PUBLIC MEETING

Walter E. Washington Convention Center
Room 206
801 Mount Vernon Place, NW
Washington, DC 20001

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10:19 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[10:19 a.m.]

CHAIR ROWLAND: All right. If we could please convene? This session of the Medicaid and CHIP Payment and Access Commission is called to order, and we're beginning our discussion today by looking at the Delivery System Reform Incentive Payment Programs, so-called DSRIP programs. We have asked our staff to really look at what some of the issues are, the structure in these programs, because one of the issues that clearly is on the top of most states' agenda in Medicaid is delivery system reform, and this is an important demonstration project going on around how to do some incentive payments.

So Rob and Ben are going to take us through some of the key issues here, and then we are going to discuss the content and whether or not this should be a chapter in our June report.

MR. FINDER: Thank you, Diane.

The term DSRIP has come up a couple of times recently in MACPAC conversations, sometimes in conversations about non-DSH supplemental payments and sometimes in conversation about delivery system

transformation efforts. Most recently, Mark McClellan mentioned them at last month's meeting as a mechanism that provides federal support for trying new health care delivery approaches.

DSRIP programs are a method to direct Medicaid supplemental payments to providers, mostly hospitals but sometimes physician practices and clinics. These payments are tied to investments in delivery system reforms, and Rob will go into a lot more detail about what that actually means in just a minute.

To better understand the use and structure of DSRIP programs, we contracted with the National Academy for State Health Policy. The analysis was done in three phases. The first phase was an environmental scan of DSRIP documentation. The second phase was interviews with CMS officials and Medicaid officials in New York, New Mexico, Oregon, and Massachusetts. And the third phase was site visits in Texas, New Jersey, and California. We would like to thank our colleagues at NASHP whose work on this was invaluable as we undertook these efforts and all of the participants in our interviews and site visits.

So today we are here to brief you on the results

of this analysis. To put this in context, we'll start by providing a recap of the Commission's work on supplemental payments. Next, Rob will provide some history on the evolution of DSRIPs and then describe at a high level the structure of these programs, including program design, how and when payments are made, DSRIP financing, and state and federal monitoring efforts. Then I'll talk about some of the themes that emerged from these analyses and some of the policy questions that this raises.

But before we get too far into describing DSRIP programs, we thought it best to recap the Commission's previous work on supplemental payments. In Chapter 6 of the March 2014 report to the Congress, the Commission highlighted the amount of money that flows from states, including federal spending, to institutions in non-DSH supplemental payments. But because states report these in the aggregate amount and not provider-specific payments, we don't have the data to determine the effect of these payments on policy objectives.

The Commission considered a range of policy options and ultimately recommended that as a first step towards improving transparency and facilitating the

understanding of Medicaid payments, CMS should collect and make publicly available non-DSH supplemental payment data at the provider level in a standard format that enables analysis.

DSRIP programs are complex and raise many policy questions, not just for DSRIP but also how DSRIP relates to Medicaid policy in general. As we move forward through the presentation today, we're interested in knowing from you what policy implications are of the greatest interest for further exploration, what further analyses are necessary, and what form should that work take; and we hope you'll keep these questions in the back of your mind -- the ones that are here on the screen. I won't read them aloud, but we'll come back to them again later in the presentation. We hope you'll keep them in the back of your mind as we discuss the work that we've done.

With that, I'll turn it over to Rob.

MR. NELB: Thanks, Ben.

So DSRIP programs are a relatively new use of Section 1115 demonstration authority in Medicaid. The first DSRIP program was approved in California in 2010 after the passage of the Affordable Care Act. Since then,

DSRIP programs have been approved in a total of six states in the following order: Texas, Massachusetts, New Jersey, Kansas, and most recently, last year, in New York.

DSRIP programs must be authorized under Section 1115 demonstration authority because of regulatory limits to supplemental payments under managed care. Although managed care provides states with additional flexibility to make Medicaid payments, it limits their ability to make fee-for-service, non-DSH supplemental payments. As Ben mentioned, these payments are a large source of Medicaid funds in many states, and so for some states, the desire to preserve or expand these supplemental payments during expansions to managed care was a primary driver to the creation of their DSRIP programs.

DSRIPs differ from other supplemental payments because of their focus on quality, as I'll describe in a bit. As a result, another policy goal of DSRIP, particularly for CMS, is to promote value-based purchasing efforts and support broader delivery system reform efforts in Medicaid and across the health system.

So DSRIP programs vary widely from state to state based on the state-specific demonstrations that are

negotiated and approved by CMS. There is not specific guidance from CMS about what constitutes a DSRIP program; rather, it's a product of state-specific negotiations. However, from the DSRIP programs that have been approved so far, they do share some common characteristics in their design.

Fundamentally, all DSRIP programs are really mechanisms for making payments to providers for achieving specific project and outcome milestones. The DSRIP projects vary widely and in response to local needs, but they generally fall into two broad categories. The first are infrastructure development projects, such as building new clinics or investing in health IT capacity. Another broad category are care innovation and redesign projects that aim to use that new capacity to provide care in more appropriate settings, such as patient care navigation or behavioral health/physical health integration projects.

All DSRIP projects are tied to corresponding improvements in health outcomes, particularly for Medicaid enrollees and the uninsured. And in the long term, these projects are intended to advance the triple-aim goals of better health, better care, and lower cost through

improvement.

Most DSRIP projects are led by hospitals, particularly safety net hospitals that previously received supplemental payments. However, given that the goal of many DSRIP projects is to achieve care improvements outside the four walls of the hospitals, many DSRIPs also involve collaborations with non-hospital providers, such as community mental health centers, physician groups, and local health departments.

As I mentioned, DSRIP is fundamentally a way of making payment, so to help illustrate how these payments actually work, we thought we'd walk through the four general types of DSRIP milestones that providers can receive payment for.

First, in some states providers can receive up-front planning funds to help develop their DSRIP project plans with community stakeholders.

Second, providers can receive DSRIP funding for actually implementing their DSRIP projects. Most DSRIP funding is in this category. Unlike a grant program, DSRIP funds in this category are allocated based on achievement of specific milestones, such as hiring a certain number of

staff or serving a certain number of patients.

Third, some DSRIP funding is allocated towards reporting to help providers develop the capacity to report both on quality measures related to their projects as well as on a set of core population measures, and the first years of most DSRIP programs are spent with providers developing that capacity to report and developing their baseline quality scores.

Finally, in the latter years of DSRIP implementation, a substantial portion of the funding is allocated towards results, also known as pay-for-performance. Specifically, providers are rewarded for improving over their baseline on the quality outcomes that are related to their project. In addition, in some states -- New Jersey and New York -- providers are also eligible to receive additional funds for achieving statewide high performance goals.

I recognize these are a lot of buzz words, so to help put it in a little more context, we thought we'd walk through a specific example of a project that we visited in Austin, Texas.

The Community Care Collaborative is a coalition

of a local health district, Central Health, and the local safety net hospital, Seton Healthcare Family, and collectively they're implementing about 15 DSRIP projects valued at about $242 million over five years. That is federal and local funds.

This funding is divided into a variety of milestones. During the first year of DSRIP implementation, the Community Care Collaborative received funding to conduct a community needs assessment with a variety of local stakeholders. This led to a region-wide plan for an integrated delivery system that emphasized primary care, which was a major need in their community.

A variety of projects came out of those needs. For example, one was a project investing in mobile health clinics, both in rural areas as well as street medicine teams. Payment for this project is based on achieving a variety of milestones, such as building a certain number of clinics, hiring staff, and ultimately serving more patients.

Twice a year, the Community Care Collaborative reports on its progress to the state on quality measures related to its project as well as on a core set of hospital

quality measures that all hospitals are reporting Beginning this year, the Community Care Collaborative will have a substantial portion of its funding tied to results on those quality measures related to its project, and some examples of those measures include improve diabetes control and reducing preventable emergency department visits.

So where does all this money come from? Well, the total amount of DSRIP funding is established in each demonstration's special terms and conditions. Like all Section 1115 demonstrations, DSRIP is subject to a budget neutrality test, which is to test that spending under the demonstration is less than or equal to projected spending without the demonstration.

There are two important things to highlight about the budget neutrality for DSRIP. First is that those prior supplemental payments that states made under fee-for-service are often included in the budget neutrality assumptions. And the second is that other demonstration savings from the larger 1115 demonstration may also be used to make payments that exceed those prior supplemental payments.

Like all Medicaid spending, states are required

to provide a non-federal share for DSRIP payments, either through their state general revenue or through public funds from local governments or public providers. For most DSRIP programs, the non-federal share of DSRIP funding is provided through intergovernmental transfers from public hospitals. This reduces the net amount of funds that those hospitals receive and also created some issues between public and non-public providers. One notable exception to this is New Jersey, which doesn't have public hospitals and funds its DSRIP through general revenue.

In addition to establishing funding levels, states and CMS both have roles in the oversight of DSRIP programs after a demonstration is approved. One primary role is the approval of DSRIP project plans, which set forth the specific projects and outcomes that each provider is working towards. States and CMS jointly establish a menu of projects and outcomes for providers to select and also have a role in reviewing those projects once they are developed.

Once a DSRIP project plan is approved, providers then report regularly on their progress, and states review achievement before payment is made.

Now, in addition to this project-specific oversight, all states are required to conduct evaluations of DSRIP with an external evaluator. To date, only California and Massachusetts have finished their interim evaluations, but no state has finished a final evaluation of DSRIP, which would, of course, provide more insight about the actual improvements in quality and the potential sustainability of these initiatives.

It's also important to note that while each state has a requirement to conduct an evaluation of their own DSRIP programs, there is currently no requirement for a federal evaluation of these DSRIP programs overall, and Ben will talk more about what we found from talking to the evaluators of these programs about some of the challenges and opportunities for evaluating the progress so far.

So here is a broad overview of the six states with currently approved DSRIP programs. More information about these is in your materials, in Table 1, which starts on page 9.

As you can see, most DSRIPs are about five years in length, which is the maximum amount of time that a Section 1115 demonstration can be approved. One exception

is Massachusetts, which initially had a three-year DSRIP program and was recently extended last fall for an additional three years. Both California and Texas are currently working on renewals of their program, but they haven't yet been approved by CMS.

In terms of participating providers, you can see that most state DSRIP programs are limited to hospitals, primarily the safety net public hospitals that were previously receiving payments, but in some cases extending to other hospitals as well.

Texas and New York are two exceptions. They provide DSRIP funds through regional collaboratives that includes hospitals as well as non-hospital providers.

And, finally, as you can see, the size and scope of DSRIP programs varies widely from Kansas, which is receiving -- eligible to receive up to $34 million in federal funds to implement four projects, to Texas, which is eligible to receive $6.6 billion in federal funds and is implementing about 1,500 projects.

Now I'll turn it over to Ben to discuss what we found from our site visits and interviews about how these projects are going so far.

MR. FINDER: We've highlighted five themes that emerged from these analyses. The first is, in speaking with providers and state Medicaid and federal Medicaid officials, differing views emerged. Providers and state officials generally reported that they pursued DSRIP programs as a way to continue to make or make new supplemental payments. Although they were generally enthusiastic about the delivery system reforms that these funds enabled them to invest in, they were uncertain about whether they could carry on with these efforts without continued DSRIP funding. CMS, however, expressed the view that these are intended to be temporary incentive payments that are designed to improve the delivery of care.

Secondly, states reported that finding a source of non-federal share was a challenge. This was particularly evident in Texas where public entities are providing IGTs to draw down the federal funds for themselves and for private providers. This creates a scenario where, on the one hand, there are incentives for public and private providers to move together to a more integrated system; and, on the other hand, private providers often go shopping for IGTs in order to

participate.

States and providers and the federal government also reported that these take considerable time, effort, and other resources to implement. On the one hand, some of these efforts shed light on which providers receive payments and what the payments are for.

Results of DSRIP program final evaluations are not yet know. Most DSRIP programs are either still in planning or implementation phase, so states are either developing evaluation plans or gathering data. And when we met with evaluators, they noted that the process of gathering data had not gone smoothly. For example, it took considerable time and effort to format data from different providers so that it would be useful for making comparisons. Final evaluations will lag renewal requests.

Which leads us to the last point that, although state officials and providers were generally enthusiastic that the projects were bringing about real change in the delivery of care and improving the health of Medicaid enrollees, they were concerned that more time is needed to fully realize their vision for transformation and that they needed continued funding to sustain improvements in the

short term, and many are likely to seek renewals.

So these are some of the themes that are highlighted in the contractor's report, which they are busy finalizing and we hope to share with you soon. In the meantime, we're interested in your feedback on what areas or further analyses we need to pursue. To that end, we've highlighted the following four questions for you:

Can DSRIP supplemental payments be considered an improvement on Medicaid supplemental payment policy?

What is the long-term vision for delivery system transformation?

What should the role of Medicaid be in supporting delivery system transformation?

And can DSRIPs be considered successful? And if so, what role should the federal and state governments play in supporting these policies?

With that, I'll turn it back to you. Thank you.

CHAIR ROWLAND: Thank you, Rob and Ben.

Patty.

COMMISSIONER GABOW: I think this is a really good paper and an important issue to address, and I would encourage us to include this in the June report.

I have four comments to make. The first I think it would be important to flesh out a little bit how this relates to DSH and UPL and to the SIM grants and the innovation acceleration program. In that regard, the table that you put up that's on page 9, I would like to see three columns added to that table: one, the current DSH payment; the current UPL; and who's doing the match, how is the match being done. I think that would help a great deal with transparency, which has been one of our issues at the Commission around these things.

The second comment really relates to the evaluation. I think that we should make a strong point that in addition to these state evaluations that there be some formal federal evaluation, and one thing I would think they may want to evaluate, for those programs that are trying to develop integration, I think this is very important with the safety net. Sara may want to comment. But as private providers are aggregating into more integrated delivery systems, in the safety net we basically have community health centers, safety net hospitals, and public health departments, all separate from each other and separate within each silo.

So I think understanding for those where there's integration, how is this comparing to the integration that's going on in that private sector, and what is the outcome of that in terms of access, quality, and cost?

I guess, really, the last point is, why are so few states playing in this sandbox? It might be very interesting to interview some state officials from high managed care states, whether UPL is also an issue, who opted not to apply for DSRIP to try to understand what those reasons are, which might help to inform how to make the program more accessible and viable for more states.

Those would be my three comments, but I think it's an important piece of work.

COMMISSIONER COHEN: Thank you.

So I thought a great, great piece of work. I totally support the idea that we would try to publish this as soon as possible in a report or independently, and I think this raises great issues.

I guess I would just make a couple of quick points. One is I just want to take a step back, and I think the chapter does it nicely but maybe could even a little bit more. This is a really big change, I think, for

CMS to be sort of thinking about Medicaid as a payer really influencing the delivery system and not just buying some form of access, so to an existing delivery system. So I think it is a really significant and important initiative sort of in the history of Medicaid and one that I applaud hugely, but in any event, it's really significant.

However, sort of with that ambitious effort to really influence the delivery system in a proactive way, I think there's a few things that we really need to add to our analysis, and one of them is most -- I won't say most -- many providers are paid by multiple payers in different proportions. Actually, most providers are paid by many payers in different proportions, and the question, if DSRIP is really focused on a true safety net, which means vast majority of the payment is coming from Medicaid or DSH or other kinds of local payments, that sort of a thing, then programs might look at certain way. And when the providers are paid by multiple payers, if Medicaid is pushing in a certain delivery system or formed direction not aligned with what other payers are doing, like Medicare and private, it's a real problem and a challenge.

So I think this issue around alignment with other

payers, especially public players over which the same entities have at least some control, and thinking about to what extent that makes sense when the payers are really very heavily dominated by Medicaid payment versus sort of more of a mixture is a really important issue to consider because I do think there are some real potential issues and concerns about Medicaid pushing the delivery system in one direction and other payers pushing them in a different direction.

And I think I'll leave it there. Thanks so much.

COMMISSIONER CRUZ: I was wondering, when these states do these evaluation programs, is there any sort of sustainable plan to what happens after these incentive payments go away? As I see, they can see these as an extra source of income, and then they have these outcomes, but eventually, these incentive payments aren't going to go away.

MR. NELB: Yes. New York is the only DSRIP that has an explicit -- in their waiver has an explicit plan to sort of transition DSRIP to more sort of value-based purchasing, sort of ACO-like payments. Other states are exploring different mechanisms. As I mentioned, California

and Texas are currently seeking renewals. The evaluations have been looking at, at least surveying providers about, their plans for sustainability, have seen different things. It's certainly a question to keep monitoring.

COMMISSIONER CRUZ: Yes. Because, I mean, if it happens like other funding, for example, from the NIH or something, that you fund these projects as long as they are funded, but there is no sustainability plan. Once the funding goes, the project dies.

COMMISSIONER ROSENBAUM: First of all, I want to add to what Patty and Andy said. My great compliments on this work because I think it really is very revelatory for people about the fact that within the structure of Medicaid as we know it today, enhanced by Section 1115, it is possible to rethink the program. We think about Medicaid as a series of statutory requirements, and those requirements are not susceptible to change as the world changes around the health care system. And I think what this shows is that, actually, the executive branch has a fair amount of running room to recast what would appear to be sort of current practice in a new light. I think you do a very good job of laying out the big picture.

There are several issues I'd like to know more about. The first has to do with the process by which one of these is put together. I don't mean so much that a state in the safety net provider approach, the Secretary, although I would like to know the genesis of them, how they come into being. I have some sense of it, but I think spelling it out for people is better, and it goes to the question that Patty raised, why so few states are doing this.

Another is the process that is used to determine what will and will not be an allowable cost under this new model. For example, yesterday in the Times, there was a huge story about the effort that Hennepin County is making to try and avert health care cost by expanding the range of interventions that the county will pay for. The article wasn't express on this, but I assume that if -- and Minnesota is not a DSRIP state, but they are doing something very similar, using their own authority. So I would like to know what DSRIP adds that a place like a Hennepin County seems to be doing without this, both bringing down cost and augmenting services.

Specifically, I am very interested in whether

room and board have been brought up as issues, have they been accepted, have they not been accepted and why, so sort of a better feel for what is and is not in.

A third area, quite frankly, because as revelatory as this is, there's always something a little disturbing about it, which is how did this get to be quite so big without a very transparent process of policy development.

I recall no specific proposed rules or final rules on DSRIP. I am not clear whether the 1115 transparency process applies here and is used here. It is actually rather difficult to go to the website and learn things about DSRIP, and if this is the kind of transformational handle on thinking about payment reform in the context of certain parts of health care delivery for an underserved population, shouldn't the process of thinking about this be somewhat more transparent to everybody, so that we didn't have to wait for you guys to put this excellent work together?

The last point is whether we ought to be making recommendations to the Secretary about using this kind of model in other areas. For example, we're going to have a

discussion today about child welfare. Child welfare programs depend heavily on government financing, and is it possible to use some of these system transformation techniques to get child welfare programs working more closely with health delivery systems and other social services to make a much better system of care for children who are in the child welfare system? And I think these are questions that we might as if DSRIP were a more transparent vehicle.

COMMISSIONER HOYT: I thought this was a great pick for a chapter topic, very timely.

My concern was if you're not a policy wonk or a Medicaid numbers geek, you might not fully catch the significance of what you guys are saying. To frame context, I was thinking of -- I like Patty's comments about listing the DSH money. I apologize if this is in there. I don't remember. But what is the total amount of non-DSH supplemental payments? And especially going forward with the adjustments to ACA, what is the DSH money projected to be in 2016 or something like that to draw attention to this?

You've got some big states here on the list.

What percentage of that non-DSH supplemental money is accounted for by these six states? I've got to believe that's a large percentage of it.

The last thing that I'd look for in context or impact -- and I don't know if you can tease this out or not, but maybe by category of provider, how significant of an incentive is this? Is this helping a safety net hospital increase their revenue 1 percent, 10 percent, or another class of providers? Whatever you can drill down to, to get that, I think that would highlight the significance of what we are looking at.

