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COMMONWEALTH  
FUND

## **Assessing Innovations in Medicaid**

**The Commonwealth Fund  
Alliance for Health Reform**

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MARILYN SERAFINI: Welcome everybody, we are going to go ahead and get started. I'm Marilyn Serafini with the Alliance for Health Reform. On behalf of our honorary co-chairs, Senators Cardin and Blunt, I would like to welcome you to today's briefing on Medicaid value and innovation. Today, Medicaid insures over 70 million Americans, making it the largest source of public health coverage. We often talk about Medicare as a testing ground for innovative approaches to delivering healthcare, but there is also a lot going on in Medicaid and that is what we are going to talk about. Today, our speakers are going to help us understand what Medicaid programs are doing to improve care and promote value and also how they are addressing emerging issues such as the opioid epidemic and the threat of Zika.

I would like to thank our partner in today's event, the Commonwealth Fund and in particular, my partner and co-moderator today, Rachel Nuzum. Rachel is Vice President for the Health and State Health Policy Initiatives at the Commonwealth Fund. And I'm going to – before I turn the program over to Rachel, I'm going to go through just a little bit of housekeeping.

If you would like to tweet with us today, we are live tweeting with the hashtag #medicaid. Normally, we would have that up on our screen, but that is my second piece of housekeeping business, is that we love our technology until we don't. And today, at least for the moment, we are not loving it so much because we don't have it yet. We have every confidence that we are going to have it at any moment. So as our speakers go through their presentations, at least at the beginning, you will not see their presentations on the screen. However, in the packets that you picked up as you were coming in, on the right side, behind the agenda, you have a copy of every speaker's presentation. You also received – it wasn't in your folder, but you received it as a handout as you walked in, a presentation for Rachel. So you have all the presentations on paper and hopefully our technology will catch up to us shortly.

So we have three fabulous panelists with us today. Deborah Bachrach is a partner at Manatt Health Solutions. She has been a Medicaid Director in New York and has been an advisor to MACPAC, the Medicaid and CHIP payment and access commission.

Gretchen Hammer, to my left, is the Medicaid Director at the Colorado Department of Healthcare Policy and Financing, which administers both Medicaid and their CHIP program.

Ben Sommers, at the end, is an Assistant Professor of Health Policy and Economics at the Harvard T.H. Chan School of Public Health and Assistant Professor of Medicine at Brigham and Women's Hospital and Harvard Medical School. He is both an economist and a physician. So we have a great group to talk about Medicaid with us today and now I'm going to turn the program over to Rachel.

RACHEL NUZUM: Thank you so much, Marilyn, and this is going to be such a dynamic, exciting conversation, we don't need slides. So, just hang on and get ready for a great conversation. So I just want to add my thanks and on behalf of the Commonwealth Fund, to both the Alliance for partnering with this, in this really important topic, that really cuts across political divides at the Federal and the State level, but also to our panelists for agreeing to be here today and really talk about a program that is near and dear to many of our hearts. One of the things that

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we were really looking to do at the Commonwealth Fund, was really try to extend the conversation around Medicaid beyond what we have been hearing a lot about in the news for the last year, last two years. A lot of focus and often rightfully so, on whether states are expanding or not expanding Medicaid coverage, what types of constraints they are putting into those types of decisions and while that has been a really important conversation, it's also just a fraction of the conversation and the issues that really surround this program. So, we are really looking to bring some voices together to really talk about what we know about how the program has evolved, what we know about areas where the program is really leading and setting some innovative examples and we are also going to ask our panelists to also identify some challenges and opportunities and some places where you all could really use your policy levers and your expertise to really kind of help kind of move Medicaid into the next 50 years. So that is really the goal behind the work that the Fund has been doing.

