get coverage, that it has administrative cost issues, but it's a state option right now, but it probably is an area that would be useful to just have an explainer on it rather than a chapter in a report. Just something short, brief, thin, Donna, thin.

COMMISSIONER CHECKETT: Fine with me.

CHAIR ROWLAND: Okay.

In this next session, we're going to talk about the recently released Medicaid managed care reg that didn't get recently released. So Moira and Chris are going to at least give us some background on what they'll be looking for when the managed care reg does come out and its implications for rate setting.

Session 10: Issues in Medicaid Managed Care Rate Setting

* MR. PARK: Thanks, Diane. An article earlier today described the coming proposed rule as being potentially epic, so we'll just join in some of that hype.

We expect CMS will release this proposed rule shortly, and once they do, we will provide a detailed summary of any of the changes or new additions to the rule to the Commissioners and also identify some potential areas where you may want to comment, if you choose to do so.

While we don't know exactly what will be covered in the proposed reg, we've done a lot of previous work discussing many of these issues. For example, last spring we held an expert roundtable to discuss rate-setting issues in managed care. This past fall, we heard from federal and state officials discussing access standards in managed

care. And Moira provided a nice high-level summary of a lot of these issues last December.

Today we'll go into some of the more -- a little greater depth into some of the payment issues. This isn't a comprehensive list of all the issues that may be considered in the proposed rule, but we wanted to lay the groundwork for some of the major topics that other people have been discussing recently.

As a quick background, under the current rule all payments and risk-sharing mechanisms under risk contracts must be actuarially sound, and this means that the payment rates were developed in accordance with generally accepted actuarial practices and standards, that the payment rates are appropriate for the services and populations covered under the contract, and that a qualified actuary has signed off that these rates were developed under those principles.

States must provide documentation of the rate-setting methodology to CMS for approval, and another aspect of the actuarial soundness requirement is that states must ensure that no other payment is made to a provider for services under the contract, except for disproportionate share hospital payments and graduate medical education

payments. Those may be provided directly to the individual provider.

One of the goals CMS has stated for this new proposed rule is to align Medicaid with existing regulations for commercial, exchange, and Medicare plans. The Affordable Care Act implemented a minimum medical loss ratio for commercial, exchange, and Medicare plans of 85 percent, and because they've done this, a lot of people expect that a minimum medical loss ratio standard may be introduced in the proposed rule.

Just as a quick reminder, a medical loss ratio is a calculation of how much of a health plan's revenue was spent for direct patient care and quality improvement activities.

Medical loss ratios are -- for a minimum medical loss ratio, if a plan's actual medical loss ratio comes in less than the determined standard, then the plan typically has to refund some or all of that difference back to either the payer of the premium or in this case in Medicaid it would be the state and federal government.

Medical loss ratios are currently used by many states. The latest Kaiser budget survey found that 27 out

of the 39 full-risk programs had some kind of medical loss ratio standard being applied.

Many experts during our roundtable last spring thought a medical loss ratio standard could improve accountability in the program, but there were some concerns about the complexity of trying to set a national standard due to the variation across states in the populations and services covered. So the Commission may want to consider first whether a medical loss ratio standard is necessary for the Medicaid program, and if so, whether there should be a national standard set or if it should be left up to the states, what types of costs may be considered and included in the calculation of the medical loss ratio, and additionally if there are other rate-setting options that may be used in lieu of a medical loss ratio.

Another issue the Commission has discussed in some detail over the past couple of years are supplemental payments and their interaction with managed care. If you recall from our discussion on the delivery system reform improvement -- I mean, delivery system reform incentive programs, or DSRIPs, during the last Commission meeting, we heard that many states have used these programs under 1115

demonstration authority to continue making these non-DSH supplemental payments to providers in a targeted manner.

The Commission may want to consider whether CMS could change the actuarial soundness rules to let states make these non-DSH supplemental payments directly to providers to preserve existing funding mechanisms while expanding the use of managed care. This could be particularly important, as we heard from the presentation yesterday on the DSH reductions that UPL payments may be made -- you know, could be considered a replacement for some of the DSH dollars that may be lost.

However, you know, the Commission has discussed several of the problems that are associated with lump sum payments that aren't necessarily tied to services, and it hampers the ability to tie payment rates to policy goals such as access and quality. And so the Commission may be fine with the current options of either using the DSRIP programs to tie these payments to delivery system reform or the option to increase the base payment rates and not rely on supplemental payments to get these payments to providers.