CHAIR ROWLAND: Okay. Yvette.

COMMISSIONER LONG: I don't want to talk about money at this particular moment. What I want to talk about is the consumer protection portion of this here.

When you guys went out to these sites or whatnot, did you talk about the quality measure? Did you see anything in reference to the quality measures? Because I have two questions. My first one is, are the quality measures good enough to guarantee consumers will be protected? That's the first one.

The second one is, what other type of consumer

protections needs to be in place to ensure that consumers don't get hurt by this new experiment or new pilot program?

Third is -- and I said two, but I think I have four questions that I need to ask. The third one is, what is the impact on, whatever you call this acronym, DSRIP, whatever, on the health care disparities?

And then, fourth, I want to talk about CMS a little bit here. CMS is taking on this here -- launching this here program and whatnot. The concern that I have is that CMS is very limited, has very limited staff, and what I am trying to figure out -- and I understand that states can play a part in this also along with CMS -- is how this is going to be monitored, and that's a strong concern that I am having.

So if you can answer those questions, the first two mainly on the quality measurements, what is it that --

MR. NELB: Yes. I can take a stab at it. So the quality measures vary, but generally, a pull from some of the various core quality measures, things like readmissions and just sort of monitoring access to care. I think one thing to keep in mind is that even though this is a Medicaid payment, it's not a Medicaid service. Therefore,

DSRIP, in some cases, supports care for the uninsured as well as care for Medicaid beneficiaries. So it's a little different from the normal protections that you have for Medicaid services, for Medicaid beneficiaries.

Health disparities is one of the focuses of many different DSRIP projects, and certainly, as it's been mentioned, there's a lot of work for states and CMS in sort of monitoring these, which was certainly a concern that was raised at the site visit. There's, in some cases, actually so much data being reported and such limited staff capacity to actually review these that it's, in some ways, hard to really identify where there are potential problems and where -- to just sort of make sense of all the data.

MR. FINDER: And I think I would just add that these are payments in addition to payments for services that the providers are providing to beneficiaries, and it really is on an ongoing basis.

A lot of them go to building capacities, so they can care for more people and provider better care for people as well.

CHAIR ROWLAND: Okay. I have Norma, then Sharon, then Marsha.

COMMISSIONER MARTINEZ ROGERS: I have a question also very similar to Yvette's, and that is that you reported that there were changes in the delivery of care, that there were changes in delivery of care. What type of changes? What were those changes that made this significant, considering that in the state of Texas, we have so many uninsured?

To tell you the truth, taking Austin, which is the capital of Texas, which is also the Austin-tatious" of Texas, if you get the meaning of the word, which is more of the elite, and if you would take Brownsville, Texas, which is South Texas, it's comparing apples and oranges. They are two completely different types of cities in the state of Texas.

So it didn't surprise me that Austin was doing so well because they have the most educated of anybody in the state of Texas, and I guess I'm asking. What are the changes of delivery of care, and did you think of going to South Texas?

MR. NELB: I can add to that. We did go to San Antonio as well and met with providers there to hear about the changes. There really are sort of a wide range of

things, and I could follow up with more specifics, but just in San Antonio, for example, we heard of efforts not just about increasing primary care, but about better care navigation. There's been a big focus in Texas working with county judges and sort of behavioral health issues, sort of a diversion from emergency departments and sort of getting folks with mental health into more care in the appropriate setting.

But you do raise some challenges, which are unique for states that aren't expanding Medicaid, have been using DSRIP in some ways a little bit differently, in some ways actually using it to provide care for the uninsured as sort of a basic service. Whereas, other states that have expanded tend to use DSRIP as a way to sort of supplement the care that those Medicaid beneficiaries are already receiving as being Medicaid in these.

COMMISSIONER MARTINEZ ROGERS: So what will happen if they are not approved for a second round of money in the state of Texas because we did not expand?

MR. NELB: I think it's too early to tell. Obviously, the state is asking for a renewal, and we will see. The providers we talked with in the state were very

concerned about the ability to sustain their initiatives without a renewal, and so we'll see how that plays out.

CHAIR ROWLAND: Sharon.

COMMISSIONER CARTE: Well, obviously a very exciting topic, but -- and while I'm clear in understanding that we're a ways off from evaluation, I just wonder if we could not ask -- reach out to the states individually to ask them for a time frame on when they would be reporting interim results, or CMS or both, so that we could begin to look at where things were headed. And I hear other people sort of wanting to know more about that.

CHAIR ROWLAND: And also picking up on Patty's earlier comment to really ask whether the federal government is or should be doing more to do evaluation of these, since there's obviously a lot of money at stake in this as well as a lot of --

COMMISSIONER CARTE: Right. And, also, I was at the fall NASHP conference, and I think the chief medical officer for New York state was there and was saying that he expected that they would begin to see some results in the coming year. So it would just be nice to know when we might look forward to that.

VICE CHAIR GOLD: A couple of points. One that I think maybe could be mentioned in this chapter, I think it goes well beyond this chapter and relates to broader commission interests, but I think it's -- I was trying to think, these are health care transformations. There are a lot of ways in which states are doing transformations, even Medicaid programs. There are the primary care case management programs. There's the CPCI, which is a multipayer version of that with some differences. There are the state health innovation grants.

I think it would be useful -- I think the states don't see these necessarily as the separate things, but they're piecing together ways of doing what they want to do. So sometime in the future -- not in this chapter -- I think it would be useful to think about where that is. But I think in framing this chapter, just the way people were talking about DSH, it struck me these are based on hospital systems. They may not be just hospitals. They're working with other things. And is that because of the DSH relationship or which is this piece and where does this -- at least let us understand this piece.

The other is to think a little bit within the

"this piece" side as to different goals, and not just what people say but what they really mean. I mean, to what extent is this financial support? Because financial support is important. To what extent is it capital support to providers who don't have access to capital? Are these short-term investments to build infrastructure that are going to pay back over time such that maybe it will become self-supporting? Or are these ongoing subsidies? Understanding -- because I think they're all really different, motivated differently, and that sort of gets to my last point about the evaluation.

I think it's -- I don't know how much the Commission would want to get into this, but it's easy to say there should be a cross-cutting federal evaluation. But these kind of things, if it's apples, oranges, and tangerines, how are you going to put that together? And you don't just want some report six years later. It seems to me that the first thing that's needed -- and whether that's done by CMS or by MACPAC or by someone -- is to say, looking across these conceptually, what are the differences and are there different buckets that these fall into? And then maybe get the data that already are being generated by

the states and try and integrate it to say what we're learning and figure out if there's certain holes about what we know across states that we can fill in, because there's a whole lot of methodological challenges in doing these kind of studies, but I think it is important to look across it. But I hate to sort of convey this word "evaluation," which sounds like a $17 million study that won't answer the right questions. And so I think thinking a little bit about what it is we really want to know at the cross-cutting level and how we get that is important.

CHAIR ROWLAND: So what I'm hearing is that as we draw this session to a close, we want this chapter to be prepared for the June report. We would like you to lay out a little more clearly, I think, how this initiative relates to the history of supplemental payments. You note here some of our recommendations on supplemental payments, but not how -- you know, you do discuss a little bit about the managed care conversion and whatever, but I think it's important to provide the context for how these are happening.

We do have questions that we want raised about the consumer issues, about what happens to the safety net

through these and about the differences. Sara raised, quite appropriately, that it would be helpful to have better guidance from the department as to what their rules and their objectives are in awarding these grants, and we'd like more information about how to answer some of the questions, whether through a -- not using, Marsha, formal, but through better evaluation methods of how to really figure out what we're learning from these DSRIP waives as opposed to where the money's going, which follows Mark's point of really looking at what's at stake in these and why the spending there is so -- I mean, it's billions of dollars in these programs. So thank you, and we look forward to continuing the work on this chapter. But I think more broadly, beyond getting this in the June report, what we're really asking for is a better landscape of what's going on with state-level innovations in the delivery system so that we can really look at where all the pieces are that are going on in different states. And I know there's other work, and we're about to turn to site visits on advanced payment models, so we will go to the next phase of what's going on in the states.

Thank you, Rob, thank you, Ben.

Jim, you're on. So we're moving from the DSRIP waivers to an update on our site visits to look at state activity in Arkansas, Minnesota, Oregon, and Pennsylvania on advanced payment models, and hopefully at some point we'll be able to weave all of these things together.

Jim?

MR. TEISL: Yes, thank you, and good morning, everyone.

So this morning I want to thank you for the opportunity to talk about another of our ongoing projects to better understand Medicaid programs activities around value-based payment. And, in addition, it touches on issues that we've talked about related to state program -- Medicaid program organization and administration.

So this particular project, as Diane mentioned, is a continuation of work that we began last year to visit states taking different approaches to try to pay more for value in their Medicaid programs. There is a report available on our website on our visits from last year, or if you want to contact me, I'd be happy to send it to you directly.

As many of you will recall, we mentioned in that report that states everywhere are trying to seek value in their Medicaid programs, and this effort is largely driven by their desire both to contain costs but also to improve access and outcomes for their Medicaid enrollees.

The statutory framework for the program obviously allows states to take different approaches to the common goal, and so we've been conducting this ongoing project to better understand approaches in the different states.

So to better understand states' approaches to achieving value, we've been conducting two-day site visits to different states to understand the factors that affected their model choice and design, the policy issues that they've considered and the implementation steps that have been required, as well as ongoing operations in the states and the way that they are attempting to evaluate their program changes.

We've conducted semi-structured interviews with state officials and stakeholders, and these have typically included at least Medicaid leadership, policy and technical staff. At times we've talked to Medicaid contractors. We've talked to provider representatives and sometimes

individual providers. We've also met with groups of enrollees, at times legislators, governors' office staff, and staff from other state agencies that interact with Medicaid. So we really tried to cover the landscape of people involved in the program and value-based purchasing reforms.

I really want to emphasize that this isn't meant to be a formal research study or an evaluation of what these states are doing. Our primary goal is really to learn and to bring information to the Commission to enhance your understanding of the different approaches that states are taking beyond what you might typically glean from issue briefs or webinars.

We do ask about indicators of program success related to things like cost and outcomes and access, but we haven't tried to independently collect data, conduct an actual evaluation ourselves, or validate evaluation work that the states have done themselves.

We tried to pick programs that represent a range of sizes, geographies, politics, and especially approaches to program administration and payment reform. We've also tried to pick states that are somewhat down the road into

implementation of these initiatives rather than go to states that are talking about payment reform or are somewhere in the planning stage in the hopes that we might be able to learn a little bit about both lessons that the state has learned and ideally some evidence of the results that the initiatives have had.

Last year, we visited Minnesota, Oregon, Arkansas, and Pennsylvania, a couple states that have implemented accountable care arrangements, one that was very focused on developing episode-based payments, and another that was focusing its reform efforts through its contracted managed care organizations.

This year, we visited two states that have actually moved away from full-risk capitated managed care as well as one that's actually nearing the end of a multipayer, patient-centered medical home pilot.

It's worth mentioning, of course, that in every state we visited, the full scope of payment and delivery system reform activity isn't really captured in these little summary statements. There's a lot going on in these states. Typically it was one of these things that led us to go there initially, but we tried to cover all the things

that were going on.

Today I'm going to provide high-level summaries of each of these states' programs. Obviously, it's hard to cover everything that we covered in two days' worth of a site visit and just a few sites per state.

We'll start with Connecticut, which has attracted some attention for its rather recent decision to switch from traditional Medicaid managed care to what's called an "administrative services organization for medical services," and this at a time when much of the discussion in Medicaid has been about states' increasingly turning to full-risk capitation arrangements through contracted Medicaid managed care organizations. In a couple of instances last year, Commissioners actually expressed interest in learning more about Connecticut Medicaid and some of these recent changes.

So a bit of context. From '96 to 2011, so 15 years or so, medical services for children, parents, pregnant women were, in fact, provided through managed care contracts in Connecticut.

In 2012, all populations transitioned to an administrative services organization to manage their

medical services. And an administrative services organization, what's commonly referred to as an ASO, is really a company that provides many of the same administrative functions that MCOs typically do -- care management, utilization review, member services and provider enrollment, and interaction activities -- but without being paid on the basis of capitation and without assuming risk for the services that the people use.

I should note that prior to this transition for medical services, Connecticut was already using ASOs for behavioral health and dental services.

So we heard a number of reasons for why Connecticut decided to do this. Some that they have sort of released publicly include these here: they wanted to build upon success that they had in their behavioral health and dental ASOs; they hoped to improve access to and use of data, as well as sort of centralize and streamline administration, and all the services that both enrollees and providers seek from the Medicaid agency.

Frankly, we heard that over time state officials in Connecticut had begun to question whether other approaches might actually improve the value that they could

get for their Medicaid spending. The number of MCOs that they were contracting with had declined from a high of 12 in the early years down to three in 2011, and it looked like one of those remaining three might actually be looking to exit the program.

They were concerned that they, you know, as a result of contracting with multiple MCOs, received multiple and not always complete encounter data sets, which, importantly to them, actually lacked payment information, and we've heard this before regarding encounter data. There were also concerns that the limitations in the encounter data made it challenging for the state to be fully informed in negotiating capitation rates with the plans.

And, finally, they felt like and they heard from providers that a lack of consistency across the MCOs in things like prior authorization, policies and processes, provider networks, payment rates and methods were challenges both for enrollees and providers in providing and accessing the services.

So Connecticut transitioned medical services to Community Health Network of Connecticut, which serves as

the medical ACO, and this was formerly one of the managed care plans that was contracting with the Medicaid program. The functions, as I mentioned before, include many of those that are common to MCOs in Medicaid programs. One that's not listed here but a specific service that CHN -- which is what the Community Health Network is known as -- provides is known as intensive case management. Under this program about 17,000 enrollees are enrolled in the program, and they use geographically grouped teams of nurse case managers and community health workers. Some of these are actually embedded in the hospitals, in the community health centers that these enrollees frequently access. They assess enrollees for their social needs, including housing stability, food security, safety, as well as more traditional medical needs, behavioral health and oral health needs, and help coordinate use of these services.

Another function that CHN provides is to attribute enrollees to patient-centered medical homes, which we'll talk about a little bit more in Connecticut, as well as the other two states. And in return for these services, CHN receives quarterly administrative services payments, and there's also a 7.5 percent withhold, which is

contingent on CHN meeting performance targets, including things related to beneficiary health outcomes, care experience, and provider satisfaction.

As far as results so far -- and I should caution that these are relatively preliminary -- Connecticut reported actually a 0.7 percent decrease in average spending per member per month from fiscal year 2012 to '13 and a 1.8 percent increase in spending from '13 to '14. They estimated historical increases under their managed care program to be around 3 to 6 percent.

There are a lot of confounding factors, and we don't have enough evidence to say how much of this recent stabilization of health care cost increases can be attributed to the ASO transition. It's safe to say, however, that officials in Connecticut are encouraged by what they're seeing.

Most stakeholders that we talked to seemed to believe that changing the payment structure, converting to the ASO arrangement, the assumption of risk or the resumption of risk by the state has helped to change the discussions between the state and its contractors from one focused on margins and profitability to one that they think

is more actually about the quality of the services being delivered. Still, there are obviously a number of issues that are continuing to be worked out and developed. There's a new emphasis on making sure that the fee-for-service claims data provides the information necessary to facilitate analysis and quality monitoring.

After years of contracting out to MCOs, there was a sense that there had been a little bit of neglect of the fee-for-service claims data, which is not terribly surprising. So there's a continuing effort to standardize claims data. There are a number of plans underway to modernize provider payment methods now that it has been converted back to fee-for-service. I mentioned the development of a patient-centered medical home program. That was implemented at the same time as the transition to the ASO. Other payment modernization activities include a conversion of hospital payment from per diem- to a DRG-based methodology.

They're looking at the possibility of bundled payments for certain services, an acuity-based formula for nursing facilities. They have recently increased primary care payments to try to maintain to some extent, though not

the full extent, of the primary care payment increase that was part of the ACA.

They're developing health homes for enrollees with behavioral health needs, and they have a major effort underway to rebalance long-term services and supports from institutional sites of care to more home and community-based services.

CHAIR ROWLAND: And they're doing all this without a DSRIP waiver.

MR. TEISL: Correct, so far without a DSRIP waiver.

COMMISSIONER ROSENBAUM: Just a technical clarification. So if we were to go and look up proportion of state beneficiaries enrolled in managed care, as a technical matter, Connecticut would say they don't use managed care anymore --

MR. TEISL: Correct.

COMMISSIONER ROSENBAUM: -- or even though, in fact, people still, I assume, have to select a primary care provider, and certainly in the world of employment-based insurance, contracting with an ASO versus an insurer doesn't suggest you're not insured. You use it -- I mean,

it's a different financing model.

So here we have the attributes of managed care, but it's a structure that's existing outside of the managed care statute, which assumes MCOs, really.

MR. TEISL: Exactly.

COMMISSIONER ROSENBAUM: And I think this will become very relevant at some point when we get to -- probably not this meeting, but ultimately when we get to the question of the new managed care rule. And thinking about the questions that Yvette might raise, you know, whether, in fact, the consumer protections should not transfer to this model since it has all the attributes of managed care, it just sort of lives outside of the technical terms of the statute. But they classify these folks as something that we would euphemistically call fee-for-service, meaning --

MR. TEISL: Correct.

COMMISSIONER ROSENBAUM: -- they're not managed care enrollees.

MR. TEISL: That's right.

And as far as assignment to a primary care provider, I'd have to check on the details of this. The

PCMH program was implemented at the same time and I think right now covers about a third of enrollees who would be assigned to a patient-centered medical home, but I'm not sure if it's the same sort of assignment that you might see under an MCO.

COMMISSIONER ROSENBAUM: But the notion that you would have, an identifiable primary care provider, and your care would be managed as opposed to just putting you back into 1974 Medicaid.

MR. TEISL: Very much so. Right.

COMMISSIONER ROSENBAUM: Okay.

MR. TEISL: So next is Oklahoma, which also decided to move away from what's, I guess, now considered traditional risk-based managed care, although this transition was in 2004.

Another difference from Connecticut is that the state, and specifically the Oklahoma Health Care Authority, which administers Medicaid in Oklahoma, brought almost all of the administrative functions in-house as opposed to contracting with a number of ASOs, as Connecticut has.

Prior to 2004, Oklahoma had a partially capitated primary care case management or PCCM program in their rural

areas. They made this partial capitation payment to primary care providers to include care management, case management services, as well as office visits, some lab services. It was roughly, I think, half of the payment that went to them was under this partial capitation, and they had more traditional contracted risk-based managed care in their urban areas.

In 2004, they decided to expand the PCCM program from the rural areas into the urban areas and take it statewide. In the time since, they have implemented a number of initiatives intended to enhance their statewide PCCM program, to improve access, coordination, and care management services.

The Commission first heard from the former CEO of the Oklahoma Health Care Authority, Mike Fogarty, several years ago, and since that time, we wanted to get there to learn more about the details of the program that he described as well as the recent enhancements that have been implemented.

The state's perspective on their program is that it's operating a public managed care organization, essentially performing all of the functions of a managed

care organization in-house or through a few limited non-risk-based contracts.

So all SoonerCare Choice members -- and that's the name of this statewide PCCM program -- all SoonerCare Choice members enroll with a patient-centered medical home. Conversely, all primary care docs that served the Choice members are PCMHs. Advanced practice nurses can also be patient-centered medical homes, and they are paid the same way that physicians are. In total, there are more than 2,000 providers participating in the PCMH program.

Provider payments for PCMH include -- as opposed to the prior partial capitation, they are now paid a monthly care coordination fee based on the patient-centered medical home tier that they achieve. Tiers depend on the number of access and care coordination requirements that a practice meets. They range from entry level to advanced and then optimal. Most providers are actually in Tier 1, the entry-level tier, although most enrollees in the program are actually enrolled with Tier 2 or Tier 3 practices.