The Fund did release a set of products today, related to Medicaid, focused on the value of Medicaid and if we were looking at the slide, which you can look at in the packet, the evidence that we have seen across multiple programs and across our work, really breaks down into four big buckets. We know that nationwide, as a national program, the benefits offered in Medicaid are pretty comprehensive and the financial protections are very strong. So, number one, really strong, comprehensive benefits and very strong financial protections for patients. We know that it provides a critical support for providers, especially those working in the safety nets, both resources that we see time and again, reinvested into infrastructure and to other payment and delivery system models that we will talk about a little bit today. We know that we have seen a lot of experimentation. We know that states are faced with this requirement that we don't necessarily share here in DC and that is to balance their budget, so there is both a fiscal pressure to do things in an innovative way, to both control costs and keep their populations healthy, and we know that a lot of innovative work around the payment and delivery models has been led at the state level with Medicaid at the center. And obviously a huge source of federal revenue going to the states and a huge expenditure from the feds going to the state. So those are kind of the four buckets that we are going to focus on today.

So as we mentioned, we do have data showing on the comprehensiveness of the benefits. We know that folks covered with Medicaid have higher rates of getting preventative care than those without coverage and we know that in large part, folks that are getting Medicaid coverage and have Medicaid coverage are pretty happy with their coverage. We are not seeing long waits and stories and things and it was one of the things that we were worried about under the ACA and Medicaid expansion. You have a huge influx of newly insured people; would the system really be able to bear those new folks on the system? And the work that our teams have done and the grantees in our survey results show that in fact, both the patients continue to be happy with it, but also that the safety net providers have not experienced large difficulties. You see, the para mix obviously changed with Medicaid expansion, but we have not seen providers reporting difficulties managing those populations overall.

The point that I made on the delivery system reform innovations, this is just one illustrative example, we will certainly talk about others today, but things like patient-centered medical homes, states have been at the forefront, you can see this chart here. This is all across the country

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in very different political situations facing the states and fiscal realities, but there is a lot that states can do and can only do when Medicaid is at the table in terms of many of the multi payer reforms that we will hear about this afternoon.

Then finally, we all know the old adage, to kind of go where the money is. It's the largest expenditure in terms of what states are spending money on and it's the largest source of federal revenue going to the states. So there is a really big opportunity to be talking about what states are doing in an innovative way to really deliver care and design the way we pay for and deliver care to really maximize the health and the investment that they are making. We also know that it means that it's probably pretty likely that regardless of election outcomes, that some entitlement reforms will be looked at or considered. So for that reason, we have put together the panel that we have today, to really walk through some of these issues and really engage in a conversation with you all. so we look forward to really dynamic conversation and please get your questions ready. We will also take questions from Twitter, so if there are folks that are interested in doing that, you can also tweet your questions to us in that way as well. So with that, I am going to turn it over to Deborah.

**DEBORAH BACHRACH:** Thank you, Rachel and thank you to the Alliance and the Commonwealth Fund for making this possible. I'm going to skip my first two slides, because I only have eight minutes and I want every second of them.

So, it's really – I'm building on what was already said: Medicaid is the single largest source of coverage today and under the Affordable Care Act, it becomes the lynchpin of our coverage continuum. So Medicaid, if we go back to the '60s, it starts as a Welfare program. It's small. In 1996, under Welfare Reform, it's delinked from cash assistance. In 2010, it's our coverage platform. Because we have this new coverage paradigm of which Medicaid is central, we are now able to build payment and delivery reform. I say this all the time when I go into states: Medicaid is the largest lever available to governors to drive payment and delivery reform and advance population health. And make no mistake about it and Gretchen will talk more, Medicaid directors get that and that is why, as Rachel pointed out, they really are the forefront driving payment and delivery reform. And an interesting factoid: In 2010, I was writing on Medicaid's payment and delivery policies and I put it into Google: Medicaid Payment Policy. And Google said: Do you mean, Medicare? Well, trust me, that is no longer the case.