Another issue that has come up recently is in

regard to midyear changes. Capitation rates are set prospectively and generally don't change during the contract year. Some recent federal policy changes and market actions have had significant impacts on the soundness of the rates. For example, the primary care bump and the health insurer fee and also the introduction of high-cost hepatitis C drugs, such as Sovaldi. The states can make a midyear change, but this typically requires going through the full rate approval process with CMS.

Additionally, there's no requirement for the states to open up the actuarial soundness of the capitation rates that are in effect, and so, for example, when Sovaldi was introduced, the states were not required to either provide documentation that the rates were still sound or required to update the rates.

The Commission may want to consider whether CMS should require a recertification of the rates if certain significant changes are introduced into the market or through state policy. Additionally, the Commission may want to consider if CMS could create like an abbreviated process to make these rate changes a little bit more simple for the states to go through or give the states more

flexibility. You know, one option may be to prospectively certify a rate range where any rate within that range would be approved. So once the costs become known, you could change the rate within that range. Or as with the health insurer fee, CMS is allowing aggregate reconciliations once those costs are known.

* MS. FORBES: Thanks. So current federal rules allow but do not require states to use risk mitigation tools such as risk corridors, stop loss insurance requirements, and reinsurance. These tools can help both states and plans mitigate some of the uncertainty associated with the rate-setting process, particularly when new populations or services are coming into the program.

CMS strongly encouraged states to use risk mitigation when states were setting rates for the adult expansion group because the states that were expanding didn't necessarily have a fee-for-service claims history that could be used and had to make a lot of assumptions.

In the new rule, CMS may include an affirmative requirement for states to use some form of risk mitigation when setting capitation rates, which would help, you know, both protect plans against excessive risk and also protect

states against excessive payment.

If such a requirement is included, the Commission might want to consider the burden that a formal requirement might put on states, as well as the effect that risk mitigation strategies might have on some of the incentives for plans to provide cost-effective care.

While Chris outlined a lot of the rules regarding the documentation of the process for states to get federal approval of the rates, there are no federal rules requiring states to share that information with the health plans while they're developing the rates in terms of the data, the assumptions, or the methodology. And there's no requirement that states cooperate or share that information before submitting for federal approval.

Some states have an open process. Some states keep things very close to the vest. You know, you hear about a black box in some states. I think it's worth noting that states have different procurement processes for managed care. Some states will accept any qualified health plan that is willing to accept the rates and accept the contract terms, and some states have a competitive bid process and really use that to drive both price and quality

guarantees.

So the degree to which the states are open about the rate-setting process I think is tied in large part to their procurement strategy. So it's a little bigger issue.

Health plans and their trade associations have asked CMS to consider, as part of this rulemaking, adding some requirements around data sharing during the rate development process or creating opportunities for plans to review or formally comment on draft rates as part of or prior to the federal review, similar, I think, to the public notice and comment period associated with demonstration waivers. You know, I think it remains to be seen if CMS adopts that, but there have been requests.

And finally, the data. Current federal rules require states to use appropriate data to set rates and to document the types and quality of data used as part of the rate submission. States can use fee-for-service or encounter data. There's limitations--you know, we've discussed many times, certainly in terms of fee-for-service, you have challenges around the timeliness, once you've had a managed care program operating for a few years, with the comparability of the populations and the

services, and we've certainly discussed the limitations around encounter data many times.

CMS has done a lot to provide technical assistance to help states improve their encounter data to support rate setting as well as program oversight. We think it's likely that CMS will include in this proposed rule some more requirements around the timeliness and the quality of the data that are used for rate setting.

Such a requirement could have a side effect of improving the quality of data that's available for other things that the Commission would like: quality measurement, making comparisons between fee-for-service and managed care, and so on.

So as Chris said, CMS is expected to publish this notice soon. I would say we have certainly heard a lot more chatter. We had a genuine concern that it was going to come out Tuesday or Wednesday this week, and Chris and I would have been up all night redoing these slides. So hopefully it will come out soon.

We'll prepare a detailed analysis of the changes and new provisions, and we will be trying not just to give you a summary, but--the Commission has certainly discussed

many times-- access, enrollment, quality -- all of these things. So we will certainly bring back to you, as part of that summary, information on things the Commission has heard before or things you may have recommended or discussed before to provide you with that context, because there's certainly a long history here.

You know, you all will determine whether you want to submit formal comments. In addition to the technical issues, things the Commission might want to comment on would be: CMS will include, as with any rule of this size, an estimate of the burden. That will be a burden estimate for the states and for the health plans. You know, one thing the Commission has discussed before is what does CMS need. If there are a lot of new oversight requirements in the rule, does the Commission want to say something about what CMS might need in order to effectively implement it and to conduct the oversight that it envisions? So there will be issues like that that we will also bring back to you in our summary.