The per-member per-month care coordination fee ranges from about $3.50 up to a little more than $8, and as

I mentioned, it depends on the tier as well as whether the provider treats children, adults, or a combination of both.

Providers in addition to the monthly care coordination fee get fee-for-service payments for the services that they provide based on a fee schedule. I believe we heard that the physician fee schedule in Oklahoma averages about 95 percent of Medicare. As a result, they didn't see a huge impact from the primary care payment increase, but they felt that primary care access in Oklahoma was excellent, partially owing to the fact that they pay relatively well.

And finally, the PCMHs are eligible to achieve performance-based, what are known as SoonerExcel payment for achieving certain milestones. These payments are about $3.5 million annually, although the state expressed some interest in moving more of the payment into these performance-based rewards going forward.

Here are some examples of the programs that the Health Care Authority has to manage the care of SoonerCare Choice enrollees. The first three of these are actually units within the agency. They include a case management unit for enrollees with very specific episodes or events.

An example is obstetric and pediatric case management for particularly high-risk cases. In addition, they have a chronic care unit, whereby nurses provide telephone case management to high-risk members with chronic conditions, a behavioral health unit that provides outreach to beneficiaries with serious mental illness or emotional illness, which they identified through required screenings, and we spent a fair amount of time talking about the health management program, which is actually a contracted program that the state has with a vendor, to provide health coaches and practice facilitation, which is essentially practice management consulting to the practices, within practices that have a particularly high chronic disease burden.

The contractor uses a predictive modeling approach to identify members who might fit the program and then the practices that serve particularly high members of these enrollees.

Currently, 39 practices have embedded health coaches. There are six practice facilitators. Since the program began, over 100 practices have actually gotten the benefit of this sort of management consulting from these practice facilitators.

Our understanding is the health management program was initially paid for through a per-member per-month payment. The payment has now been transitioned to one based on the number of FTEs, full-time equivalents, that the contractor provides.

A recent enhancement to Oklahoma's program is the addition of health access networks. These are contracted networks of primary care providers as well as specialists. There are three currently in existence, the two main state universities as well as a small health access network made up of a group of providers in a more rural county, Canadian County, to the wets of Oklahoma City.

In addition to providing care coordination across this network of providers, the HANs, as they're known, also provide practice facilitation to members to try to get them to higher tiers of PCMH recognition, and they receive a $5 per-member per-month for each member whose primary care medical home is participating in the HAN.

The state reported it has funding for about 55,000 members. I think it was 25,000 for each of the two big state universities and then 5,000 for the smaller county-based HAN, with the provision that the state

universities could actually exceed the cap as long as they were able to put up the non-federal share to go beyond what the state had available. Obviously, the county-based providers wouldn't be able to do that.

Before moving on, actually, I wanted to touch on a couple of evaluation results. The state of Oklahoma had the Pacific Health Policy Group do a recent evaluation, and they included looking at these three main enhancements that we talked about, the PCMH, the HMP, or health management program, and the HANs.

For the PCMHs, they did see improvement in the visit rates among enrollees. Emergency use rates declined, as did average per-member per-month expenditures.

One interesting thing was that the results were for all PCMH tiers combined, but they didn't actually see differences in outcomes depending on the tier of PCMH achieved by the practice.

For the HMP, they actually saw a reduction in inpatient spend and spending for chronically ill patients. They reported high provider and member satisfaction and a savings of $181 million, and this was net of the vendor payments for the entire life of the program, which I think

was five years when the evaluation was done. So they estimated a return on investment of over $5 in spending for every dollar in administrative expenses.

Finally, the HANs were relatively new when the evaluation was done, so they deemed the results preliminary because there was a lot of growth in HAN membership at the very time period that they were trying to evaluate.

They saw a similar utilization overall between the HAN and non-HAN-affiliated practices. They did see a modest reduction in ED use and overall saw comparable claim costs between the two groups, although they observed that the enrollees of HAN-affiliated practices actually seemed to be higher risk than the non-HAN, so they felt like they had similar spending despite the fact that they were higher risk enrollees.

Finally, we visited Maryland, which was a little bit different from the other two. We went to really look at their multi-payer medical home program. This was a pilot established in state legislation in 2010, and it is coming to the end of its pilot phase at the end of this year.

It's administered by the Maryland Health Care

Commission, which is interesting because it's the first of our site visits focused on a program that's actually not administered by the Medicaid agency. Instead, it's a program in which Medicaid participates along with all the other main payers in the state.

Participation is required of all payers with premium revenues of over $90 million, which I think includes the five major commercial payers in the state as well as Medicaid. Federal and state employee plans, TRICARE, and some private self-insured employer plans also participate.

In addition, the Maryland Health Care Commission, which oversees the program, is also allowed to authorize single carrier programs, and we'll hear in a moment why that was important in at least one case.

The pilot itself is relatively small. It's about 250,000 patients, and about a quarter of those are Medicaid patients. At the same time, one of the largest, if not the largest, commercial carrier in the state decided to implement its own single-carrier program, and because of that, practices in Maryland had to decide whether they wanted to apply to be part of this multi-payer medical home

pilot or enroll with this large commercial carrier's separate patient-centered medical home initiative.

Ultimately, 52 practices were selected to participate from around 200-or-so applicants. The practices receive fixed transformation payments, which are per-member per-month payments made twice a year to the enrolled practices. Payments range from about $4 to $6, and they're tiered, depending on the size of the practice and, again, the level of NCQA, National Center for Quality Assurance, PCMH status certification level that the practices achieved.

Providers, perhaps not surprisingly, felt that these fixed transformation payments were really helpful and allowed them to make investments in their core infrastructure, including hiring care managers, improving their use of health information technology. There were mixed benefits about the value of practice coaching, which was also part of their signing up to participate in the multicarrier program.

We heard some differing opinions on whether practices wanted to participate in the state's multi-payer program versus go with the largest commercial payer

program, the single-carrier program, which I neglected to mention, actually included a million patients. It was much larger than the multi-payer pilot.

In a couple of cases, we heard that practices tried to enroll their more Medicaid-heavy practices into the multi-payer pilot, while ones that had more of a commercial payer mix opted to participate in the single-carrier program. Others, which actually seemed to be bigger participants in the development of the multi-payer program just wanted all their practices in the multi-payer program.

They were relatively unanimous in agreeing that having an embedded care manager that could provide services to all their patients, regardless of payer, was really valuable rather than trying to coordinate with care managers assigned by individual payers.

They also thought the multi-payer nature was an advantage because, obviously, with the majority of their patients enrolled, it sort of gave a critical mass necessary to move towards the incentive that that program created. They worried a little bit about variation among programs if instead every individual payer had its own

patient-centered medical home program.

Payers, on the other hand, seemed to feel a little bit removed from the program. A lot of them reported that they were already employing similar strategies to do the same thing that the multi-payer program was designed to do. There were some specific concerns regarding transparency of the attribution and the shared savings methodology that the state had employed. They reported not being to validate -- or not being able to replicate some of the results and some delays in getting the information that would allow them to do so.

In general, the payers didn't really favor the up-front fixed transformation payments. They felt like they weren't tied enough to provider achievement necessarily, also that they should be temporary and providers should graduate to other arrangements over time.

Providers were also eligible under the multi-payer program for shared savings based on the total cost of care and meeting certain provider metrics. One reaction from payers is they would like to see some downside potential over time as well.

A significant decision for Maryland, as it's

moving towards the end of the pilot, is whether to continue with the model design that the pilot created or consider alternatives. An alternative, for example, would be to encourage single-carrier programs, and then the state could play a role in trying to standardize them to address some of the concerns providers had about variation.

Evaluation results based on just the first year showed about half of practices managed to share in savings, which totaled nearly a million dollars. They saw some significant differences, although most of the 48 measures that they looked at didn't differ from the comparison group, though the researchers caution that this might be due to only having one year of data, even though they are actually nearing the end of the full pilot.

From a Medicaid perspective, it was clear there were some concerns about the fixed transformation payments as well, budgetary concerns, especially if the program were to expand beyond the initial pilot.

There was also some concern that the care management approaches and incentives that met the needs of a typical commercial population were different from those that might be more appropriate to a Medicaid population,

and obviously, this is a challenge that any state would have to consider if they were trying to implement a multi-payer program such as this one.

I won't go into it a lot, and I know we're sort of pressed for time. We also spent some time in Maryland talking about their all-payer hospital waiver, which would probably be an interesting subject to take on more at a later point. The important thing is in Maryland -- and I think many of you are aware of this -- all hospitals receive the same payment. Each hospital receives the same payment for the same service, regardless of the payer of the service. So all payers -- Medicare, Medicaid, even the uninsured -- are all charged the same amount by a given hospital.

Maryland recently modified the waiver, so all hospitals in the state are now going to operate under a fixed global budget; that is, they are provided a fixed amount of revenue per year and have to care for all their patients within that amount of revenue, the idea being that this will actually provide a very strong incentive for hospitals to keep people healthy and treat them in the most appropriate and lowest cost setting which likely would not

be through inpatient care.

There are a number of tests that they are going to have to meet in order for this to happen, limiting annual growth to about 3.5 percent per capita, holding down all Medicare service growth to no more the national level, reducing readmissions, reducing hospital-acquired conditions, and things like that.

So we want to continue monitoring the states that we visited, both the four we visited last year and the three this year, for program developments and any additional evidence we can glean on effects on cost and access and quality. We're planning a roundtable where we're going to invite representatives from each of these states to focus on some of the issues that are presented here. We hope to continue to learn what's working to improve value, what might not be and why.

And with that, I welcome any comments or questions or thoughts you might have on things we want to follow up on going forward.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: Thanks. Jim, as always, a very nice report. I have four comments.

[Laughter.]

COMMISSIONER GABOW: I think that it's interesting what people have used in these states, given the literature, and maybe you could comment. I mean, the medical home literature has been mixed in terms of outcome. The telephonic management, particularly for high utilizers, has found to be ineffective. Embedded coaches have had a mixed review. Camden project is pulling out all their embedded coaches because they've found that they're being used for many things beside -- when you put them in a practice, the practice has needs, and we've found this, too.

So, I think some discussion about how evidence based were these interventions that were used, because I think for these three that seem most common in what you reported, the evidence is far from robust.

And then the issue about the evaluation, and maybe Marsha, as evaluation queen, can talk about this, but many of these evaluations are pre-post, which gets you to the regression to the mean, and when you have such small percentage changes, whether these are really real or not, I think, is a big question. So, some thought about what do

you think is really the robustness of the evaluation.

So, the evidence-based intervention, the robustness of the evaluation, I think for all of -- I know we are not doing the evaluation, but, I mean, of the evaluation that's being done.

COMMISSIONER ROSENBAUM: I think you did a great job here. I mean, this stuff is sort of heavy to plow through, and for those of us who, unlike Patty, did not spend our entire lives thinking about how payment changes system behavior and provider behavior seems a little daunting.

I think it would actually be interesting to try and do some cross-model synthesis so that we can see that in these various -- in these disparate models, there actually are some common themes, some common tests of ideas. It might help those of us who really are not expert in payment reform to understand what people are thinking about.

And, again, I want to come back to this issue that I raised midway through, because it is, I think, a concern to watch, and that is to the extent that payment reform is sort of happening outside of established

structures in the statute, so, you know, in 1997, we rethought the managed care provisions of the statute and they were rethought for particular kinds of creatures, we'll see what CMS has done in its modernization of the managed care rule, which, I mean, they've got a lot of running room to do lots of stuff.

But, I am a little concerned that whether we're talking about, you know, what is commonly labeled acute care or long-term care, whatever you want to call it, that these models involve the pretty aggressive management of patients, and for good reason. I mean, that's a plus. But, I want to be sure that -- I mean, it's always a little hard to have changing markets -- have regulators keep up with changing markets. But, I think we also need to do some work on whether -- how these models, as they're evolving, fit into existing regulatory structures, and whether there are important, particularly consumer safeguards.

I mean, I think that providers, there are certain safeguards, but a lot of it comes out through negotiation. But, I think that the patients are the third party, the beneficiaries of the model, and yet they're really not

represented in these large payment reform negotiations. So, it's the same theme carried over from our first session on DSRIP. Here, we have it at sort of a more micro-cosmic level, and how do we know that patient interests are being represented, particularly when the arrangement is happening outside of structured environments. So, I -- structured regulatory environments.

So, I would recommend that we do a little bit on cross-sectional work and a little bit on what's the underlying basis for this, you know, where does this come from and how do important patient or consumer protections get dealt with.

COMMISSIONER RILEY: I'm struck, the more we talk about the variation in the program and how it varies state by state and get frustrated. On the other hand, here we see a perfect example of the value of that variation. On the one hand, we have Connecticut, which has focused in, moved away from a traditional all payer managed care world to focus really very vigilantly on just the Medicaid population. Then we have Maryland, that's got this pretty long history of all payer work.

So, it seems to me it begs the question of how

does the Medicaid population fit and fare in both those models and is there a significant difference, because I think the world is moving increasingly to all payer, and I would argue that's probably right. But, so, here we have a wonderful, it seems to me, laboratory of experimentation where we can take a drill down at how the Medicaid beneficiary fares in both kinds of models.

COMMISSIONER COHEN: Thank you, Jim. Great presentation. But, I'm going to admit to a little surprise, because when I heard the topic, I kind of expected that the subject matter was going to be a little bit different, and I'm just looking at it through my own personal lens. In New York, there's a lot of work going on to sort of define what value-based payment, like, will mean, and what Medicaid providers will need to be doing, and it's very focused on the payment from the payer to the provider and sort of systems of payment.

And, so, you know, I'm like, oh, right, well, I guess value-based payment could certainly be to the payer, like an ASO. It could be to a provider, or it could be a lot of different things. It could be picking a model that you think is valuable, like PCMH, and paying extra for it.

It could be based on metrics or measures or whatever. But, it did -- I mean, there's a ton of variation.

But, it strikes me that in terms of thinking about our work, it might be useful to sort of, over time, take from this variation and start to develop a sense of what we think the definition of value should be, because it's a buzzword now, and anybody who wants to do anything new and different in health care says it's pay for value or it's about value. There are some definitions, but I think making sure that we move towards defining it in a way that includes consumer protection, that includes quality, that includes cost, I mean, you know, sort of the things that we think are important in what way, because, again, it does -- like, there's a need for some framing, I think, to help separate wheat from chaff in some sense.

So, you know, where you can really measure against metrics, it's very different than when you're saying we kind of like an approach and we're going to pay more for it, but where's the evidence base. Does value require an evidence base? What kind of an evidence base? I mean, I think these are some of the questions that we might start to think about and tackle. But, I understand

you need an environmental landscape first, but I'm realizing how much we actually -- that begs the question of what it all sort of -- what it means and what it should mean for Medicaid and what it should mean in an all-payer context and if Medicaid is any different or not.

CHAIR ROWLAND: Jim, I think it's been very helpful to continue to watch the evolution of these models, but I think we're also asking that now, and I hope your roundtable will begin to get us there, that we figure out, are there pieces of these models that really are very important, that are delivering better care to the beneficiaries, that are better payment models that could be potentially replicated or maybe incorporated into some of the other choices that states make, and following up on Trish, what happens if you manage the Medicaid well but you're not in an all payer versus if you're in an all payer. So, we look forward to continuing this conversation with you, as always, and thank you.

MR. TEISL: Thank you.

CHAIR ROWLAND: And, now we're going to turn to another issue that has been one that we've struggled with. As you know, our title is the Medicaid and CHIP Payment and

Access Commission and this brings us to look at the access to care issues, especially for access to specialty care, and Anna has done sort of a data lay of the land on what we know, and here, we really just want to set up and cue for you where do we go next on looking at the access issues with regard to specialty care.

MS. SOMMERS: Thank you, Diane. That was a very nice introduction. I'll skip mine.

[Laughter.]

MS. SOMMERS: The purpose of the session is, as you said, to report on a review of literature and data on access to care in the Medicaid program.

Access to specialty care, again, as you noted, has been raised as a potential issue in Medicaid, namely because fewer specialists report accepting new Medicaid patients as compared to accepting Medicare or privately insured patients. Specialists do play an essential role in the diagnosis and treatment of patients with uncommon and uncertain problems, in the co-management of patients with complex conditions, and management of complex treatment regimes.

So, we've reviewed the available literature and

data in order to distill for you, really, at a 20,000-foot level what we know about this topic, and then to consider what we need to know to support evidence-based policy work for the Commission.

Our review focused on access to specialists who provide direct patient care, and so excludes specialists practicing only in inpatient settings, such as hospitals. Of course, they do provide direct patient care, but I mean to say, provide direct care in outpatient settings. It's also limited to physician specialists, but, of course, it should be acknowledged that specialty services are provided by physician assistants and nurse practitioners with specialized training, and also by primary care physicians. So, it's helpful, also, to keep in mind that experts emphasize the wide variation in the degree of involvement from specialists sought by primary care physicians.

Our review found that the available evidence falls short of providing clear-cut answers about potential access problems in the Medicaid program. So, at the end of this presentation, we offer several approaches to future work that we believe will build a richer body of evidence from which to evaluate policy options.

Evidence on access to care is summarized in your brief from the perspective of three broad domains from our access framework: Provider availability, utilization, and enrollees' experiences accessing care. All of these measures have their various weaknesses, which we should keep in mind as I present the data.

For instance, provider surveys from which we measure physician availability, they may overstate the number of providers available within managed care plans that selectively contract with physicians. Data sources that measure utilization have limited ability to identify the people who actually need specialty care in a consistent manner, thus making comparisons between populations problematic. And, then, household surveys where we tend to get enrollee experience, those typically ask individuals about problems accessing care over the past year. So, the problems reported could have taken place when the individual had another source of coverage or was uninsured.

The review, of course, discussed in more detail in your brief these findings, and I'm going to highlight findings that reflect, really, the key take-away points from the review. So, first, we'll review provider

availability.

So, this table shows you a very commonly reported measure of provider availability, which is the percentage of physicians who report accepting new patients with different sources of insurance. This table is from a federal survey of office-based specialists, and in the first column, we see that among psychiatrists, 43 percent were accepting new Medicaid patients, compared to 55 percent accepting Medicare patients and 67 percent accepting new private patients. And then for other specialists, the acceptance rate is about 75 percent for Medicaid patients and about 95 percent for private patients.

Now, these estimates are based on the question posed to physicians, are you accepting any new Medicaid patients in your practice, and we know from other physician surveys that they often limit the number of new Medicaid patients they will take by capping the number they will accept or requiring long wait times to an appointment. And, so, this would increase the difficulty level of an enrollee's search to find a specialist who will see them.

And, so, we can see the effect of this physician

behavior on provider availability by looking at a GAO survey of physicians serving children in their practice that asked questions a bit differently. And, in this survey, they asked first physicians if they participated in Medicaid and CHIP as an enrolled provider, and then if they accepted some or all new Medicaid and CHIP patients. Of the specialists serving children in their practice, 71 percent reported participating in Medicaid and CHIP, but only half of these specialists accepted all new Medicaid and CHIP patients. What this means is that only 36 percent of specialists serving children both participate in Medicaid and CHIP and accept all new Medicaid and CHIP patients.

Provider availability can also be measured by asking primary care physicians about their difficulty finding specialists to see their patients. The same GAO study asked primary care physicians about their difficulty referring children to specialists based on the child's type of insurance. Again, here, we see a stark contrast between provider availability for Medicaid-covered children, in the left column, compared to privately insured children, in the right column.

Thirty percent of primary care physicians reported great difficulty referring their Medicaid and CHIP-covered children. None reported great difficulty referring privately insured children. And 72 percent had no difficulty referring privately insured children.

I want to point your attention to another finding from the same survey that says somewhat surprising result in a comparison of rural and urban physicians. When primary care physicians were stratified by their urban and rural status, they found that urban physicians more often than rural physicians reported great difficulty referring their Medicaid patients. Thirty-four percent of urban and 26 percent of rural physicians said they had great difficult referring their Medicaid and CHIP patients.