**RACHEL NUZUM:** And not what you meant.

**DEBORAH BACHRACH:** And not what I meant, needless to say, I am a complete Medicaid groupie.

So this slide says, Medicaid is driving payment delivery reform, it's driving population health, and it's really the state's most powerful tool to address public health crisis. And I say this, I'm going to focus on one, the opioid crisis, but when I was working with my junior colleagues to put these slides together, I used the word "nimble". Medicaid is nimble. And she kept saying, I want to get "nimble" in the title. And I said, no, no, everyone in Washington will roll their eyes if I describe Medicaid as "nimble". But honestly, in the context of an emerging crisis, think how

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long you have been debating CARA, how much money should you put into Zika? And to address the opioid epidemic? States can move the Federal government partners with states to move when a public health crisis emerges or when a man-made or natural disaster occurs – 9/11, Hurricane Katrina, the floods in Baton Rouge, every one of these, Medicaid steps up and it steps up quickly. Lead poisoning, the Zika virus – read the documents coming out of CMS telling states what they can do and how they can use Medicaid.

So, let's go to the opioid crisis. You know this one; I'm not going to use time reading you the data. We have a crisis and it's affecting millions of people. What is interesting is, even before the Medicaid expansion, Medicaid was the single largest payer for mental health and substance abuse services in this country. That is pre-expansion. That is under a Medicaid law that made coverage of mental health and substance abuse services optional. And many states only provided substance abuse services to pregnant women, pre-expansion. And despite that, Medicaid was the largest payer for substance abuse services. With expansion, Medicaid's role is greatly enhanced and it's imperative to step up even more so. So why do I say that? Well, first of all, expansion is bringing on many, many more adults in many states. Remember, expansion just – in case there is anyone in this room that doesn't know what we are talking about, brings into coverage all childless adults with incomes up to \$16,500 a year. That means, any adult without a dependent child under the age of 18 at home. And it brings in a lot more parents. And we are finding in disproportionate numbers in that population, substance abuse disorders. So we are bringing into coverage, people, adults. We are finding some level of substance abuse problems and for the first time, Medicaid is obligated to cover both mental health and substance abuse services because unlike old Medicaid, when it was optional, now it's a mandatory benefit, just as it is in the exchange. So, Medicaid is stepping up. I'm going to make one comment: What is interesting is, in states that expanding, where we have not seen coverage before, for substance abuse, they are providing it for the new adults, but they are also providing it to their old eligible. So we are seeing the availability of substance abuse services going up dramatically.

So what can Medicaid do? Everything on this page, every bullet, every service, can be done under a state plan. No special federal approvals and states are moving to do this. Medication assisted treatment, expert health homes, new provision in the Affordable Care Act, which permits states to provide, authorizes states at their option, to provide a comprehensive intervention. A comprehensive health home with enhanced matching rates for two years. And lastly is the social support services. A lot of attention on social determinants of health. A lot of attention on non-clinical factors that influence health and health outcomes. Medicaid can cover some of those interventions in ways that no other payer has or will. So Medicaid, when we are talking about treating individuals with substance use disorders, is in a position to cover and pay for the added benefits that make recovery more possible.

Now, what Medicaid can't do as a routine matter, Medicaid can do through waivers. Again, here is where you see CMS saying to states, we recognize the crisis, we want to partner with you to make sure you have the tools you need to address this crisis. So earlier this year, it puts out guidance to states that said, we know Federal Medicaid law does not permit coverage of institutes of mental disease – IMDs. Inpatient and residential treatment centers for individuals with mental health and substance use disorders. But we are going to give you a waiver to cover

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those services if it's part of a comprehensive model. So we got two things: You are giving states that financial benefit and the dollars they need and they are linking it to improved and more comprehensive coverage models. I have so little time, or I would say lots more about how states are using waivers to reach out and address individuals with substance abuse. Hopefully you will read it carefully in my slides.