But it's certainly helpful for us to get a sense now of what kinds of things you're interested in or what kinds of things you might want to take a position on,

because there will be a lot for us to go through, and the more we know when the reg comes out, the easier it will be to provide us with information that's most helpful to you.

CHAIR ROWLAND: Thank you. I think that we've talked before about also having you quickly flag for us some of the key things you're looking for in the reg when it comes out to have us comment on, so that I would urge you to pull that together so that when you send us the summary to review, you have, you know, these are the five areas that you have previously been concerned about and this is how the reg addresses them so that it helps us to relate whatever comments we might make to the work we've done in the past.

Other comments? Who's going to predict when the reg will come out? I think at the last meeting we thought it was about to come out, right?

MS. FORBES: It's been published on the -- OMB released information on what they have under review, and that was in March. So we really do think it will be soon.

VICE CHAIR GOLD: Just a question. You know, we were talking yesterday and we've talked at other times about sort of new models of managed care, new issues that

are coming up with multipayer or partial capitation of provider, and I don't know to what extent you're expecting that the reg is going to address issues of quality oversight, network requirements, access requirements, financial solvency. But, you know, when I looked here, these were all very specific things around rates and data, and I didn't know, you know, with all the discussion of the managed reg being earth-shaking and whatever they were saying today, groundbreaking, what you're expecting in the way of other kinds of major thrusts of policy that may be related to some of the things we've been talking about.

MS. FORBES: Sure. I certainly think you're right. What we didn't want to do was to waste your time this morning speculating. And on the rate-setting issues, I think there's been a lot of actual policy papers put out, and so we were trying to summarize those here. But I think you're right that that's another area that we're likely to see a significant new amount of rulemaking in and will probably be a big focus of what we come back to you with.

COMMISSIONER CHECKETT: Well, you know, it has been incredibly interesting just waiting for the release. I do think it's going to be a very interesting reg to

analyze. I think it will be a great issue for the Commission, because it really seems we're going to have a very public discussion about the tensions that go with the concept of managed care. I personally would love to have a similar discussion about the problems with just fee-for-service, which I mean very sincerely, but, you know, we do have genuine issues about access, about networks, about medical management, and about rate setting, and also when I think we see state Medicaid agencies looking to solve all their problems by putting everything under managed care and then wondering why there are problems with it.

So I think it's going to be a very important reg. I look forward to reading it and discussing it with the Commission.

COMMISSIONER HOYT: I'm glad you did this and you brought the topic to us. Whenever it's issued, I'm sure they're going to hear from the managed care plans, obviously, and probably American Academy of Actuaries or somebody else. Some of these seem pretty obvious to me, like the midyear changes risk mitigation. I'm not sure what place -- it doesn't immediately become clear to me what place we have on that, but for the Commission, I think

something like the minimum medical loss ratio and the type things that the plans would say, I think with some justification, is this just penalizes the high-performing plan, whoever does really well, then you're going to smack us. And you already do--most of the states now do risk adjustment, do pretty high-powered rate development.

What's the intersection of this with innovation? If we're concerned with plans innovating, there's pretty clear migration of enrollees into managed care contracts. Is there some way that this would inhibit innovation or hold plans back, would be a good thing for us to think about.

With the supplemental payments, I think maybe what -- I don't know what they're going to say about this, of course, but if we feel supportive of this, this clearly has a certain kind of randomness to the way the supplemental payments are calculated and distributed to hospitals. But if we support that and see value in that, then we may want to comment on that, finding a way to make sure that continues, I guess depending on what they say. There's no maximum medical loss ratio, right?

COMMISSIONER MILLIGAN: Epic presentation, Chris.

So I would, I guess, suggest that some of where it might be going also is where they've gone with some of the other recent releases in non-Medicaid areas. I think we should anticipate some requirements about maintaining a fairly accurate provider network so that there is a way of scrutinizing who members have access to and that there's some relationship between the provider network that's available at the time somebody's choosing an MCO and the provider network that is actually within that MCO. And I do think that this is going to be an area where some of the access issues happen.

So I think that to me, you know, the last go-round of a big managed care rule, I was the Medicaid director in New Mexico and part of the managed care TAG that was looking at it from the Medicaid director association, and there was a lot of patient bill of rights pieces of it, too, appeals and grievances issues, and all of that.

So I think that the flavor of it is probably going to touch on some of those areas that we should just anticipate as well.