We also know from the literature that some specialties are more difficult to access than others. Surveys of primary care physicians, states, and health plans have identified specialty areas most difficult to access for Medicaid patients. They are listed here, and you can see there are quite a few. In some cases, there is an underlying physician shortage in the country and a concentration in metropolitan areas. Because physicians

favor privately insured patients, Medicaid patients can be disproportionately affected by that shortage or maldistribution.

Now, I'll review some key findings on utilization and enrollee experience.

Studies suggest that utilization of specialty care by Medicaid enrollees is comparable to individuals with private insurance when we're talking about children, and service use is lower in Medicaid when we're talking about adults.

Among children, observed differences in use appear to be attributable to income and socioeconomic factors rather than coverage type, whereas among adults, utilization of specialists is lower for Medicaid enrollees than privately insured after accounting for these socioeconomic factors.

The richest evidence base comes from studies about enrollees' experiences accessing specialty care. These studies consistently show Medicaid-covered children and adults report greater difficulty finding specialists and getting appointments. Some of this research comes from asking enrollees directly. Other studies have used secret

shoppers who pose as patients with the same condition but different types of coverage and try to schedule appointments over the phone.

The findings here appear robust for children because they've been conducted in geographically diverse communities and appointment availability for a variety of specialties and conditions have been examined, and they've all found more barriers to getting appointments for Medicaid patients and longer wait times to the next appointment. However, studies of adults are more limited.

So as you can see, there are many gaps in the literature, and that leaves us with little information about access to specialty care in a number of areas of particular interest to the Commission. So our future work will aim to collect more information on these questions.

In the briefing paper prepared for you, we have suggested next steps that we could take to look more closely at questions most relevant to the work of the Commission and to set priorities. We could solicit input from experts on a range of outstanding questions such as strategies to gauge appropriate use, identify health conditions and medical events where specialists can have

the greatest impact, or identify access barriers for special populations.

We could also conduct empirical analysis with claims data to describe utilization patterns for these conditions and services, in which case we would want to obtain benchmark data from commercial or Medicare databases.

And, finally, we could summarize the lessons derived from efforts to improve access to specialty care and analyze policy options to support effective program interventions.

So we look forward to getting some feedback from you on how we could proceed to delve deeper into this issue.

CHAIR ROWLAND: You know, one of the difficulties here is that whenever we talk about Medicaid versus private, we are talking about a big income differential in terms of the population, and that I think one of the things that we don't look at that would be helpful to look at is also where the Medicaid population lives in contrast to where the privately insured live and what the resources are there, because many of the physicians who participate in

Medicaid are in what we term "medically underserved areas," but many of the specialists are far away from the geographic location of some of our population. And I think really looking at that is an important contribution.

COMMISSIONER GABOW: Thanks, Anna. This is a really, I think, very important area to look at. I can tell you from my 40 years' experience at Denver Health, 20 years as a specialist, that this was a big issue. Community health center docs told us directly all the time, "We can't get a specialist, so we tell our patients, `Go to the Denver Health ED because that way you'll be able to get to see a specialist that we are not able to get you referred to.'"

So I think 60 percent -- I believe that is the correct number -- of all ambulatory visits at safety net hospitals are for specialty care, and I think talking about the role of the safety net hospitals as a provider of this specialty care is really important. And I don't know if there's any way from claims data to look at ED visits by specialist, because I suspect that you would find many more special visits in an ED environment for the Medicaid patients than you would for insured, if there's a way to do

that.

The other thing we talked about -- and I was bad about not getting you the data -- is an indirect way about looking at access to specialists is to look at the procedures that only specialists do, so ENT for kids, things like hernia repair, cystoscopy, EEGs, cardiac ultrasound, obesity procedures, genetic testing. And one of the big areas where I think there really was difficulty getting people in was oncology, amazingly difficult. And so some things that oncologists might be the only ones to order, like PET scans, and then some DME that you only get if you get to a subspecialist, like diabetic infusion pumps, you're not going to get one of those unless you've seen an endocrinologist, and yet diabetes is a really common issue.

So I think if we could -- maybe it's by talking to specialists, but get a list of both DME and procedure codes that would give us better insight into real access, because it's hard to get to this access directly, I think, would be useful.

COMMISSIONER RILEY: I was interested in the issue that both for children and adults access to

psychiatry was an issue, and it seems to me that's one we want to drill down on. Given the spending in Medicaid on behavioral health and how really extraordinary it is, what a big payer they are for behavioral health and how much of that service is provided by an array of professionals in community health clinics who are not psychiatrists, I'd like to know, you know, who is it who needs psychiatric care and what are these referrals and for what services down to diagnosis, and how does it interplay with the behavioral health system?

COMMISSIONER SZILAGYI: Actually, you both made the points that I was going to suggest. First of all, very nice summary, Anna.

I think this may be one of those areas where it would help to drill down to the topic area, like mental health or oral health or specific -- because it can't all be about payment, because the proportion that psychiatrists get for Medicaid versus commercial, that difference, that delta may not be very different than for other specialties. So there's something else going on even beyond payment about access. And to expose that and to sort of think about what might be causing that and what might the

solutions be might really help access for the patients that we care about. It's not going to just all be about payment. And certainly any of the behavioral health areas are, I think, paramount for this population.

COMMISSIONER ROSENBAUM: Again, my first observation echoes Patty's and Peter's, which is I think this is one where we have to look for those specialty practice types that really can only be carried out by the specialist. It's sort of like the same dilemma with dental, with oral health care; you know, you have certain things that can only be done by people who are quite specialized. And so I would favor more research into that.

And the other thing that, of course, I'm eternally curious about -- and, again, the new managed care reg may cause us to think about this, anyway -- is getting a roundtable together of managed care organizations or ASOs -- if you're in Connecticut, the ASO -- to try and learn from them what they do to overcome limited access. I mean, here in D.C., you know, a city that is -- what are we, 30 square miles or something like that? We're now talking telemedicine from Northwest to Southeast because of travel time and, you know, the big issue is how much managed care

organizations are using payment, new technology, other kinds of devices to build what is supposed to be a network that's adequate to do the job, which means having some specialists in it.

COMMISSIONER WALDREN: First, I agree with Peter and Trish about behavioral health and the need to really drill down specifically into that.

When I think about referrals out to subspecialists from primary care, you can categorize it by what specialty that we're going to send our patients to. You can also categorize it by why are we sending it out. So there has been some discussion about, oh, only something that a specialist could do. Well, what is that? Is that a procedure? Is that a physical evaluation? Is that a determination of a care plan or a determination of, you know, a diagnostic workup?

And there are now some new technologies out there that are being used in primary care where a doc can go, "You know what? I'm just going to send a message out to this network online" -- you know, it's a secure messaging type of thing -- "and say, `I got a patient, this is what's going on. What do you think I should do?'" And the

specialists are set up, and they get paid like 25, 30 bucks to respond to these things. And they say, "Well, here's what I would do." And it's that curbside consult. So I think if we think about why are those referrals happening, I think there are certain things that we could do that, and if we think about, you know, again, the way we're changing payment to more of PMPM payments or like that, there's now opportunities for those primary care docs to say, "I'm going to get onto this network," and the subspecialist doesn't care if it's Medicare or it's Medicaid, it's private insurance, uninsured, doesn't matter, because they're just responding to a request from me as a doc saying, "What do you think I should do for this?" And then I can make the decision of saying, "Okay, I can handle this. I'll go ahead and do the workup," and some of these patients will not have to go to the subspecialist.

COMMISSIONER CRUZ: I was also thinking that maybe there was another dimension to this. What happens after the physician refers his patients? Do they actually go to the patients? Are there barriers as to accessing those services? Any barriers from geographic location to language to time between patients or the referral and the

time of appointment?

Also, is there something related to administrative difficulty that it also adds to this difficulty on referring? Is there something related to prior authorization or something that makes these patients, Medicaid patients more difficult to refer or to get them to refer to other specialties? I think that would add to the context of this.

MS. SOMMERS: Yeah, that's a good question. Just quickly, we did not review the state-by-state benefits or how they're structured in a way that might require prior authorization for some specialists or other specific services.

VICE CHAIR GOLD: Hi. This is -- I really like this brief, and this is a very important issue. I think the studies before suggest, and yours confirms, that this is a problem area in Medicaid. It may be more or less in some specialties than others, some places than others. But I think we've heard quite a bit, and there's a long history of people talking about these problem areas. And so I think you've reinforced it.

In terms of looking at priorities, some of the

guidance that we might give you is hard when we don't know what's feasible. So what I was thinking of is three sort of criteria as to what I would think of would be the most important.

One is we do know it's a problem, even if we don't always have good data for it. So some tracking of what options have been tried to improve it, and what we know about it, and that's not just data you collect. It could be looking at what other people are doing and doing an environmental scan so we can see what's on the radar screen.

Similarly, this is a hard area to collect, and I would like to know if there are innovative ways that states or researchers or other people are going about looking at this, what they found out, whether there's some feasible things to do. Ultimately, if there were some feasible methods, this could be an area where we would recommend that this be part of ongoing monitoring or best practices or something, however we presented it as, you know, what we decided to do with it. But I think methods for tracking this is really important.

And then in terms of the empirical analysis to

fill gaps, this is one area where if we thought something was doable, we could do it. I don't know if there is one that's hot that no one else is doing. I hope we're monitoring what other people are doing in the literature and anything they come up with which is relevant here.

I was thinking that a couple of things that could be useful is any evidence -- it goes back a little bit to your what's appropriate question, but it puts it another way. What do we know about what happens to people who don't get specialty access? I know in the past sometimes things go away. Other times people die, you know, depending on what the study is. The more we can find out about where the barriers are most important in terms of health would be useful, and any high-priority things that are low-hanging fruit where one could take the data and do something would be good.

So I don't know if that gives you some more concrete guidance, but it's an important area.

COMMISSIONER MARTINEZ ROGERS: A quick response to Gustavo's question on Medicaid, why is it that we don't have access to specialties has a lot to do with what Diane was saying, which is we don't have access to it because

where do we live, where do people who are on these programs, where do the underserved lived? And it's not in the areas where specialists are.

CHAIR ROWLAND: Well, I think this has clearly given us a lot of thought for how to go forward. I think one of the things that would be helpful, as Patty pointed out, perhaps doing specific procedures. But when I look at your data and we know that over 50 percent of the births in this country are paid for in many places by the Medicaid program, maybe to take a few specialties like OB/GYNs and really try and figure out where the access barriers are. Is it because some of them don't practice near where Medicaid populations live? Or is it because they refuse to take new patients? What keeps them from participating in the program?

And then the other area that I remember from some of our earlier presentations is the number of specialties that are very difficult in numbers for children, and that maybe working with the children's hospitals to see to what extent they have gaps in specialty care, and maybe, Herman, you could help give us some advice on some of the procedures there that we might want to look at or some of

the ways in which children, who one-third of the nation's children get their care through Medicaid, what's happening to them?

And then I think really following up on the suggestion of meeting with some of the managed care plans to find out how difficult it is in their networks to get access to primary care referrals to specialty is implement.

COMMISSIONER SZILAGYI: And just maybe one other -- and, Marsha, you were really talking about this. I think some of the what to do is going to come from qualitative sort of case studies of what has worked in certain areas and not so much from quantitative analyses of any of these large data sets.

COMMISSIONER CARTE: Just briefly to follow up on what you were saying, it might also involve looking at certain specialized service sectors like foster children and those that go across a couple of sectors where there's going to be a real intensive need for certain kinds of --

CHAIR ROWLAND: Right, okay.

COMMISSIONER COHEN: I have really struggled with the "what to do" question that I thought Marsha did a great job of starting to think about and address. And I also

feel like one of the challenges here is it's hard -- like, what's the actionability of a national picture when there's so much variation within states and state to state and, you know, different policies that are driving this, and it's so hard to understand.

I guess I'm sort of oriented towards not so much trying to answer the questions. You have flagged issues, like there clearly are some issues, and I think I'm kind of attracted to the suggestion that Steve was hinting at, which is that rather than trying to get to the bottom of exactly and targeting exactly where the problems are, might we say Medicaid should be encouraging new solutions that technology and communications can enable, and maybe thinking about criteria for when Medicaid, when federal policy or state policy should sort of look favorably upon those, you know, sort of ways to do it efficiently, not open flood gates, you know, not reduce quality or other sorts of things, instead of really trying to get to the very bottom of exactly where the problems are, which I think is terribly hard to do.

COMMISSIONER GABOW: I think this is an important paper to put out because so much of the emphasis on care

has been in primary care, and yet when patients have an oncological issue, a cardiac issue, they need to see a specialist, and that has been so underemphasized as we look at how we're going to care for this growing Medicaid population.

So flagging it and putting -- even though it varies across states, putting a spotlight on this as an equally important problem that we have to solve if we're going to give high-quality care to this population is really important.

CHAIR ROWLAND: Okay. Well, this is a great start, and we obviously want to continue. Thank you, Anna.

At this point we do have -- we're running behind schedule, but we do have time for public comment if anyone would like to offer a public comment before we close for lunch, and we will reconvene at 1:00. Any takers?

[No response.]

CHAIR ROWLAND: Well, with that, have a -- oh, here comes someone. Come quickly.

DR. WHELAN: Ellen-Marie Whelan. I'm a senior adviser at the Innovation Center and the new chief population health officer at CMCS, so thanks for amazing

work here.

I have one question about the last with the specialty services. Is there any ability to better understand where we may not need to be referring to specialists and expanding the role of the primary care providers, especially in an era of team-based care, freeing up some of that time for physicians to be able to maybe do things that would have typically been referred to specialty, neurology for headaches, rashes-dermatology? And that's not a paid service when specialists support primary care, and so when we're looking at technology, also looking at the ability to actually expand, and some of these things had been primary care years ago, and we've kind of been in this tradition of referring to specialty care, but maybe looking for opportunities to bring it back to primary care.

CHAIR ROWLAND: Great suggestion. Thank you very much. And I know Steve will follow up on that as well.

Okay. We will stand adjourned until 1 o'clock.

[Whereupon, at 12:16 p.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION

[1:01 p.m.]

CHAIR ROWLAND: Can we please reconvene? We spend a lot of time talking about Medicaid's evolution and how Medicaid has gone from its old welfare roots to a program that provides broader health insurance coverage to low-income families and children, but one of the remaining strong links that Medicaid has to the welfare system is the foster care program and the role Medicaid plays for foster care children.

We noted in our last meeting that there was a theme that ran through many of the reports on psychotropic drugs and others that the foster care population for their behavioral needs really differed, and so we asked that we could learn more and put together potentially an issue brief or even a chapter in our next report that begins to at least shine a spotlight on some of the key issues around the foster care population.

And just coincidentally, to help further this along, the staff was asked to do a briefing for the Senate Finance staff on the foster care issues.

So we're going to ask Martha and April today to

share with us two things, their findings and their story, that they think we should be trying to tell about the foster care population, and then they have included in your materials an outline of a potential chapter, which obviously has not yet been drafted, but as we work through the discussion today, if there are points or rationale that you think warrant being in a chapter and that we should try and move forward with it, I think it would be a great contribution to our June report.

So, Martha and April, take it from here.

MS. HEBERLEIN: Thanks, Diane, and as she mentioned, given the Commission's interest at the last meeting and the intersection between behavior health and psychotropic drugs, we are coming to you today with sort of an outline for a proposed June chapter, which is included in your materials, and basically, our idea for the chapter will provide a brief background on child welfare and child welfare-involved youth, a description of Medicaid's role for this population, and a summary of some of the Medicaid-relevant policy issues that focus mostly on eligibility as well as services and access to care.

To sort of take a step back and talk about who

we're thinking about here, children and youth in the child welfare system have either been removed from their home for abuse or neglect or are receiving in-home services as a result of an allegation of maltreatment.

I would like to note that we have been using sort of the shorthand "foster care," but the population is much broader than that. So when we talk about the child welfare population, this includes children who are living in foster care situations, but also includes those receiving adoption assistance or under legal guardianship as well as youth who have aged out of care and children who are served at home. So it is a much broader population than just those who are in foster care.

Just to also note that in order to receive federally funded child welfare services, these children must have very low incomes, actually tied to the 1996 AFDC standard, so very, very low.

They also have significant health care needs and other social needs. So while the population of these children may be small because of their significant needs, their spending is actually disproportionate to their share of the population.

The health and supportive services that these children and youth require often, which is a result of their connection to the child welfare system and the trauma they have experienced, heightens the importance of the coordination across multiple federal and state agencies.

So just to sort of take a step back, the child welfare system is responsible for the safety and well being of these children and connecting them to a permanent home. Whereas, Medicaid may provide health coverage to many of the child welfare-involved youth, but it's not a guarantee of Medicaid eligibility. We'll talk a little bit more about how these children get involved in Medicaid a little later on. Coordination is key between these various agencies to be sure that the kids get the appropriate care that they need.

Ensuring the timely and appropriate health care of the children involved in the child welfare system is further complicated by a variety of issues. This includes their frequent changes in placement and caregivers, the trauma that these children experienced by both prior to and as a result of the removal from their home, and the behavioral health needs may not necessarily be

appropriately addressed, as we have heard about the overuse of psychotropic drugs, for example. There is also a lack of behavioral health care providers that are trained to diagnose and treat childhood trauma, which can also result in inappropriate use of psychotropic drugs.

There is also fragmentation across the Medicaid child welfare and behavioral financing streams and poor interagency coordination, both in terms of data sharing as well as a lack of knowledge among program staff about what benefits the other program offers.

So, with that, we will talk a little bit about the child welfare-involved youth and Medicaid. In fiscal year 2013, states conducted more than 2 million investigations involving 3.2 million children. Approximately 1 million children received services in-home, and about a third were removed from their home and received foster care services.

Of the 238,000 who left foster care, about 60 percent were reunited with their parents or living with another relative. Almost 30 percent were adopted or placed in legal guardianship, and 10 percent were aged out or were emancipated.

Just a few other points of interest. Children who are younger are more at risk of this victimization, as are African American children, and rates of victimization are similar for girls and boys. 60 percent of families that were investigated for child abuse and neglect had prior reports of child maltreatment. So it's often they're coming in contact with the child welfare system on more than one occasion.

One quarter of these families had trouble paying basic needs, and a smaller share had other issues in their lives, such as domestic violence, mental health problems, and substance abuse.

So the child welfare population has significant needs. As I alluded to before, the share of children and families investigated for abuse and neglect to have a chronic health condition is at least one and a half times higher than that of their peers.

One study found that more than 85 percent of young children entering the child welfare system had physical, developmental, or mental health needs, with more than half displaying two such conditions.

Children involved in the child welfare system

have greater mental health service needs than children generally and are more likely to have social competency and behavioral problems as well.

The primary goals of the child welfare programs are to promote the safety, permanency, and well-being of children. Most federal support for these programs comes under Title IV- and IV-E of the Social Security Act. Title IV-B programs provide capped grants for states for a variety of child welfare services. Whereas, the majority of funds come through Title IV-B, and this is how states get reimbursed to provide foster care payments, adoption assistance, guardian assistance, as well as support for those children who have aged out instead of finding a permanent placement.

Child agency, welfare agencies are required to ensure the health needs of the children, but they cannot expend any of their Title IV-E dollars to do so. They also must ensure that with the Medicaid agency that they develop a health oversight plan to coordinate health care services for the children served under child welfare.

So Medicaid's role for these children, automatic eligibility for Medicaid is linked to Title IV-E status.

So, as I said, some of these children are eligible through a 4E pathway and receiving IV-E funds but not all of them. So other children might be eligible under another pathway, such as the low-income pathway or on the basis of a disability, and because the mandatory ties to IV-E coverage in Medicaid may be intermittent as children cycle in and out of the system.

Finally, before I pass it off to April, just as I talked about a little bit, because this population is broader than just foster care, it's also hard to identify in the administrative data just who these children are because they may be coming in through the Title 4E mandatory pathways, so we can identify them as foster or child welfare-involved youth, but if they're coming in through a low-income or other pathway, we may not be able to identify them as such.