So my last slide, because my seconds are ticking away – what is remarkable that states are doing now – oh, before I get to this slide, what I didn't say and I really have to, is we know that individuals coming out of our jails and prisons are disproportionately afflicted with substance abuse problems. What is so compelling is the fact that now, individuals coming out of jails and prison in expansion states, are eligible for Medicaid. And states are really engaging, ensuring those individuals have coverage, are connected with care and what our hope is and what we are tracking, is that we are going to see reductions in recidivisms, in EDUs and improved health. And law enforcement and county executives and mayors and state Medicaid Directors are working together and I think it's a really exciting opportunity.

Which brings me to my last slide and its leveraging Medicaid's purchasing power. So, Medicaid is the largest payer in every state and state Medicaid directors are using that power, governors are using that power and they are saying, okay, we will increase payment rates to increase our substance abuse capacity. That is what Governor Christie did in New Jersey. Funding it with savings from expansion. Other states are saying, much as they did with patient centered medical homes, we are going to pay more when the substance abuse providers meet best practices. We are able to do that; Medicaid has those dollars. You know many states, most states, are delivering coverage and care through Medicaid managed care plans. States are using their contracts to require plans to contract with certain providers and they are dictating some of the payment methodologies, all with the goal of addressing the needs of high need populations.

And my last point here is: Some of the states, and I give you three here, Arizona, Florida, New York, have developed comprehensive Medicaid managed care plans, with added social supports and they target individuals with serious behavioral health problems. Not carving out mental health and substance abuse services, integrating physical health, integrating it with social supports. So bottom line, Medicaid is a powerful tool for states to step up and address a public health crisis and you are seeing it every day when it comes to the opioid crisis. Thank you.

MARILYN SERAFINI: Thank you. We will turn now to Gretchen.

GRETCHEN HAMMER: Terrific. Thank you for the opportunity to be with you and to share a little bit about our experience out west in Colorado. So thank you to the Alliance and to the Commonwealth Fund for bringing you this from the other side of the Mississippi. We are a large state in the west. The fifth largest land mass state in the nation. And so we face some unique challenges overall with our healthcare system. And Medicaid plays a critical role in ensuring that all Coloradans, no matter which community they live in, rural or urban, have access to needed services.

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A little bit about our population. The Medicaid population in Colorado has changed since we have expanded Medicaid. We did take that option as allowed under the Affordable Care Act, but we had been on a path toward expanding access to services for individuals with disabilities, for parents, for pregnant women, for children and for some individuals who are, as Deborah described, adults without dependent children, through some state-based legislation. So we had, to some extent, a stepping stone, if you will, to some of the further expansions that were allowed under the Affordable Care Act. As of today, our population is about 44% children, which means we have a significant and important role in making sure that children in Colorado who are low income and face what we continually call the social determinants of health, have the supports they need to navigate their childhood toward a path of success as adults. We do also serve adults. 42% of our population is adults. 7% are individuals with disabilities. We talk a lot about income eligible Medicaid enrollees. But Medicaid plays a critical role in ensuring services for individuals with disabilities that cannot get those services other places. The ability to get up, get out of bed every day. to have the support that they can have to live life in a community. This is another important role that Medicaid plays and Colorado has a very proud history of action in this part of the Medicaid program. And then Medicaid also plays an important role for low income adults over the age of 65. We know from our Department of Labor data, that approximately 74% of adults on Medicaid are working. The Colorado economy is a service based economy. We are not home to many large industrial entities that have comprehensive benefits. We are drivers, waiters and waitresses, childcare workers, cashiers – those are the kinds of jobs that make a wage that would enable someone to be still working and eligible for Medicaid. And as Deborah said, as a reminder, that is about \$16,000 a year for an individual and a family of four that lives with a family annual income of about \$32,000. So in that situation where the family resources are that tight, the ability to have comprehensive healthcare coverage can make a real difference.