COMMISSIONER HOYT: I may have only one other

comment I forgot on encounter data that we might want to think about, which would be if you do this in a number of states like Mercer does or managed care plans do, there's no consistent definitions of what service goes in which line state to state. So even if you had reporting of the encounter data in the different states, it's virtually impossible to compare and contrast because of inconsistent sorting of data between outpatient or ambulatory care or what other kind of definitions they've used for different things, and we might want to think about not just enforcing sanctions or improving the reporting but getting some kind of consistency across state lines. It would also lower the administrative expense for some of the national plans that play in a number of the states.

CHAIR ROWLAND: Do you have a comment?

COMMISSIONER COHEN: Just hear, hear, Mark. I mean sometimes someone has got to do it.

CHAIR ROWLAND: Trish?

COMMISSIONER RILEY: It strikes me that we have a whole bunch of work to do on the regs themselves and the depth of the regs, but we also ought to step back maybe and take some review of what we heard yesterday in all the

discussion about payment reform and ACOs because, as we were listening to the ACOs, I almost thought, well, instead of fixing the MCO problems, we're just going to layer this new thing on top of it, and maybe the regulations give us an opportunity to really think about payment reform differently and how you use a platform that we've really built over time, and it's become fairly sophisticated in the states to do the kinds of payment reforms that state anticipate.

And it might be the intersection of where payment reform ACOs and all the sort of innovation with these new Medicaid managed care rules, it seems to me might be a place for MACPAC to make a unique contribution.

CHAIR ROWLAND: I've have to look at whether the managed care rules lock us into a past model or give us the ability to move forward to new models.

But I also think that we raised yesterday some very important issues about HHS's ability to enforce, and this might also be a time when we want to comment on whether these are terrific regulations, but will they be enforceable, and what would the administrative capacity be at both the federal and the state level to do it, because I

think one of the other things we've always pointed out is how stretched states are in their administrative capacity, especially around these newer models of care. And I think we might want to bring that up as we look at the reg as well.

Steve.

COMMISSIONER WALDREN: Just one quick question about encounter data. So if value-based payment gets its way, there won't be encounter data. It will be really about quality data. So one thing that we may want to look at, too, is there any kind of quality measurement? Right now, it's kind of at a plan level or at a provider level, but do we have something to look at the beneficiaries as a whole across a state or across the country too?

CHAIR ROWLAND: I guess you guys will be really busy when this -- okay.

Well, thank you, and certainly, we will be not in public session when the regulation comes out unless it waits until September. So I would hope that you would send a memo, and we will certainly post any comments that we are making on our website for the public to see.

And at this point of our meeting, if there are

any individuals in the audience who want to offer any comments on this topic or any other topic to us, we would welcome those.

[Pause.]

Public Comment

* MS. LIPSON: Hello. I am Debra Lipson from Mathematica Policy research again. I'm glad to be back, and I'm obviously very interested in all of the capitation rate-setting discussion that just occurred, I was involved with Moira and Chris in the Dental Advisory Panel last spring in looking at these issues. Mark was there.

I just -- may I propose some of your other comments about taking a step back and looking at the capitation rate-setting process itself in the broader payment context? And by that, I mean that -- you know, and I have been very in the weeds with some of the issues around the mechanics of rate setting and where the data comes from and how you do risk adjustment and so on and so forth, but I guess I would caution that there are so many ways to affect payment to managed care organizations outside of the strict rate-setting process itself, and many states do that.

And as far as I know, for example, there are rate ranges that are established. I don't think that's unusual for states to do, but within that, they do a lot of withholds, so that if the managed care organizations are required to meet various requirements to get the full per-member-per-month rate for all of their enrollees, some states -- not too many -- do the upside where they would provide bonuses on top of the regular PMPM rate for meetings or kinds of quality of performance standards. Those are just two of the most common, but there are many other permutations.

Payment, it's -- incentives can be done in other ways as well. If the managed care plan is performed better than others, they may be preferentially assigned the auto enrollment, the auto-assigned enrollees.

So just to emphasize that as important as the capitation rate-setting process is itself and all the mechanics involved there, don't forget about the broader payment reform and quality and the performance incentive framework in which those exists.

CHAIR ROWLAND: Thank you.

Any other comments?

[No response.]

CHAIR ROWLAND: Then we will adjourn this meeting and look forward to working very hard over the summer and coming back in September with answers to all of these issues we've raised here today and in the past.

Thank you all very much.

[Whereupon, at 11:31 a.m., the meeting was adjourned.]