MS. GRADY: Okay. Thanks, Martha.

I will talk a little bit about some of the statistics, the Medicaid information we have on children who are coming in through child welfare assistance pathways, and as Martha said, the children we can identify as being eligible for Medicaid on the basis of child

welfare assistance is not the entirety of the population.

For example, as she said, not all of these children are in foster care. There are actually a substantial number of children who are eligible for Medicaid on the basis of child welfare assistance, who are in adoption and receiving adoption assistance, actually more of those children than who are in foster care.

The other thing I want to point out is that our statistics on Medicaid exclude children who are being served in the home. Those are children who are not eligible for Medicaid on the basis of their child welfare assistance but may still be in the program, and we can't identify them.

So of the children we can identify as being eligible for Medicaid based on child welfare, there are about a million of them. This is about 1 percent of all Medicaid enrollees and 3 percent of nondisabled child enrollees, so it's a relatively small population in the context of Medicaid. However, their Medicaid spending does total nearly $6 billion based on the most recent information we have. That's about 2 percent of all Medicaid benefit spending and about 10 percent of

nondisabled child spending. As Martha said, they are disproportionately expensive in part because of their significant health needs.

Spending per child enrolled based on child welfare assistance is almost $6,000 per year. This compares to about $2,000 for a nondisabled child and about $14,000 for a child who is enrolled based on a disability. So they're sort of in the middle of those two spectrums.

Talking a little bit about the Medicaid service use and diagnoses for children in foster care, or the first thing I want to point out is that the share of children who are eligible for Medicaid based on foster care, other child welfare assistance, who had at least some health care contact, is about 90 percent, and that's very similar to that of other children enrolled in Medicaid. The big difference between these two groups, though, is in the types of care they use and in the amount of care.

So, for example, among children in foster care who are on Medicaid, they had many more outpatient visits per year than other children. So if you had at least one visit and you're a child in foster care, you had an average of nearly 30. If you are a child not in foster care and

you had a visit, the average was more like nine visits per year. These high numbers are in part due to substantial receipt of behavioral health services, so individual therapies, and other things where you're frequently going to a provider and having regular contact.

Children in foster care have much longer inpatient stays, 31 days versus 6 days for children who are not in foster care. That's partially driven by the fact that inpatient stays here include treatment in residential facilities and other rehabilitation facilities that have longer term treatment plans for those children.

As Martha mentioned, there is a much higher prevalence of mental health and substance use disorder diagnoses among these children, about half compared to about 10 percent of children who are not in foster care or child welfare assistance programs.

We have talked extensively about psychotropic medications at the February meeting. You will also hear more about our June chapter in the session that follows this one, but just to remind you, about a quarter of children enrolled in Medicaid based on child welfare assistance have psychotropic drug prescriptions, and one of

the big concerns here is about polypharmacy for these children. About half of them are prescribed two or more psychotropic drug classes during the year, and about 20 percent are prescribed three or more during the year. Of course, you've heard about the risks associated with these medications. That can include suicidal thinking and behavior as well as weight gain and metabolic disorders.

Here, I will turn it over to Martha to start off with some policy issues.

MS. HEBERLEIN: So looking at eligibility, as I mentioned that children in the child welfare system may or may not be automatically eligible for Medicaid, the categorical eligible foster care groups is tied to Title IV-E status. So, as April said, there are a lot of children who are in the child welfare system that are not getting Title IV-E funds but may in fact be eligible for Medicaid under another pathway. So this again sort of raises the questions of continuity of coverage as they cycle in and out of the system and are they connected to Medicaid as their situation changes.

One study suggests that these children are faring okay or fairly well, actually, when that continuity of

coverage found that about 90 percent retained their coverage, although what source of coverage sort of changed. So over looking at a three-year period, 90 percent remained covered by some sort of insurance, but whether that was Medicaid or private insurance may have changed over that period of time. So this may not be a huge issue because they are finding some sort of coverage.

The other policy issue that looks at eligibility is the implementation of the new pathway under the ACA up to age 26, and this provision was designed to mirror the other provision in the ACA that allows children to stay on their family's plan until the age of 26 in thinking that these children don't necessarily have a family, so let's provide them with Medicaid until that point as well.

In order to be eligible for this pathway, however, there is a hierarchy of eligibility, which means that they can't be eligible or enrolled in another mandatory category. So states would need to confirm that they aren't eligible as a low-income child or as a parent or as a pregnant woman prior to enrolling them in this category.

There is also the question of identifying and

enrolling these youth. Children who are aging out at this point in time have to go through a transition plan should include talk about health coverage, so hopefully they are connected to Medicaid as they're aging out of the system. I think it might be more difficult to connect those children who have already aged out, sort of identifying and reaching them if the child welfare agency doesn't know where they are, for example.

There's also the question of states can rely on self-attestation for former foster care status or look for some kind of data match or required documentation. So depending upon the level of verification the states require, it may be easier or harder for a former foster youth to show their status.

There's also the proposed state option. This was in some regulations that have not yet been final to cover children who have aged out in other states. So states are required to cover the children who have aged out in their own state, but if a child, for example, ages out in Maryland and moves to Delaware, Delaware doesn't necessarily need to cover them. So, at this point, there are 12 states that have taken up this option to cover

children who have aged out in other states but not all states are doing it.

MS. GRADY: Okay. So I will talk a little bit about some of the policy issues with services and access to care.

As with all children enrolled in Medicaid, there are concerns about the receipt of timely and appropriate care for children who are in the child welfare system. And in particular, screening services that are required as the "S" in Medicaid's EPSDT benefit are really important for identifying health conditions and referring children to follow-up treatment. However, delayed and missed screens are common for children in foster care. The HHS Office of Inspector General just came out with a report a few weeks ago indicating that nearly a third of children in foster care who are enrolled in Medicaid did not receive at least one EPSDT screening, and about a quarter had at least one screening that was delayed and not received on time.

So, certainly, this is again a concern for all Medicaid children but particularly for the children in child welfare programs, given their high needs.

Although EPSDT requires coverage of all medically

necessary services that are named in the Medicaid statute, regardless of whether a state otherwise covers them as an optional service for adults, the actual receipt of services depends on the degree to which states have policies and infrastructure in place to facilitate access to those services. And by policies and infrastructure, I mean things like, does the state have federal approval to cover a particular service as it's described under various Medicaid statutory authorities? Does it have state policy documents like provider manuals and allowable billing codes that allow the service to be paid by the Medicaid program? And do they have participating providers who are qualified to diagnose and treat the particular conditions that children have?

Of course, there are special concerns about access to behavioral health services in particular due to the history that children in the child welfare system have with potential abuse and neglect, and here, I would point out that it's most common for children to receive traditional treatment, such as individual, group, or family therapy. These services can be very helpful, but there are also a number of more nontraditional types of services for

which there is an emerging evidence base. And state Medicaid programs don't necessarily have explicit coverage policies in all cases, and that would again mean things like billing codes, just descriptions of the coverage, and the lack of those policies and infrastructure can inhibit children's access to these services.

Some examples of these more non-traditional services include trauma informed cognitive behavioral therapy, which is a particular type of therapy, individual therapy, for children; intensive in-home supports, where a team of providers actually comes in to help the family assess their situation and give guidance related to the particular challenging behaviors they might be experiencing with the children in their care; and peer supports, where other families who have gone through the process of fostering or adopting a child provide assistance to current families who are facing their own challenges.

And, finally, therapeutic foster care is one type of in-home support that I wanted to mention, because it's been raised a lot as a particular intervention for children who need intensive in-home services, but it's also one where the Medicaid statute sort of pushes up against this.

California recently submitted, for example, a state plan amendment proposing to do therapeutic foster care and CMS's response was, okay, well, that sounds good, but what are you going to do for the children who are not in the child welfare system? In general, if you provide a Medicaid service to one child, you have to provide it to all of them. You can't limit based on their participation in child welfare assistance, so there's an issue of comparability that has to be met from CMS's perspective.

As Martha mentioned, child welfare agencies are ultimately the ones who are responsible for monitoring and oversight of the health of children in their care, but given that most of these children are enrolled in Medicaid, clearly, interagency collaboration is important.

As we previously discussed, there are particular concerns regarding psychotropic drug use, and on the next slide here we have some examples of interagency collaboration, both at the state and federal level on that issue, many of which you've heard about before in previous presentations, so I won't belabor this point.

I will focus on the last one here, which is the President's budget that proposes funding for joint

Administration for Children and Families and CMS efforts to reduce over-prescription of psychotropic drugs, and this would provide funding that's intended to build the infrastructure I mentioned that's necessary for providing some of these home and community-based services that states may not already be covering.

Some of the other policy issues that may be of note include the use of state dollars that were previously allocated for child welfare to draw federal Medicaid match, and this is happening in one of two ways. One is the example where a child welfare agency will actually ship money to the Medicaid program to support the provision of behavioral health services, so it will contribute the non-federal share from the child welfare agency budget.

The other is child welfare agencies themselves taking stock of the activities that they are performing to look at which of them are actually Medicaid services and, therefore, billable to the Medicaid program.

Another notable issue is the availability and sharing of data. I think we actually talked about this at the February meeting, the availability of 90 percent federal match for upgrades to integrated eligibility

systems, so Medicaid can actually pay right now for changes to child welfare eligibility systems to make sure that they talk to Medicaid and that the transfer of information is more seamless.

The other area with regard to data is the advancement of electronic health records, where there are sort of two purposes here. One is to facilitate health information exchange between the health care providers that are serving these children and the state agency staff, be it the child welfare staff or the Medicaid staff, who are trying to oversee and put policies into place that make sense for this population.

The other purpose is to give foster parents and the children themselves a record of their health conditions and service use. If you are talking about a child that has potentially ten or, you know, up to 15 -- there was just a New York Times article today about Arizona and moves over the years. You could imagine that health records are not something that they're necessarily going to have easy access to.

The last point we want to touch on is Medicaid for parents with child welfare contact. As Martha

mentioned, there are many instances where a family is contacted by the child welfare agency because of an allegation of abuse or neglect, but the child may not be removed from the home. Even if they are, it's an opportunity to facilitate access to mental health, substance abuse, or other services that the parents themselves might need, either to keep their child in the home or to be eventually reunited with them. So, this is something -- in expansion states, Medicaid expansion states, in particular, many of the adults may be eligible for Medicaid, so that's something that states can follow up on.

We also have some supplemental information here. We're not going to run through these slides, but just wanted you to have it, more information on eligibility and data related to these populations.

If you have any questions, we'll be happy to take those.

CHAIR ROWLAND: I'm going to turn to Sara, who I asked to review the slides beforehand, since I know she has to leave to teach. And then, Steve, did you have your hand up?

COMMISSIONER ROSENBAUM: Thank you, Diane.

It was excellent, and this is, of course, a particularly complicated area because a lot of the modern framework for the Medicaid relationship to child welfare was set by the Child Welfare Amendments of 1980, which presage by many years sort of the revolution in Medicaid eligibility for children. So, back in 1980, and, of course, preceding lead-up to the 1980 Amendments, Medicaid was highly categorical for children and so we added these additional categories for children in order to be sure the children in the child welfare system would have coverage. In some ways, it's been eclipsed by the fact that we now cover low-income children, and so we have one of those situations that's not unlike what we run into in Medicaid generally, which the Commission has touched on, which is, in the end, is it advantageous to the program to keep dozens and dozens of eligibility categories, or, at least in the Medicaid expansion states for adults, switch over into a simpler system, which CMS has tried to do, where you have low-income children, low-income adults, a couple of special categories for people with very highly specialized needs who get extra -- the methodologies for determining

their eligibility are somewhat different.

So, what you have here mixed up together is this sort of fractured eligibility system where we're using eligibility to try and tell something about children who are getting foster care services and the eligibility category didn't do it back in the early 1980s and it's really not doing it now, even more so. It may be much more important for us to think about systems where we are asking ourselves how many children who depend on Medicaid are also getting child welfare services, as opposed to how many children getting child welfare assistance under the various child welfare services are getting Medicaid. I think that's sort of the effect of moving off of categorical eligibility for children.

So, one point we might want to make is whether a restructured eligibility system makes us ask the question differently, because once you know that a child who is low-income and getting Medicaid is also receiving child welfare services, whether they're in the home or out of the home, then a whole series of second-level questions get asked, like where does the child get services? How much? Who's responsible for the service? What's the quality of the

care? How are the specialized services that might be going to that child integrated back into the child's health home? Does the child even have a health home? How is managed care being used for these children?

And, I think on that score, and this is where Herman or Peter would potentially know a lot more, a lot of children's hospitals and a lot of public hospitals have specialized child welfare units precisely because it's so hard to piece care together, and in many states that use managed care, there are different approaches. If a child is in a formal status, the child gets taken out of a managed care plan. Sometimes, a child may get left in the managed care plan, but the services are supplemented.

And, so, I think understanding what the different approaches are to sort of bundling up the services for these children would be important, especially, as you point out, because of the problem with over-treatment with certain drugs. You could imagine in a situation where you have two or three different systems of care all trying to deal with children and their families in crisis and not really talking to each other so that it's much easier to over-treat.

I actually think that the point you made at the end, April, about sort of these coordination issues with Medicaid and child welfare are important, because, unfortunately, a lot of the attention paid by Medicaid to child welfare has been all about stopping what Medicaid has seen, CMS has seen, as over-reliance on federal Medicaid financing in inappropriate ways by child welfare agencies and less on the fact that, by law, child welfare agencies cannot use their funds to deal with health needs of children and certain tools that CMS has, health home tools, CMMI, DSRIP, SIM, I mean, we can go on and on with the list of acronyms, you know.

What I think we really need is an active effort by CMS to embrace this population, not just around the psychotropic drugs, although it's very important that they're doing that, but on a much bigger level around innovations in addressing the needs of these children and families, particularly in the Medicaid expansion states where there's a good chance that the parents will also be eligible, and where you'd like to see some thinking about how -- and, you know, this is a time when we're so focused on Medicaid and its role in health more generally -- these

families are so burdened with poor health that if anything is going to work for these families, something has to be done about their health, their mental health, their physical health. Health is a big factor and always has been.

So, I would say, you know, from my perspective, and going back to my time at the Children's Defense Fund almost 40 years ago, the issues remain much the same, but our tools are much better and we don't seem to be using them. You know, we have smoother eligibility options where you don't have to keep jerking children around between categories. We have much more innovative service delivery options, much more focus. We know a lot more about health outcome measures that might look at family health. But, we don't seem to be applying those tools as much as we should to this population.

I should note that before, it was about 40 degrees in here, and now it's like a day at Bethany Beach.

[Laughter.]

EXECUTIVE DIRECTOR SCHWARTZ: We've asked for the temperature to be adjusted again, so --

[Laughter.]

COMMISSIONER CARTE: I'll vote for spring over winter.

[Off record discussion.]

COMMISSIONER WALDREN: Actually, being from Kansas, it feels like home. It's cold in the morning and hot in the summer.

So, a quick comment for the group and then a question about the data.

So, as it relates to electronic health records, what I saw in the slide there was there were three policy pieces or things we wanted out of the EHR, two of which, I think, are well done right now in regards to health policy. So, one is the exchange with other providers and the other is exchange with the patient.

The Health and Human Services National Interoperability Road Map, which is currently out for public comment, and the new regs that were released on Friday for meaningful use are very explicit about those as defined outcomes for electronic health records. There's not, though, a discussion with other agencies inside the federal government and type of interoperability, and actually, there's been an issue with exchange with public

health and state-based immunization registries. So, if we think that that type of exchange with those agencies for this population is important, we should probably make a comment about that, because it's not in the national policy around electronic health records.

My question about the data. The source of the psychotropic data in regards to what's being prescribed or what's being used, what's the source of that data?

MS. GRADY: It's Medicaid claims data, so copies of what's actually being dispensed at the pharmacies.

COMMISSIONER SZILAGYI: First of all, congratulations. I think the outline is really good. This is a very important population. And, I like -- essentially, I think, what the chapter would look like is who are these children and families? What are their problems, and what is the management, if not best management, what should the management be? And, this is an area where, for this population, there are guidelines. There are national guidelines for foster care, so you can refer to that.

So, just a couple points about this. In terms of the importance, who they are, this population is bigger

than all children with diabetes, epilepsy, sickle cell disease, heart disease, and cancer put together. So, it's a very prevalent population with serious problems. And, so, I think it's important that we focus on it.

Secondly, I really applaud you for getting into -- and Sara was talking about this a lot -- getting into this area is so much where Medicaid and social services and those two systems have to be integrated and work together, because they're indispensable to each other and to health. And, so, I don't really know what the policy, you know, clear policy steps would be, but if any population needs these two to work together, it's key.

The third point is one area that I didn't hear maybe enough mentioning, and one special issue for foster care is the issue of parenting. There's an emerging evidence base about evidence-based parenting for both biological parents and foster parents. I actually don't know who pays for that in all of the different states, so that may be worth looking into, but that's an area that I didn't hear anything about in this chapter, so I would encourage you to add.

In terms of the mental health needs, to me, the

psychotropics are a canary in a coal mine, because these kids are on psychotropics because they are not receiving adequate mental health treatment and adequate social and integrated treatment. If they were, they wouldn't be on so many -- many still would be on psychotropics, and there will be a whole chapter on it, but much fewer would be on psychotropics. And, I do think we have to be a little bit careful with the data, because if you have a child who goes to multiple different homes, multiple different systems, people will write different prescriptions because they have to, and it's not necessarily that the child is on all of those different medicines.

Just a couple other quick points. I kind of think this patient population needs EPSDTT, and the second "T" is trauma-focused therapy, which should be an essential health benefit and necessary for all these children, because the common denominator for these children is trauma.

One quick anecdote. There was a DA in Rochester, New York, who said the following, based on 30 years of experience. He had never seen a murderer who wasn't a victim of child abuse, in 30 years. Every single person he

prosecuted had been a victim of child abuse, because it causes -- not in all children, fortunately, but it causes sometimes very, very, very, very significant changes in their brain.

And, that gets me to my final point about long-term outcomes, that this is one area where if we really focus on this high-need population, we might be able to address long-term outcomes. You may want to look at a group of studies called the ACE studies, A-C-E, the Adverse Childhood Experiences study, which shows that there are so many adult outcomes, including mortality, that are directly linked to trauma in childhood.

COMMISSIONER GRAY: I agree with you 100 percent, Peter. I think you looked over my shoulder at my notes.

The outline is great, and I think it's really important that we highlight this population of kids that is relatively small, in some respects, but high cost and definitely high need. At the risk of sounding more like an advocate than a Commissioner, perhaps, we can do much better in serving children than what we're doing with this population of kids. The Adverse Childhood Experience, that's growing science, and the challenge with it, at least

partly, is that the distinction between what is mental health care, behavioral health care, and medical care, the lines are getting more and more blurred and the regulation and the law isn't keeping up with the science and what these children really need.

And, if you've suffered extreme physical or emotional abuse early on and you have organic brain changes as a result of that, and then you compound it with systems that don't talk to each other very well and all these siloed categorical approaches to paying for their care, and then they bounce from four to five to six different providers in a short period of time, and you have a foster parent that doesn't know what to do with them because they, of course, have been inadequately trained or not trained at all, of course, they're going to be on psychotropic drugs. They need to be managed. They're bounding off the wall. They're depressed. They're angry. They have organic brain diseases.

So, I absolutely agree that it's a good description. The drugs are simply the canary in the coal mine. And, I certainly don't blame the child welfare system. They're doing their best to try to keep these kids

alive and to prevent them from being further abused.

But, the coordination issues are really very, very significant. Not a day goes by in our hospital that -- multiple times a day in our hospital that a child will come in with a foster parent who has no clue what their medical condition is, no clue. They've been to four or five different physicians, not even the most basic information. And, you ask the local child welfare agency, so, why are they here? What's their medical condition? Well, they're here because every time they change home, they have to get a physical. Okay. So, like, where's the record? Oh, well, we can't share the record for confidentiality reasons. What do you mean? We're the care provider? And they won't share the information with the foster parent. So, there are just really huge issues in coordination between agencies.