We have, in our state, the second or third largest health foundation in the nation – the Colorado Health Foundation, and they did amazing economic impact study, looking at not only is Medicaid good for individuals and an important piece of the healthcare landscape, but it also plays a critical role in our overall economic picture in the state of Colorado. So I won't go through these slides, you can reach each of them, but this essentially shows the current and estimated impact on our state based gross domestic product in terms of economic activity that is generated through the expansion of Medicaid. The second relates to cumulative increase in employment. We know that when a community health center or a community mental health center, particularly in our rural communities, has the ability to bring on staff, that is staff that shops at the local store and buys shoes for their kids and backpacks for their children to go to school and contributes to that economic vitality of that community and can in fact, play a role in diversifying a rural community in Colorado whose only income may be a local mine or whose major industry may be a mine or other things that can be a little volatile in economic times.

Then we also know that the role of Medicaid has played an important role in annual household earnings. So, not only at the state level from a gross domestic product level, and from an employment perspective, but actual extra dollars in individual's pockets from the expansion of Medicaid. So it's an important thing to think about when we think about our healthcare system overall. We actually have an economic development strategy in the state of Colorado to promote

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our healthcare industry. You may know that Boulder, Colorado is in Colorado and it has a wellness industry that surrounds it, with tofu and yoga and those kinds of things. And that is a part of our administration's statewide economic strategy, is to promote Colorado to be the amazing place that it is and to promote those health and wellness as well as our core health institutions that can serve as centers of excellence. And so this economic impact here is specific to Medicaid, but Medicaid participates in the larger healthcare landscape.

Medicaid also, as I mentioned in my opening remarks, plays an important role in a community-wide impact. So I took this picture with my iPhone, I think that should be in a commercial, and I took this picture at my child's soccer practice last week. So I live in urban Denver. I live three miles from the capital and my son plays soccer 12 miles outside of the Denver metro area. And that is what the outside of Denver looks like. It becomes the eastern plains very, very quickly and so it is an important role that Medicaid plays, in particular as we look at the shifting, exchange based marketplaces and others, to have Medicaid as a stable source of coverage. The map on the right of the slide is the density of Medicaid enrollees across the state of Colorado. And as you can see, certainly concentrated in what we call the "front range" or the communities that line the I-25 corridor from Fort Collins to Colorado Springs, but also importantly, in all parts of the state of Colorado.

Medicaid also had an impact at the individual level. We have from our claims based data, that more than 73% of the individuals covered by Medicaid, have received their physical. We had nearly a doubling in flu shots and more than \$7,000 additional diabetes screenings, since we have expanded Medicaid. And I know, in the public policy time frame, there can be a long leap between diabetes screening and eventual budgetary savings. I certainly understand that. But from a human perspective, that leap is quite small. And that is that people who have identified diabetes can get treatment earlier and have a chance of managing their disease without the very important consequences that can come along with unmanaged hyper tension, diabetes, et cetera. So it's really an important piece. As I mentioned, we are also very proud of our rating of having the number of people who live out in community. We have a strong commitment to not having people in institutions if with the right services and supports. They can live in a community along with the rest of the community and participate in daily life along with their disability. So long term services and supports plays an important role. And then as mentioned, Colorado was a national leader in this concept of a primary care medical home. We identified it in statute and started paying differentially from it on a Medicaid program using our purchasing power. And it really has become the foundation for how we believe our healthcare system works best, which is an individual has a relationship with the provider so that when they are sick or injured or need health advice, they know where to go.

That is all that I will share, because I think there is lots of time for questions after Dr. Sommers.

**MARILYN SERAFINI:** Thank you, Gretchen. We are going to turn now to Harvard's Dr. Benjamin Sommers, but before he begins speaking, I just wanted to remind you that after his presentation, we are going to turn to your questions, so you can start getting your questions ready. If you would like to join the conversation on Twitter, I wanted to remind you that the hashtag is #medicaid. So please join us, we are having a live conversation on Twitter. You may

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also tweet your questions to us and they will be brought up here and we can present them to the speakers. You will also be able to ask your questions – you have a green card in your packet. You can write your question on the green card, our staff will come around and collect those from you and bring those up to us. We also have a couple of microphones in the audience where you can ask your questions. So, right now, we will turn to Dr. Sommers.