The electronic health record certainly could help with that, if we could figure out a way to address it.

You know, I'm a simple pediatrician. I haven't been a lawyer at the Children's Defense Fund or studying this for 40 years, and if you're trying to figure it out still, imagine how I might feel about it.

[Laughter.]

COMMISSIONER GRAY: The training of foster parents, I also agree, it's just really -- or biologic parents who get reunited with their kids -- is just really critical, because these children need more than just loving, ordinary care. They need, really -- they need care that helps --

COMMISSIONER MARTINEZ ROGERS: By an angel.

COMMISSIONER GRAY: I'm sorry?

COMMISSIONER MARTINEZ ROGERS: By an angel.

COMMISSIONER GRAY: By an angel. They need care that is really aimed at their specific needs that are based on their psychological or psychiatric challenges.

At the very least, I think, outlining the challenges that this population faces in the chapter is critically important, and even simple recommendations like for every other child population that we've looked at, 12-month continuous eligibility coverage, however it's defined categorically, at the very least, these children should have reliable, predictable health care and access to care that doesn't require them to disenroll from one managed care plan to another, that allows them to have some

continuity in the mental care that they're provided.

COMMISSIONER MARTINEZ ROGERS: [Off microphone.]

CHAIR ROWLAND: We've talked a little bit about training and the parents, but I assume that under the current way in which Medicaid is structured that training for the parents may not be a reimbursable expense. And so maybe one of the issues to look at is what kind of complementary issues like training or other kind of integration mechanisms or case management may need to be part of what the Medicaid program covers, recognizing that the caregivers are often the people who need the most help in figuring out how to manage the care.

COMMISSIONER GRAY: But if the kids got their EPSDT screening, it might be eligible because it would be defined under the EPSDT plan that it's --

CHAIR ROWLAND: That they need parent training.

COMMISSIONER SZILAGYI: You are right, but the parenting training is typically covered under DSS, not under Medicaid. It's under the social service --

COMMISSIONER ROSENBAUM: It's in EPSDT, anticipatory guidance or preventive benefit.

CHAIR ROWLAND: It's an issue. Since we're

always looking for issues that we can comment on, it seems like a good one.

COMMISSIONER COHEN: Related to this conversation, thinking about your comment that there are models and practices with the developing evidence base -- oh, sorry.

CHAIR ROWLAND: If when you go out those doors it's cooler outside, could you have them leave the doors open?

COMMISSIONER ROSENBAUM: I'll tell them they cooked us all [off microphone].

COMMISSIONER COHEN: You know, there's a developing evidence base for trauma-informed -- you know, I'm hearing around the table, you know, a random survey of two experts who say, no, this actually is, you know, state-of-the-art care. They would describe it as sort of, I think, tried and true, maybe. I don't know who the authority is for determining when something with a developing evidence base has sort of hit the point where it really is -- should be covered by Medicaid, but I actually think that that is one of the kinds of issues that we might tackle in a bigger way, and this might be a great sort of

exemplar to get into that.

I think there's the question of whether or not a practice or a service or a model could be covered by Medicaid, and then there are the practical sorts of issues that you indicated, like in theory almost anything could be covered under EPSDT if a doctor says it is necessary to treat something. But the practical realities of coding and what a state has historically done or how they've defined EPSDT or whatever sort of the issues are, I feel like this is a sort of perfect area to explore some of those things a little bit more deeply, because ultimately I think what we're hearing today is that there are treatments that can serve these children better, and Medicaid doesn't make the connection very easily. And I feel like it's a little bit about what is the point where a clinical service is sort of sure enough that Medicaid should cover it. And then how do you make sure that it's actually on a practical level done? And I can't imagine an area with higher priority as well as one where really it is really specifically a Medicaid problem, and there is no other health program that can sort of own this in the same way.

So I think it's a great area for us to go deeper

on this connection between clinical advances and coverage and practical reality of making it available at the state level.

COMMISSIONER MARTINEZ ROGERS: Just kind of an FYI. There is a program that has been started in San Antonio working with these children, and it's called "Walk and Talk." Actually, it's counseling therapy, but it approaches -- when you approach it from a Walk and Talk, to a child it becomes kind of engaging. And there are about eight therapists involved in it, and they also work with the parents or whoever is taking care of them. They're doing both type programs.

But it is a major, major problem. I've seen it so many times because, you know, now we know that more women are going to jail and prison than ever before, and all those children become foster kids.

COMMISSIONER SZILAGYI: Just a very quick point I forgot to mention. When you talk to foster care experts, I think you'll learn that there are several states that are doing pretty innovative -- have some innovative programs. So, for example, the state of Texas has guidelines for psychotropics and a follow-up mechanism that is led by

David Harmon that's working real well. The state of Illinois has a preferred provider organization for -- not an organization, a network for primary care physicians who become trained to take care of kids in foster care. The state of Wisconsin is doing interesting things for parent education and training.

So we often put those in our chapters, and that might be a little section in the chapter about innovative programs in different states.

COMMISSIONER GABOW: I think it would be interesting to -- I don't know the answer to this, but it would be interesting to know what legal barriers there are related to HIPAA or other information -- about information sharing across between schools and health care providers, between social service departments and health care providers, because I think that -- and the mental health and substance abuse laws also overlay these.

So I think that thinking about what are the barriers to information sharing and what is the way forward out of that while still protecting privacy is going to be important, because I know that our lawyers always got into this issue with the social service department people about

what could be shared and what couldn't. And so some look at that would be useful, and some template about agreement for sharing across organizations would be helpful so that we don't always have individual lawyers creating these rules.

CHAIR ROWLAND: I said Patty had the last word, but I'm going to let Trish have it.

COMMISSIONER RILEY: It's only because -- 20 years ago, NASHP did a study on health passports, pre-electronic health records to try to deal with this population, and I have to say of all the work I've ever done, this is the one I remember most vividly, because it's just so painful to accept that these kinds of conditions exist for kids.

So for Medicaid's role, which is so fundamentally important not just for these kids but also for all the families at risk, and maybe what we need to do is place this work in a context of at-risk families, how to support families, how to try to prevent the kinds of things that we see, at the same time shoring up the work on foster care. But I think it really speaks to Medicaid and its unique role in ability to support families, especially now that

parents can be covered, both of them, if there are such -- if there are both of them.

CHAIR ROWLAND: It also speaks to poverty and social determinants and all the other issues.

So I think what we'd like to have done is I think this chapter is a good start at laying out the situation, and we've obviously raised a lot of issues that we want to pursue.

In previous work for our reports, we've done something similar to this where we have said here's some data and information that really highlights a population that is very vulnerable, that is in need of attention; and here are some of the questions that we plan to pursue going forward as a Commission to address this. But I think this is a very good example of an area where we can make a difference by really shining a spotlight on an issue that's rarely talked about in the general, big-picture discussions of Medicaid, but is a place where, as Trish has just said, Medicaid plays an incredibly important role and can play a better role if we really look at some of the options going forward.

And so you've started us on a good path forward

to really be able, I think, to contribute to improving the care that not only the children get but that their families get and the support that they need to not end up in this situation in the first place. So thank you.

And so this will be a chapter in the June report. We will share it with -- you've seen the outline. If you have any comments on the outline, please get them in soon because it will be converted quickly to a chapter that we will send out to you for review, since obviously it wasn't written today to be in your books.

EXECUTIVE DIRECTOR SCHWARTZ: I just want to give a little public service announcement. Somebody dropped a SmarTrip card out in the hallway. So you might want to pat your pockets before you get to the Metro, and they have it at the desk out front.

CHAIR ROWLAND: Now what we're going to do is to look at the other three chapters that we are planning to have included in the June report to Congress. The first is on coverage of adult dental benefits in Medicaid, the second is on behavioral health in the Medicaid program, and the third is on the use of psychotropic medications by Medicaid beneficiaries.

What we're going to do right now is to have a very quick overview by each of the lead authors on these chapters. After each one, we're going to take a quick pause for any comments. We won't have all three presentations go in a row, but please be mindful that we can't spend all our time on the first one because we have two more to go.

So, with that, Sarah, you can start us off on dental.

MS. MELECKI: Thank you. Last month, I presented information to you on coverage of Medicaid dental benefits for adults, and you noted interest in including a chapter on adult dental benefits in the June 2015 report to Congress. So we're currently preparing such a chapter -- you have the draft in your briefing materials.

Today I am briefly going to summarize the draft chapter, which is very similar to last month's presentation, and then I'll note important changes that we've made after hearing your feedback.

So the draft chapter is divided into several sections. The first section includes the importance of oral health for overall health status as well as quality of

life and employment. The second presents information on dental coverage rates by income level. And the bulk of the chapter's content focuses on current adult dental benefits in Medicaid. This includes information on specific benefits provided by states as well as information on possible differences in adult dental benefits for pregnant women, certain disabled adults, the Medicaid expansion population, and by managed care organizations.

Next, information on recent changes in state Medicaid dental benefits is provided. Both national trends and state-specific examples of changes are included. And, finally, the chapter includes information on the use of dental services and utilization changes when benefits are cut.

At the February Commission meeting, several of you offered comments to improve the draft chapter, and we've incorporated changes based on your comments. For example, we added additional disparities data. We included information on the high percentage of black and African American adults with untreated dental caries compared to white non-Hispanic adults. And we also included information on individuals age 65 and over regarding

edentulism, which is the condition of being toothless at least to some degree.

In addition, we included information on adults age 65 and over in our analysis of the percentage of adults who had a dental visit versus a doctor or other office-based medical provider visit in the past year. We added information on the importance of discovering oral cancer at an early stage. And, finally, we emphasized the importance of oral health for adults with low incomes specifically.

As a reminder, like all draft chapters, we are sending this chapter for external review to Medicaid Directors, CMS, and subject matter experts.

And with that, I will conclude, and I look forward to your comments.

COMMISSIONER CRUZ: I'll be brief. Anne had asked me to review the chapter, so I made several comments, and some of them I will discuss here, some of them I will give you in writing, because it's about figures and tables and stuff.

One of the important changes that the chapter needs is an expanded discussion on the workforce issues. We had a good discussion last time on workforce issues in

terms of scope of service, maldistribution of dentists, and coincidentally, too, I think about a month ago HRSA released a new report highlighting a shortage of dentists nationwide for the next decade.

So I think this sort of discussion of workforce issues, and especially sort of innovative models of how do we go about when we don't have enough dentists to provide services, and that I will give you in writing because sort of parallel to that, HRSA has the authority to fund residency programs, and they spend around $35 million in residency programs, most of them in pediatric dentistry and others, and they're going into trying to evaluate what happens to these residents who are the ones that provide the most services to dental -- to Medicaid adults, what happens to them after they go -- after their residency programs. The government paid for the residency programs, but then they go into private practice and don't accept Medicaid patients. So there is sort of a disconnect in terms of investment the government is making in training these dentists and what happens to them after they graduate. I think there is information on that at HRSA and others, as well as the IOM report of 2011.

Two quick things. I think there should be a discussion on sites of care of delivery of dental services for adults. These are a little bit different. Most of them happen in schools of dentistry and residency programs, as I said, that are community-based, some others in local health departments.

I think the role of FQHCs should be highlighted. They provide a tremendous safety net. They have been expanded tremendously because of the Affordable Care Act, and most of that infusion of money is going towards building dental clinics, but at the same time, they cannot keep up with the demand. And I think we had a discussion on that with Sara the last time.

A little bit on the reimbursement and financing issues and how that sort of affects the access to care and the quality of services.

And, finally, I think there should be a section on possible policy options, because the chapter looks very much -- looks excellent in terms of the need and the problem, but it has very little deep discussion about what are some of the possible policy considerations. Should Medicaid mandate coverage for adults? Should Medicaid

define or develop a standard set of oral health benefits? Should Medicaid sort of fund some demonstration projects relating to innovative workforce models?

There is a lot of interest in this area. There is very little being done that has been done on adult Medicaid policy. There has been the Surgeon General report of David Satcher in 2000, the IOM report in 2011, but it has been a broader sort of umbrella. A lot of it emphasized children. So I think this chapter would be sort of very eagerly awaited by many constituencies, and that could provide a really good impact on policy.

CHAIR ROWLAND: Thank you. That's a pretty tall order for Sarah in the weeks ahead. I think what we would probably do is to really highlight the policy issues that need to be addressed going forward, and then really put that on our agenda to continue to look at and work toward recommendations on how to really improve the access within Medicaid to dental benefits at both levels.

COMMISSIONER GABOW: I wonder if in creating some context to this, a comparison of adult dental coverage overall -- I mean, it's not a covered benefit in Medicare, and there's a lot of dental issues among seniors. So while

I think this is important -- I mean, we're MACPAC, but I think putting some context about oral -- coverage for oral health both in employer-sponsored and in Medicare would be useful.

Also, in addition to the community health centers, I think the safety net hospitals' role -- I know our dental clinics were just overwhelmed.

And one other issue that comes up with adults -- and I don't know what data is available -- is that adults who are poor tend to get less preventive care or less sort of, you know, things like implants or all those kind of things. They get a tooth pulled. So part of the reason why there is edentulousness in this group is because the therapeutic option available when they come in in an acute crisis is they pull the tooth.

So I think if there's some way to think about that in the context, it would be useful.

COMMISSIONER CRUZ: That fits with it. Since it's not a mandated care and it's always on the budget block, on the cutting block, the services vary. And you have a great table on it. So there's no chance of really continuing to have care or prevention. So they wait until

they can go and just pull the tooth.

VICE CHAIR GOLD: Just two small things that I think may tighten it a drop. One is on table 2, and then in reference, I think you talk about it at the bottom of page 3. I think if you look at the table, you'll see that most states pretty much either cover emergency services or you have an annual limit usually based on services with a limited package, because you separate those two, you never make that point. And I think that may help draw the point in that the coverage is pretty limited.

The second, on page 14 at the bottom, if there's a way to -- if the data are there, to just bring it back to talk about the effect of losing benefits on any health status effects when people lose, that would be a useful sentence to add, if there is something there.

CHAIR ROWLAND: Okay. Behavioral health. Amy?

MS. BERNSTEIN: Thank you. Shifting focus a little bit, last meeting, I presented on behavioral health use and expenditures, and you asked that we draft a chapter that described the behavioral health population using those data. And we thought it might actually be useful to expand that a little bit and add some additional sources of data

that you'd rather see, that you have seen in previous presentations.

The chapter describes the behavioral health population served by age and basis of eligibility, as you saw in the last meeting, by children, not elderly adults, and adults 65 and over by their basis of eligibility, which includes disability and welfare assistance status. It identifies the subpopulations based on their different needs and service use patterns, and it's designed to be just a starting point for future work that you may want us to undertake and that you may want to discuss to identify more targeted policies and practices that may help improve the care and control expenditures for these very different population groups.

So the chapter really has two sections. First, using a variety of data sources, most of which you have seen before, it describes the prevalence, socio-demographic characteristics, and access issues of different behavioral health populations, and it compares Medicaid privately ensure and uninsured people.

You saw in September of 2014, for those of you who were Commissioners then, a description of the probable

CHIP population of children, and we pulled behavioral health diagnoses from that survey, which was the National Survey of Children's Health, and then in October, we presented using the National Survey on Drug Use and Health, and that survey surveys people age 12 and over, so it can't be used for the younger children. And we included tables from both of those surveys in the chapter, in the draft chapter, and there's some fairly detailed information by socio-demographics as well as need for services, use of services, and prevalence. And this is primarily to show this sort of disproportionate use of these services and need for these services by the Medicaid population.

In addition, we then move on to sort of highlight the data that you saw last time, which uses the 2011 Medicaid statistical information system, and again, this is by enrollee age group and basis of eligibility.

A lot of the tables in the draft that you have now are blank, and that is because we are rerunning those numbers to exclude dual eligibles which we -- persons dually eligible for Medicare and Medicaid -- excuse me -- to exclude people with limited benefits and people with part-year coverage, so we can examine them separately

because obviously there are different issues for those groups, and also to include states that had questionable encounter data. There are sort of reasons to include it and reasons not to include it, and we thought it would probably be better to just exclude those states if we're not really sure about the data, which is, I believe, nine states.

In addition, you asked for more detail, and so when we are rerunning these numbers, we are doing some additional analyses. First of all, we are looking at comorbid conditions for all of these different groups. So we are looking at how many different kinds of both behavioral health and other diagnoses they have for selected conditions, so we're looking at high-prevalence conditions for each of the age and eligibility groups and seeing whether they have more than one and what percent of them have these particular conditions.

We're also looking at their use of services in very broad groups. So we're looking at whether they use institutional care, home- and community-based services, hospital care.

And in addition, we are looking at the

distribution of expenditures. So we are looking at the top 5 percent of total cost users and seeing if their use patterns and comorbid conditions are different than people who are not in the top 5 percent.

In addition, in those tables that you have, they are not probably labeled as well as they could have been. There's different groups that are based on the chronic illness or disability, or CDPS, payment co-methodology, and what this methodology does is it takes ICD-9-CM codes in diagnosis groups. So for psychotropic conditions or behavioral health conditions, let's say that they have a group that's called schizophrenic or called bipolar disorder, and then it's taking specific subcategories within those groups and using different information from a large number of claims data, classifying them into high, low, and very low cost conditions.

So we can say, for example, that most of the people who have a diagnosis of schizophrenia fall into the highest cost group, and ones who have minor depression or tobacco use disorders -- you know, they can't quit smoking -- they're in the very low group. So it's sort of a way of classifying people by condition, but the condition is then

sort of categorized by whether they usually have high or low costs.

So we are then looking at all of these different things, these comorbid conditions and use of services based on where they fall in that distribution. For example, do people in the highest cost group, which is largely people with diagnoses of schizophrenia, have different comorbid conditions than people who fall into the lowest cost group?

These tables are -- I was talking to Commissioner Gold earlier, and these tables are kind of complicated. These are basically the data that we are running, and we might simplify the tables later, and I would welcome comments on how to do that. But that's the kind of information we're getting because that's what you requested.

And so I welcome any comments.

VICE CHAIR GOLD: Yeah. Anne and Diane asked me to look at this chapter, so I'll lead it off.

I appreciate your coming forward. It was only the last meeting, maybe three weeks ago, that we decided we were having this chapter, and so, obviously, what you have sent us isn't the final chapter. There are numbers that

aren't here that will be here, and once you see those, it will be easier to tell the story, and we'll get to see it again, so I appreciate that.

I think the analysis will be useful. I do have some suggestions for tightening it and making it stronger at once as you move forward.

I think that the focus could be a little tighter. There's a lot of numbers and things, and so it seems like in the beginning, the message is behavioral health is important in Medicaid because it's a disproportionate share of the burden, and then the real focus is the tables we saw before and your additional one as well where it talks about the fact that if we are going to figure it out, we have to look. These are different kinds of subgroups of people, and we need to understand them, so we can figure out where some of the problems are and see where the priorities are.

I think you can make that message clearer, and I think there's too much now in the beginning. It takes too long to say what you're saying, and I think if you could figure out sort of the four main points or something like that that are there and summarize it in a page or two with a table, that might get across the point but let you get to

the other stuff sooner. So there's lots of ways to do that, and you guys can talk about it, but I think most readers will probably want to get the message first.

The other thing that Amy and I were talking about -- and I think it waits till the data there -- it would be useful. It seems to me that the two tables you presented earlier were very useful and easy to present. When we start getting into all these distributions, we run the risk that we are going to totally lose ourselves and not know what the message is. So it seems to me that once one sits down with the data and looks at what it's saying, it would be important to reconfigure how it's presented, so that essentially there's a clearer message.