DR. BENJAMIN SOMMERS: Great, thank you so much. It's exciting to be on this panel and I think from the previous two speakers, Deborah and Gretchen, gave us a great sense of some of the issues that are going on in Medicaid innovation at the state level. And what I'm going to do is step back a little bit. I spend my time as a researcher and also as a primary care doctor. Wearing mostly my researcher hat, I want to just walk you through a little bit of what we know so far on Medicaid's effects under the Affordable Care Act. I will show you some national data and also some data from some innovative state approaches.

So the first thing, and this should be familiar to most people by now, is that Medicaid expansion has played a really hard role in the historic drop in the uninsured rate under the Affordable Care Act. We have new numbers out from the census this month showing the lowest rate of uninsured Americans in recorded history and Medicaid has played a big part in particular for some of the highest need members our communities, those people with low incomes. So this graph here shows what the uninsured rate was for low income adults before the Medicaid expansion kicked in and then after. And what you see is first off, these numbers are high. So look at baseline before the ACA expansions kicked in, back in 2012 and 2013. 40% and in some states, even higher, of low income adults had no coverage. So very high rates without access to health insurance and healthcare related to that. What we see is the blue line starts the January 2014 expansions and while there is a little bit of a drop in the uninsured rate in non-expansion states, which you may have heard about as something called the woodwork factor, the welcome mat. There were eligible people who were not yet enrolled in Medicaid that the ACA and a lot of media coverage and public outreach, streamlined application and other factors, led to enroll. But then a much bigger drop in the uninsured rate in these expansion states. And this is continued over the last two and a half years as more states have expanded and people have more opportunity to sign up. It takes time for these expansions to hit their full effect.

Okay, but we are not just interested in giving people an insurance card. So what we want to look at in the next couple of slides, I want to show you some of the data from studies by others and our research team in Harvard on what the impacts have been, both on some of the elements of the healthcare safety net, as well as the people getting coverage. So this is a study from Health Affairs earlier this year and this is looking at hospital level funding and looking at basically, what share of people discharged from the hospital have each type of insurance? And what you see in the solid lines are Medicaid expansion states and in the dash lines are the non-expansion states. And again, you look at the beginning of 2014 and you see the curves start to shift. We see a big increase in the share of patients who are going to the hospital who have Medicare coverage and a big drop in uninsured patients. The patients that hospitals typically can't get all of their costs reimbursed and ended up with bad debt, uncompensated care. And not surprisingly, in the states that expand Medicaid, we see a big drop in uncompensated care, where the hospitals in non-expansion states don't have that benefit.

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So that is what's happening for hospitals. What about for the people getting coverage? So the next couple slides are going to be some evidence from a study funded by the Commonwealth Fund that we have been conducting for the past three years in three states and we looked at Kentucky, Arkansas and Texas. And the reason to study these three states – well, there are a couple of factors. First is that they are taking very different approaches to the Medicaid expansion or the Affordable Care Act. Kentucky is doing a traditional Medicaid expansion, did not file a waiver and essentially provided most of the low income people who enrolled, with Medicaid managed care. In Arkansas, as many of you might know, they pursued the innovative private option where they took the federal funds under the ACA and got permission to enroll those individuals in marketplace plans. So, private insurance, instead of Medicaid, for the lower income adults in their state. In Texas, they chose not to expand under either form, meaning that most low income adults in that state are not eligible for coverage. If you are a parent, your income typically has to be in the range of about 20 to 24% of Federal poverty to qualify for Medicaid in Texas, so if your income is \$6,000 or \$7,000, that is too wealthy. And if you are a childless adult, without a dependent child in the home, essentially it doesn't matter how poor you are, you would not be eligible in Texas and other non-expansion states.