I think with looking at all those distributions of spending, probably the most important thing is to figure out sort of is there a distinction between the chronically mentally will who have certain use patterns a needs versus the acute care stuff where we're mainly talking about coordinating primary care and mental health services, and if we can distinguish those groups, one of which is large in number but smaller in total expensive, from the other groups and maybe profile the diagnoses that may be

associated with each of those groups, that would be important. And you probably can get that across without all the detail that's in the tables, but it's hard to say how to do that till one has a chance to look at that.

So those were my comments, and I've given some additional written comments that Anne will pass on to you, and I'd be glad to talk with you. I'd love to see the tables when you're finished with them, if you're eager to have anyone else try and make sense of them.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: Yeah. I would agree with Marsha. I found it a little bit difficult. You're reading about children and older adults, and you do it twice. So if there's a way to sort of organize it and make it more precise, it would be great, and I realize that this is just the early draft, so I know that's to come.

I also sort of struggled with the differentials in populations. The severe and persistently mentally hill are really -- they're the foster care equivalent of this discussion. Then there's a whole range of folks and diagnoses, so I think it would be strengthened to take a look at that.

You mentioned it, and I think I'd put it in a bigger context that this issue will take on new importance with the expansion of Medicaid, especially around the issues of substance abuse where there wasn't a pathway, and now single adults, childless adopts are eligible, and they may bring with them disproportionate amounts of need.

So framing it, I think, around where expansion might take us will be important.

VICE CHAIR GOLD: I would agree with that, and I'd just also note that all these numbers are pre-expansion. So, if anything, Medicaid is going to get much larger and just make that point in the beginning, so the point there being it's important and it's going to grow even more important.

CHAIR ROWLAND: That's why some of the analysis you have of the uninsured population is helpful because much of that population is going to become shifted over the low-income part of that population shifting over.

I also think that the introduction of the comorbidities is an important piece because what we're looking for here are high-need, high-cost populations, and we also know that when you have a mental health diagnosis

combined with some of the other issues, you're into a more expensive population.

So I think Marsha's point of as you go through and fill out these tables, then you're going to have a thousand points that need to be really figured into what is the story, and I think some of the tables, you might pick out he story from them, and then maybe these could be appendices, so that people who want to delve deeper will look at the other thing.

So I think what we're really struggling with is how much information to write about in the chapter itself to make the points versus information that is useful to have on MACStats or to have in the chapter, but I think there's been so little information about behavioral health issues that this is really a great contribution. It's now just figuring out how to untangle it.

Norma.

COMMISSIONER MARTINEZ ROGERS: I do think it has to do with the wording also. Just kind of when I read it, it was -- you have given us a lot of information, which I am extremely appreciative of, but I think that just the narratives needs to be tighter.

The older adult part, I think there has to be some emphasis that there is going to be an increase of older adults in that part of it because as we go to the expansion of Medicaid -- I mean Affordable Care Act and Medicaid, we're going to really have to look at this issue even more so. And the increase of the population is what I am talking about.

Thank you.

CHAIR ROWLAND: Thank you.

SO now we'll go from behavioral health to psychotropic medications. Chris.

MR. PARK: Thank you, Diane.

During the last Commission meeting, I presented on the use of psychotropic medications by Medicaid beneficiaries, and the Commission expressed interest in including this as a chapter in the June report.

The chapter is primarily descriptive providing our analysis of the use of psychotropic medications, some of the risks associated with these drugs, and some of the federal and state activities that are aimed at improving the use of these drugs and ensuring that they are prescribed appropriately.

I will quickly highlight some of the information that I presented last month, and then I will present a few new analyses that we are going to include in the chapter. And to the extent that you have anything that we should do to move forward with this chapter, I'll appreciate it.

The chapter begins with our analysis of psychotropic drug utilization and spending. In 2011, Medicaid spent $8 billion in fee-for-service, which was about 30 percent of all fee-for-service drug spending. Overall, 14 percent of Medicaid enrollees use psychotropic drugs, and this varied by eligibility group.

The highest use were for individuals eligible on the basis of disability where about half uses psychotropic drug, and children eligible on the basis of child welfare assistance were about a quarter uses psychotropic drug.

In addition, within these two groups, the users used about twice as many psychotropic prescriptions per year, so they used around 16 to 17 psychotropic drugs per year, where the other eligibility groups, individuals who qualified on the basis other than disability or child welfare assistance used around eight.

COMMISSIONER COHEN: So 16 or 17 prescriptions.

MR. PARK: Per year.

COMMISSIONER COHEN: Prescriptions filled per year.

MR. PARK: Yes.

COMMISSIONER COHEN: Okay.

COMMISSIONER GABOW: Let me ask for a clarification on that. It's confusing to me whether that's like if you have 12 prescriptions per year, is that one prescription that was refilled every month, or is it 12 prescriptions that had three month supply of drugs? It's hard to parse that into what it really meant about drug use. If you could clarify that, I was a little confused.

MR. PARK: Yeah. And we're going to try to do an analysis that will get to some of that.

The chapter will also present some of the risks of adverse health effects and death. For example, antipsychotics can increase the risk of weight gain and metabolic disorders in children and adults. It also increases the chance of illness or death in elderly adults with dementia.

Given these risks, the chapter then presents some of the federal and state agency initiatives that are aimed

at ensuring the appropriate use of psychotropic drugs. For example, CMS, the Administration for Children and Families, and the Substance Abuse and Mental Health Services Administration have been coordinating efforts to disseminate information on what state activities are out there that are aimed at improving the use of psychotropic drugs, and states have implemented several processes, such as informed consent, peer review and consultation, and provider education.

Previously, we described that this analysis identifies users of psychotropic medications, which is not necessarily the same as individuals who have a behavioral health diagnosis, which Amy will be including in her chapter.

So to put this into better context, we are linking some of the information that Amy has done on identifying individuals who have a behavioral health diagnosis with our drug analysis, and so over half of Medicaid enrollees with a psychiatric diagnosis use a psychotropic medication, and about 30 percent of psychotropic drug users did not have a recorded psychiatric or substance abuse diagnosis, and this may be due to the

fact that some of the psychotropic medications we included in our analysis, such as anticonvulsants are used for conditions such as epilepsy.

And, Patty, this is an analysis that we're doing to try to get to your question about how many of these people are short-term versus long-term users, and so the analysis will look at -- and we're still in the process of doing this analysis, and it's not included in the draft that you see today, but we'll provide it to you before the report goes to publication.

So part of the analysis will be a distribution of prescriptions per user, and this will get to the point where we'll be able to say what share of these users maybe used like one or two prescriptions during the year versus like 20 or 30.

And then another part of the analysis will look at the number of months an individual had a psychotropic prescription, so we can kind of see if they had continual use throughout their eligibility span.

And with that, I'll end the presentation, and if you have any comments or suggestions for the chapter, I'll appreciate it.

COMMISSIONER SZILAGYI: Yeah, thanks. I was asked to kind of provide first comments.

I think this is very strong and really a very good, important chapter. You've come a long way as well in a month or so. And I recognize that there's probably not an enormous amount of time between now and the June publication, so most of my comments are going to be more on editing rather than super-substantive.

I would suggest initially kind of laying out what the chapter will do, so it seems to me that you have five big issues you're trying to tackle: users of psychotropics, which is a database analysis; and then a review of the literature, which is another method about what psychotropic medications -- what the guidelines are; and then inappropriate use, which is also a literature review. And then you switch to a third method, which is review of the websites for states, I think, and that's how you reviewed what different states are doing. So I would just lay out ahead of time what you're doing in the chapter so people can kind of see it. So that's one thing.

So then getting into the first part, which is psychotropic utilization, I guess the one big question I

have here, so the outcry, what's, you know, the brouhaha right now is psychotropics for kids in foster care. But the group that we're looking at here are children who are eligible because of child welfare, which was just discussed in a previous chapter, that's a much larger group than kids in foster care.

So I went back and forth in my mind. I think it's okay, but you're going to have to really describe who that group is and that this isn't just kids in foster care, this is kids who are eligible because of child welfare. It's actually three times as large as the number of kids in foster care.

So just so people don't misinterpret, you know, where you're going with this chapter. So essentially you're defining the columns in all your tables, Chris, you know, be very clear.

And then I would also early on lay out what you lay out later, which is what you can't do with just an analysis of utilization. You can't tell anything about appropriateness or about multiple different drugs or adherence or whether the dose is right. So just that's okay, because you can do a lot, but just so people don't

expect that your analysis or utilization is going to dig right into all of this, you know, why are kids being overtreated, because they can't do that.

So then the second part is the risk of psychotropic medication, and I would again -- I made this point for a previous chapter. I would mention that -- a key point, that the reason so many of these kids are on psychotropics is because they're getting -- they're not getting the appropriate -- the other types of mental health care that they need to. And you would get that either from the literature, which this section is a literature review, or you would get it from talking to experts.

In terms of the -- and I'm almost done. In terms of the next section, which was, what are states doing to try to address this? I think what you did is you reviewed the state websites. Is that right?

So, you know, I was wondering how good is that? You know, some states that have better websites or they're better web masters, you know, I mean, did you interview anybody at states? So I just didn't know about the accuracy of that section.

MR. PARK: Right.

COMMISSIONER SZILAGYI: Although some of what you were saying in there rang true with what I know also about what states are doing. So I think it's probably okay, but I was just wondering about that method.

MR. PARK: Yeah, it wasn't a comprehensive review of what states are doing. It was just meant to provide some examples of the activities out there.

COMMISSIONER SZILAGYI: Yeah, so future activity, you might think about interviewing states, if not all 50 states, a select group of states. And as I mentioned in a previous chapter, if you wanted to do a case review in this chapter, Texas would be a very good -- because they have really tried to take on the issue of psychotropic drugs. So if you wanted a box or something in the chapter where you do kind of a case review of what a state is trying to do, that might help the chapter.

And then in the last part, which is a very short part, you know, looking forward -- and this is where you're going to do an individual-level analysis, I think, where you could really dig down about how many different kinds of drugs kids are on or adults are on, polypharmacy, number of 'scripts, et cetera, I think that will be useful. I'm not

so sure you're going to be able to put that together with this chapter. That's going to be a massive chapter. Or is that going to be sort of another piece?

But I thought overall this was a very, very nice chapter. You know, be really clear about the foster care versus child welfare, because everybody's talking about the foster care population, and that's actually -- that's a subset of what you're dealing with here.

COMMISSIONER WALDREN: I agree with your comment about with the limitations. I think without the SIG piece of it and the count from the 'script or the diagnoses, it's hard to look at the appropriateness.

The other thing I would say is I would probably try to steer away from the use of the word "'script" and be more specific about what do you mean. Do you mean fulfillment? Do you mean the claim? Payment? Because if I write -- if one writes a 'script for 90 days and one writes a 'script for 30 with three refills and one writes three different 'scripts, it's the same amount of drug, but what is the number of 'scripts relative to that? So I'd just be explicit, but if possible, stay away from "'script" because I think that's confusing.

COMMISSIONER GABOW: One source of information which you might want to look at about drugs is the National Poison Center because they get -- they have a tremendous amount of data about calls regarding issues about certain drugs and overdoses and questions about use. And try to pull in some of that data. I think they can be quite granular about which -- because they run off of algorithms and protocols, so they usually can give you a lot of rich information about any question you have about drug use. So that might be a place to look.

The other comment is any of these states -- and it may not be for this chapter because you may not have time, but any of the states that have tried different methods, do we have any outcome data about does X work or does Y work or do we not know if anything works? What's the evaluation basically of the different things that people have put in place I think would be useful.

COMMISSIONER RILEY: I'd also like to see a little bit more fleshed out the off-label issue, because it's not just off-label for other diagnoses, but there are off-label uses against common evidence by psychiatrists for certain of these drugs, and I'd like to see that played out

a little bit more, because I think maybe something -- at least a nod that Medicaid spending on these drugs works in a marketplace about which we have no control, and physician practice is one, and drug -- I mean, in your chapter the list of drugs correlates with Cymbalta, Lyrica, all the advertising that goes on. And there have been studies about drug prescriptions and advertising are linked. So maybe to talk a little bit about the marketplace in which these decisions are made and that Medicaid has little control over that.

COMMISSIONER HOYT: Two questions. On the fee-for-service number in that data, does this include people in correctional facilities who are on Medicaid?

MR. PARK: I think to the extent that they are Medicaid covered, it would include them. But I can't specifically say like how many people that might be.

This is from 2011 data, so at that point I don't think they would have been included.

COMMISSIONER HOYT: The other question I had, this isn't exactly new. I don't think this is conclusive by itself, but I think it's interesting data. Do we know who prescribed the psychotropics? What percentage came

from a psychiatrist or a psych RN versus other, something like that?

MR. PARK: We haven't looked at the quality of the prescriber ID on the data, but that field is available, so that could be a feature analysis where we look to see how many of these prescriptions may be coming like from a PCP versus a psychiatrist or another provider.

VICE CHAIR GOLD: This is the same issue I raised last time, I think, and it's the same point. I don't think it's appropriate to have a section on elderly adults when it's only based on 0.4 million people because most -- you're excluding dual eligibles. So these are the odd -- you know, people that are dually eligibles, and it may or may not be reflective of Medicaid. So in part, I don't quite mind having it on the table if there was a better footnote that said these people are just a very, very small subset of total Medicaid. But discussing it as if it characterizes the Medicaid population just I think is going to result in confusion because Part D is what covers most of Medicare beneficiaries, and there are other data on that that this may or may not match up with.

CHAIR ROWLAND: I presume you also took the dual

eligibles out of the under-65 population?

MR. PARK: Yes, that's correct.

CHAIR ROWLAND: Okay. Other comments?

[No response.]

CHAIR ROWLAND: All right. We're going to then move to have these three chapters plus the previous discussion put together. It strikes me that we actually have some symmetry between at least three of these chapters: the intersection of Medicaid and child welfare, then the behavioral health, and the use of psychotropic medications. And so it might be nice to actually put them together with some sort of over-framing that this is looking at different aspects of some of the most vulnerable populations within Medicaid. And then, of course, we will have the dental chapter which will go there, too, so those will be the main chapters of our report. But we can frame that in the cover transmittal letter as well or in an introduction to the volume.

Okay. Sarah, you are back on.

MS. MELECKI: Thank you. As you know, MACPAC is required by statute to review and provide comments on reports to Congress that relate to access policies in

Medicaid and CHIP, and so this presentation focuses on a report released by the Secretary of Health and Human Services in November of last year. The report assesses the agency's progress in implementing approaches for identifying, collecting, and evaluating data on health care disparities in Medicaid and CHIP.

CHAIR ROWLAND: You'll all recall that the statute says we have six months to review and comment on any secretarial reports.

MS. MELECKI: Yes.

CHAIR ROWLAND: Regs, we can choose whether to comment on or not, but secretarial reports are in the statute.

MS. MELECKI: So I'll begin today by presenting the Affordable Care Act provisions regarding disparities data and then discuss specific data elements relating to disparities data from the Department of Health and Human Services' standards, which were released in October of 2011.

I'll provide a brief summary of the HHS Secretary's report to Congress, and I will conclude with potential areas for MACPAC comments. Based on your

discussion, following this presentation we will draft written comments for inclusion in a letter to the Secretary and congressional committees of jurisdiction.

The ACA directed the Secretary of Health and Human Services to develop data collection standards for race, ethnicity, sex, primary language, and disability status. These standards were created and released in October of 2011.

The ACA also directed the Secretary to collect data on these five demographic characteristics specifically in Medicaid and CHIP.

And, finally, the act required an evaluation of approaches for the collection of data in Medicaid and CHIP that allow for the ongoing, accurate, and timely collection and evaluation of data on disparities and health care services and performance on the basis of these five categories. And the November 2014 report that I'm presenting on focuses on this evaluation.

So as I mentioned before, the five demographic characteristics for which HHS was directed to develop data collection standards are race and ethnicity -- these are different concepts that may be thought of in terms of

social and cultural characteristics as well as ancestry, and I'm going to talk more about these in a minute -- sex; primary language, which is a complicated concept that involves how well a person speaks and understands a language, what language is spoken in the home, and more; and disability status, which, once again, is very complicated, so I'll talk more about that in a moment.

Looking specifically at race, the 1997 Office of Management and Budget standards require a minimum of five racial demographic categories of which a person may identify with more than one. The categories are: American Indian or Alaska Native; Asian; black or African American; Native Hawaiian or other Pacific Islander; and white. The standard created by HHS in 2011 expand upon two of these categories, offering more detailed options for the Asian and Native Hawaiian or other Pacific Islander categories.

Turning to ethnicity, the HHS standards allow for a person to identify their ethnicity as Hispanic, Latino/Latina, or of Spanish origin; and the standards offer additional subcategories. It's important to note that the HHS standards indicate a preference for self-report based on a response's definition of their own race

and ethnicity. However, self-reports may vary because all people do not identify themselves using a uniform set of rules. For example, a person of multiple races may choose to identify as one race, while another person of multiple races may identify as more than one race.

Looking at disability status, data on disability can be collected in many ways. For example, administrative data often base the definition of disability on programmatic features, such as a person's eligibility for Medicaid. However, survey data often base the definition on questions about functional ability. And, importantly, some surveys include more detailed questions than others.

Because of these differences, measurement and analysis of disability characteristics has not been consistent among different data sources. The HHS standards released in October of 2011 require a six-item set of questions in surveys to identify disability status, and information on that can be found in your brief.

The report released in November of 2014 by the Secretary of Health and Human Services focuses on the department's efforts in two areas: improving data collection and improving data analysis and reporting of

disparities measures.

To improve data collection, HHS is working to modernize Medicaid and CHIP data infrastructure, which includes the Transformed Medicaid Statistical Information System, or T-MSIS. HHS has also incorporated the new standards into the streamlined enrollment application and is working to incorporate them into patient experience surveys. The standards have been added to all new surveys and are being incorporated at the time of major revision to existing surveys.

For example, in the National Health Interview Survey, they began incorporating the six-item set of questions on disability to the Family Core questionnaire in 2010, and those questions were retained in 2011.

Multiple race categories showed up for the first time in 2012 data on MEPSnet, which provides data from the Medical Expenditure Panel Survey. And the Medicare Current Beneficiary Survey began asking questions about race and ethnicity with granular response options in 2013.

To improve data analysis and reporting, HHS is promoting the use of the core sets of health care quality measures, which were identified by CMS and stakeholders, to

identify and evaluate health care disparities in Medicaid and CHIP, and as a reminder, the Commission submitted a comment letter to the Secretary and congressional committees of jurisdiction on the core measures in November of last year. HHS is also promoting data sharing, collaboration, and analyses between CMS and other HHS offices, such as the Agency Healthcare Research & Quality.

The report also includes two recommendations for the agency's own future work: to improve the quality of federal health care disparities data, including the accuracy and completeness of data across Medicare, Medicaid, and private insurance; and to improve the completeness of health care disparities data collection in managed care.

Moving on to possible areas for Commission comment, for clarity we have divided potential comments into three groups: survey data, administrative data, and quality measures.

Regarding survey data, the Commission may wish to comment on the importance of timely implementation of the new data collection standards, which are being incorporated at the time of major revision to existing surveys. Some

surveys incorporate some or most of the new categories, but not all categories. For example, the National Survey on Drug Use and Health and the Consumer Assessment of Health Care Providers and Systems Medicaid Survey do not have questions regarding primary language.

The Commission may also wish to comment on the importance of the five disparities measures mandated by the ACA but also additional measures not mandated, such as household income, geography, veteran status, public program participation, and literacy level.

The Commission has spoken a number of times about the need to improve data reporting and quality in general, including in the March 2011 and June 2013 reports to Congress. And this comment letter provides another opportunity to stress the importance of these issues.

The Commission may wish to comment further on further efforts by CMS to improve the completeness and quality of key variables in administrative data, particularly in T-MSIS.

And the Commission may also wish to comment on more complete and accurate data collection and reporting by the states, which in turn leads to improved reporting to

the federal government.

And finally, regarding quality measures, MACPAC submitted comments to HHS and the Congress regarding quality measures in June of 2011 and again last November, and this comment letter provides another opportunity to discuss the Commission's concern about the voluntary nature of data collection and provision by states to CMS.

Specific to this report, the Commission may wish to comment on the limited number of quality measures being examined by demographic categories. For example, participating states in the adult Medicaid quality grant program are required to report three out of four selected adult quality measures, but only for two out of the five demographic categories identified by the ACA.

So that concludes my presentation, and I will be listening intently to draft a letter.

CHAIR ROWLAND: Data, one of our favorite topics.

I think it might be helpful for the Commission members who were not on the Commission in November to receive a copy of the letter that we sent at that time around data requirements, and as you know, in our statutory responsibilities, one of them is to look at what data is

needed to both manage and evaluate the program. So I think this is an important report for us to comment on beyond the disparities issues.

Comments from other Commission members? Marsha.

Marsha never likes to do anything with regard to data.

VICE CHAIR GOLD: No. Actually, I don't know the Commission's history with this because I'll look forward to seeing the letter, but I've worked a lot with both the National Health Plan Collaborative working through AHRQ to try and deal with the health plan issues with getting data because the providers are the primary source of it or the eligibility side, and also looked at some of the issues within HHS at getting these data.

They are not trivial to get these changes made. I think it's really important that the ACA had them, had the requirements in there, and I think it's really important that we reinforce them going forward. It seems to me it would be useful to -- this isn't just a data exercise. This is because you need these data if you are going to monitor and really intervene with quality improvement and with performance that they're critical to

have for that and just sort of reinforce that it's not just for data's sake.

Personally, I am in favor of getting lots of additional disparities data. I don't know what you said before. I'd be happy if they could get what they're trying to get now. So I think while we should say there are lots of other things as well, sort of the main message should be keep on this, I would think.

That's all.

COMMISSIONER WALDREN: In general, when I think about data, too, and data collection, I mean, there is a burden to data collection, no matter what you're trying to do. So if it's not being used for analysis and for that monitoring that you mentioned, Marsha, then I don't think there's -- you have to have that in place before we can expand it, so the question would be how much of the data that's currently being collected is actually used to monitor for disparities today.

CHAIR ROWLAND: One of our previous comments was that there's a lot of things that would be nice to know, but you only ought to ask for the things that you plan to be able to use and to make it useful, and we are in the

Medicaid program very aware of the limits on state capacity to produce some of this data, but we do want high-quality data to monitor access to care and to monitor the quality of care. So I hope that this report will help get us closer there.

Other comments?

So you will prepare -- you have drafts? But you will prepare some draft comments based on the materials that are in the book, and we can get comments back to you. And this does not have to go into the June report, so that we can actually finalize it at our next meeting.

EXECUTIVE DIRECTOR SCHWARTZ: I have Chuck Milligan, who couldn't be here today -- he sent me some comments, so I'll just read what he had to say because it's brief.

"I support the areas that Sarah identified for comments. I wish to add a couple; first, a recognition that HHS and CMS have made great strides and that MACPAC appreciates those efforts even as MACPAC would like to continue advancing the knowledge base. Second, that HHS needs to ensure that data collection also is tailored to reflect the fact that some races and ethnicities have

multiple ways of identification. For example, for Native Americans, the data can come from both eligibility information, which is self-report, and from claims data, from providers like the Indian Health Service that are only permitted to serve Native Americans, and find that proving source is not in HHS databases, such as the presentation of a tribal membership."

CHAIR ROWLAND: So we'll look through this, and you'll look through the proposed comments, and then we'll take this up to finalize it at the next meeting. Thank you.

And Martha is going to now share with us new findings from the Health Reform Monitoring Survey, which I saw Urban had a new release just today.

MS. HEBERLEIN: Yes. I saw the new release, and I'm not actually going to talk about that. I'm going to talk about something else that they did specifically for us.

So just to give you a quick overview, I am going to start with an update on coverage and the Medicaid enrollment changes following the ACA and give you a little bit of background. We've talked a bit before about the

Health Reform Monitoring Survey, or the HRMS. I'll update you a little bit or give you some more background on that, and then what we've asked the Urban Institute to do for us is to look at the characteristics of the newly enrolled adults in the Medicaid expansion, so what the new group looks like. And that includes their demographic, socioeconomic characteristics, health status, access to care, their use of services, and their satisfaction with coverage.

So starting with the coverage in Medicaid enrollment changes, last week ASPE, the Assistant Secretary for Planning and Evaluation, at HHS put out some new coverage estimates on who has gained coverage as a result of the implementation of the ACA. So this is overall insurance coverage gains, and this includes people who have gained coverage, both through Medicaid and the exchanges.

So they estimate that 14.1 million uninsured adults have gained coverage since the beginning of open enrollment, which was October of 2013, and the uninsured rates during that point declined by 7.1 percentage points.

As we've reported before, coverage gains were larger in states that expanded Medicaid, as expected.

Specifically, for those below 138 percent of the FPL, expansion states saw a 13 percentage point decline, while non-expansion states saw a 7 percentage point decline.

So during this same time period, Medicaid enrollment also increased. I just want to note that these numbers are different than is in your slide because they came out Friday afternoon, but we want to give you the latest and greatest. So as of January 2015, there was approximately 70 million full-benefit Medicaid and CHIP enrollees. States saw an overall increase of 19.3 percent. This is about 11.2 million people newly enrolled in Medicaid since open enrollment of October 2013.

COMMISSIONER COHEN: Sorry. Can I just ask this question?

MS. HEBERLEIN: Yes.

COMMISSIONER COHEN: Is that 70 million in January? Is this like our one-month total or our over-a-year total?

MS. HEBERLEIN: Yeah. These are one month.

COMMISSIONER COHEN: Point in time.

COMMISSIONER RILEY: Is the 11.2 million of the 14 million? Of the 14 million, how many were Medicaid?

MS. HEBERLEIN: There are different data sources. The ASPE report is based on the Gallup Poll, which we've talked about a little bit in the past when we reported to you in September, and then these are administrative data, so it's not an apples to apples sort of thing.

So, again, as reported in the past and as expected, expansion states saw much larger increases in enrollment than non-expansion states did.

This slide should look very familiar because we presented it when we were here in February, but I just wanted to recap about sort of the number of people who we think are in the new group, and so these data are a bit older, back in March of 2014. We had about 5 million expansion group adults in the states that were reporting. So this was about 18 percent of Medicaid enrollment in the 22 expansion states with data at that point. Note that three states were not reporting, and four states have expanded since then, so we expect that this number is larger than 5 million.

So moving on to the Health Reform Monitoring Survey, we contracted with the Urban Institute to provide us an early indication of data that we can't from other

sources yet -- federal surveys and administrative data will give us a little bit more in the future but not quite yet. So we wanted to see what we could get from this particular data source.

The Health Reform Monitoring Survey is a quarterly Internet-based survey of non-elderly adults, and it collects information on health status, health care coverage, access to care, and affordability of care.

The data I am going to present here are primarily from quarter 3 and quarter 4, merged quarters, in order to get a large enough sample size and while still presenting the most recent data available.

There's a couple places. If you notice, there's a longer memo in your packet that includes some tables, and there's a couple places where it's not these quarters, but for the most part, it is quarter 3 and quarter 4 data.

So just to sort of explain a little bit about who these expansion -- how we are defining the expansion adult out of this particular survey, so it includes adults aged 18 to 64 who report Medicaid at the time of this survey. They were uninsured for part or all of the past 12 months, so they didn't have prior Medicaid coverage. They live in

an expansion state, have income at or below 138 percent of the FPL, and this may include some previously eligible but not enrolled adults. But we expect this number to be relatively small, given the low eligibility thresholds in place prior to the expansion in most states, but just note that it probably does include some so-called "woodworker" effect adults.

So why are we so interested in these folks? Well, their health status has been a subject of much talk, and it's important both for cost and beneficiary access. Should a large number of people with health care needs enroll, that could have impacts on both costs and service access across the program.

So to date, we've only really had some anecdotal information from a few states about what these people look like as well as some pre-ACA projections or expectations about what their take up and health status might be. So the HRMS allows us to get a first picture of who's getting coverage under the Medicaid expansion, and the analysis compares estimates for the expansion population to the full-year Medicaid population, so those people who were previously eligible and enrolled in the program as well as

exchange enrollees, adults with employer-sponsored coverage, and uninsured adults.

So now what you've all been waiting for, starting with the demographic characteristics. Slightly less than half of the expansion population is between the ages of 18 and 34. Almost 60 percent are female. About 44 percent are parents. Nearly half are white, and almost a third are Hispanic.

These characteristics are not different from the full-year Medicaid enrollees, so the previously eligible population, except in terms of gender, the share of female enrollees in the expansion population is lower than the current enrollees, which makes sense, given the categorical eligibility.

In terms of socioeconomic characteristics, over 40 percent of the expansion population was employed. The majority of these people were working part-time. This is higher than the number of full-year Medicaid enrollees that were working.

Approximately 70 percent report income below 100 percent of FPL; 60 percent were uninsured prior to enrolling. Half of the expansion population were receiving

SNAP or food stamp benefits, and more than a quarter claimed the EITC, or earned income tax credit.

Looking at their health status, adults newly enrolled under the Medicaid expansion are more likely to report fair or poor health than those with coverage through the exchange or employer-sponsored insurance. They are also more likely to report a higher average number of poor health days, both physical and mental health from this group.

They reported fewer poor physical health days than those with full-year Medicaid, so the previously enrolled population, but they were comparable in terms of poor mental health days to the pre-expansion population.

In terms of access, six out of ten newly enrolled adults in expansion states reported having a usual source of care. This is a smaller share than those with exchange coverage, employer-sponsored coverage, or full-year Medicaid. A larger share of the expansion population reported access barriers, including trouble finding a doctor and unmet need due to cost, but as Anna talked a little bit about earlier, we just want to note the responses about recent access experience and difficulty are

based on the prior 12 months, and so some individuals will have experienced changes in coverage, and specifically, our definition of the expansion population had a change in coverage. By definition, they have newly gotten Medicaid, so it's not clear to us from the data whether these access problems occurred before or after their enrollment, so just a note of caution here.

I also want to point out that there is a higher share of full-year Medicaid enrollees had reported a usual source of care and a routine checkup within the past year, and they reported fewer access barriers than the new enrollee population.

And finally, satisfaction with their current coverage, adults that are newly enrolled on their expansion are less satisfied with the availability and quality of services compared to those with exchange or employer-sponsored coverage.

Similar differences are actually seen between the newly enrolled and the full-year Medicaid enrollees. So the new enrollees expressed less satisfaction in their choice of doctors, ability to see a specialist, and the quality of care than those Medicaid enrollees that had been

in the program for the full year. So this suggests that maybe once these enrollees are established patients, they may report higher satisfaction with their coverage.

Additionally, compared to those with exchange or employer-sponsored coverage, the adults newly enrolled under the Medicaid expansion report less dissatisfaction with the cost of their care when compared to exchange or employer-sponsored coverage individuals.

So thinking about our future work, we will continue to monitor the surveys, the HRMS and other private surveys as well as the federal surveys that are mostly due out in the fall and what we can do to inform our work on ACA implementation. For example, we're thinking of using these data to help provide more insight on the level of churn and what the impact of churning is between different coverage sources.

We'll also be looking at the administrative data from CMS, just to keep tabs on how many people are enrolling, how many people are in the new group, as well as using some encounter data to better understand their health status and use of services.

COMMISSIONER GABOW: Thank you. This is

interesting.

I think going forward; there are two points to make out of the socioeconomic characteristics. The fact that 70 percent had a family income below 100 percent of federal poverty, I think has implications for states that have a desire to add copay or premium to the new population, and so I think emphasizing the amount of money that is and the amount of discretionary income those patients have, those people have would be very important, and it's further reinforced by the fact that half are on SNAP as well. So I think underscoring how poor this population is and the implication for what that means in terms of copays or premiums is important.

I also think the fact that half are on SNAP and a quarter are on earned income tax give us an alternate path to enrollment by using these methodologies for automatic enrollment that we've talked about in other venues, and enabling states to use those modalities is important. So I think those two points --

CHAIR ROWLAND: I think it is also important to note that the expansion populations do not necessarily have the same benefit package that the typical Medicaid patient

would have, and in some of the expansion states with these negotiated waivers, we know there is cost sharing, and there is some effort to try and even do premiums for the people above 100 percent.

Gustavo, then Mark, the Andy.

COMMISSIONER CRUZ: Yeah. I have a question. Do we know -- let me begin again. You said here that 60 percent of those covered under Medicaid expansion reported a new source of care. Do we know what source of care? Is this public, private?

MS. HEBERLEIN: Yes. Hold on. We do know the usual source of care. Fifty-three percent reported that it was a clinic or a health center. Forty-five percent reported doctor's office or HMO as the type of usual source of care.

COMMISSIONER CRUZ: Do we have an item like when was the last time they went to the doctor or the physician or --

MS. HEBERLEIN: The closest we have is the time since the last routine check-up --

COMMISSIONER CRUZ: Uh-huh.

MS. HEBERLEIN: -- and about 60 percent of the

expansion population reported having a check-up within the last year.

COMMISSIONER HOYT: So, Medicaid eligibility was never my strong suit to start with, and now I'm even more confused. Only 40 percent of the expansion population is employed? That confused me, because I know this is too simplistic, but I was thinking their income is above whatever the state eligibility line is and below 138. So, how could you have income without a job? But, I guess, the asset test is gone? Was it that significant?

MS. HEBERLEIN: So, yes, the asset test is gone. In most states, adults without dependent children were not eligible for coverage prior to the ACA expansion, so that brings in some of that part. And, then, parent eligibility, the median threshold prior to the expansion was 61 percent. So, there are still people between 60 and 100 percent, parents, that would be brought in through the expansion. And, then, you know, when you have to make under 138 percent of poverty, I don't know what minimum wage -- I'd have to do the math, but what minimum wage full-time work would get you and whether you can still be working and working part-time and have a job but still

qualify.

COMMISSIONER RILEY: But, isn't the question -- I think the question is, under MAGI, what counts as income, because, clearly, only 40 percent of the -- you would expect people between 100 and 138 have some income. They're not working. So, what counts under MAGI as income for the rest of those people?

MS. HEBERLEIN: You would think that the population between 100 and 138 were part of that working population. I would assume that. I don't -- we didn't break -- we didn't look at the break of new enrollees by income and by work. So, you would assume that those with income are probably more likely to be the workers, but we didn't look at the data in that way.

COMMISSIONER RILEY: I had a question on the same slide, and that was given the ideological political fights around expansion, 40 percent of people, of new enrollees, were previously insured. And, on your chart, it was a little confusing, because ESI and private non-group don’t kind of add up. Do we know anything more about where they were insured and how many of those were Medicaid eligibles who might have had insurance?

MS. HEBERLEIN: We don't know how many are Medicaid eligible. I mean, if they were -- I mean, they are Medicaid eligibles under the new group, right. The population we have is that 60 percent were uninsured. About six percent had employer-sponsored coverage and 2.5 had non-group.

[Off microphone.]

MS. HEBERLEIN: Yeah.

CHAIR ROWLAND: Martha, could you speak at all to some of the potential limitations of this survey data?

MS. HEBERLEIN: So, as I said, it's a quarterly Internet-based survey. It's a small sample size. There is, in that question that you were just asking, there is a sample size of 304. So, there's a lot of variability in the data and just things we don't know, which, I think, is part of the reason why we're all eager to get the federal surveys that have much larger sample sizes and some of the more detailed questions, you know, like the National Health Interview Survey will let us look a lot at what happened in terms of coverage and where they were before and why they might have switched. So, I think we can get a lot more from some of the federal surveys, and I can't wait until

September.

[Laughter.]

CHAIR ROWLAND: And, there's a lot of difference between an online self-completed survey and one in which there's an interviewing process asking questions, so --

MS. HEBERLEIN: And follow-up questions and you can probe more.

CHAIR ROWLAND: Okay. Any other questions?

[No response.]

CHAIR ROWLAND: Okay. Thank you.

So, we've come to, again, the time of day when we are drawing to a close for this meeting and would welcome any public comments. If someone has a public comment, we'll bring a mic over for you to address us, and please offer your name and your organization.

MS. WATSON: Hi. I'm Maria-Rosa Watson. I'm a local public health dentist right now working alone, finishing a Robert Wood Johnson Health Policy Fellowship until August, and I have a couple of comments.

First of all, I want to commend you for taking a chapter on adult access to care, dental care, because this is fantastic. This is, you know, as a fellow, I think,

working on reports with three states, and each very hard to find data on adults. I just hope that it's beyond annual dental visits. You know, when you look at the literature, it's easy to find just information on an annual dental visit, and I think we need more information.

I wanted to second the comments from Dr. Cruz, Commissioner Cruz, who I think were very, very important. I think there is something that MACPAC could have a great role on helping elucidate the role of Federally Qualified Health Centers. As you probably know, HRSA, and there was an article in the New England Journal of Medicine looking at incorporating oral health into primary care. However, when you go to the practicality of how do you do it, there's still lots to be elucidated. I think more funding in that area would be great.

And, even if you look at children, there's states that have very good reimbursement for dental provision in children and they're able to incorporate oral health in private practice. However, when you look at Federally Qualified Health Centers, which is, you know, the bulk of the population that we're interested here, it's unclear how to do it. And, I can tell you, I think working on a pilot

to do it in a Federally Qualified Health Center and the resources are too thin. The providers are too busy. It's very, very hard. So, I think that's another area.

And, I think, as Dr. Cruz mentioned, residency models could also work on these kinds of pilot programs to elucidate, how can we do these. So, I think that's another thing to think about.

Also, a comment about looking at oral health access from the standpoint of Medicaid versus Medicare. I really -- there's recent articles that show that oral health maintenance care can really improve health care outcomes and oral health outcomes, especially for people with multiple diagnoses and chronic care, and there's not much done in that area and I think this is a great opportunity for you guys to address that.

I have -- oh, and the other thing that there's not enough data and I don't know if your researchers could do it, is the return on investment of maintenance care, and if at least it could be done as a pilot on, you know, how caring for people early that are developing diabetes and cardiovascular disease and other conditions, how the return on investment at the end of the day pays off, not just

outcomes.

The third comment, just really quickly, there's so much to be done still in terms of health promotion and education and it's really, you know, primary care at the Medicaid, Federally Qualified Health Care settings, and health literacy needs to be mentioned, as well.

So, those are my dental comments. I have a behavioral health comment, as well, because I'm a co-investigator in a NIH Community Infrastructure Grant, and I didn't hear your full chapter that you presented last month, but I wanted to mention that, especially for minority populations, the primary care setting, they prefer to seek care at the primary care setting rather than go to mental health providers. And, I think when you look at the utilization of data, it's really, really important to look also, you know, where is the place of diagnosis for behavioral health. There is data to show that even though this population prefers care at primary care settings, they are more likely to be missed, the diagnoses, at the primary care setting. So, I think that type of data will be very, very important, as well.

Thank you, and great job.

CHAIR ROWLAND: Oh, thank you. Great job for you. Those were very helpful comments and we appreciate them, and we appreciate all of you who are with us this afternoon.

We did cancel tomorrow's meeting, so please don't try to come to a MACPAC meeting tomorrow. We will be busily working on trying to get these chapters together and in order for our June report, and our next scheduled meeting is on May 20-something.

[Off microphone discussion.]

CHAIR ROWLAND: May 14 and 15, and we will be at NGAUS, so we will be back on the Hill at the National Reserve Officers --

EXECUTIVE DIRECTOR SCHWARTZ: No --

CHAIR ROWLAND: No, at the National --

EXECUTIVE DIRECTOR SCHWARTZ: National Guard Association.

CHAIR ROWLAND: -- Guard Association, NGAUS, whatever it is, Massachusetts Avenue.

Thank you all. We are adjourned.

[Whereupon, at 3:17 p.m., the meeting was adjourned.]