So what we see here is, after two years of expansion in Arkansas and Kentucky, what changed, compared to Texas, where they hadn't expanded? The story would look similar if we looked at most other non-expansion states. I forgot to mention, the other reason to look at these three states is not just that they are doing something different in terms of the ACA, but we also know that if you go back to pre-ACA data, that they had really high uninsured rates. They had high rates of lack of access to care, affordability barriers and higher poverty rates. So these are some of the states that have potentially the most to gain from expanding coverage and that is going to play out over the slides I show you now. So, in those two years of coverage expansion, we see a 12%-point increase in the expansion states of the number of people who report having a personal physician. We want people to get primary care. I don't say that just because I'm a primary care doctor, we think that is how people get plugged into the system and get the kinds of care that we think is most advantageous, most beneficial for their health. We see a big drop in the number of people who put off the care they need because they can't afford it – and 18% drop. Prescription drugs – a mainstay of keeping people with chronic conditions in good health. We see that they are less likely to skip their medications. We know from previous research that large numbers of people who are supposed to be on daily medications for things like diabetes, high blood pressure, heart disease, don't take them as they are supposed to, because of affordability barriers. And we see a big drop in our two expansion states, after the ACA kicked in. We see a reduction in people who say they can't pay their medical bills. This ties back into what the hospitals and other safety net providers like community health centers are seeing, that their patients can now pay for their care, which helps both the patients and the healthcare providers. Then we see an increase in prevention. So Gretchen showed some numbers from Colorado and this among the full low income adult population in these states, we see that Medicaid expansion or the private option, both led to big increases in checkups in the past year.

Let's drill down a little bit more. You want to know, are we getting good value for this money? What kinds of care are people getting? So this is a paper we published a month ago in the

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*Journal of the American Medical Association's Internal Medicine* and what we found was that by 2015, we saw a shift away from the emergency department. So we see a drop in the number of low income adults in our expansion states that said that they had visited the ED in the last year. Six percentage point drop. And we saw fewer people who said that the ED was where they got their regular care. If you ask a patient, where do you go when you need medical care? In these two expansion states, we saw fewer people saying, I go to the Emergency Department. Why? They had an increase in the number of office visits and I already told you an increase in the number of preventative visits and having primary care. Then we also see that they are getting more preventative service. So we see people getting a glucose check in the past year. Someone who doesn't have diabetes – or doesn't know they have diabetes, this is a key way to figure out if they are healthy and whether they need to be treated for diabetes. And then among those who already know they have diabetes, monitoring glucose levels is a key way to prevent complications like vision loss, renal failure, heart disease and other factors that can significantly harm people's quality of life and increase healthcare costs. And we find that people with diabetes in our study also were more likely to have glucose screening after Medicaid expansion. Finally, if people had one of any of the nine conditions that we assessed in the study – so we asked about diabetes, depression, emphysema and lung disease, asthma and other factors and we found that in that group of people that said they had one of those conditions, we saw a big jump in the share that said they were getting regular care for those conditions. So overall we are seeing more office based care, more preventative care and better management of chronic diseases, which is key to improving quality of care. And we are seeing less reliance on the Emergency Department, which is an important way to improve care and potentially reduce costs in that setting.

And finally, we asked people both about the quality of the care they were getting as well their overall health status and this table got cut off, it only shows the self-reported health status, but what you see is that after expansion, low income adults in these two states reported a relative improvement in their health status compared to the low income adults in the non-expansion state. This wasn't evident in the first year. It's not until the second year of coverage expansion that this started to show up. We also asked people to rate the overall quality of their healthcare and we found that expansion again was associated with an increase share of people saying, I get good care. My healthcare quality is good or excellent. And one of the really interesting findings here is not just these benefits across the board and that they take a little bit of time to develop, they don't all show up in the first year, some of it comes out later on as people get used to having their coverage. But we also compared Kentucky and Arkansas. We said, alright, coverage expansion clearly has a lot of benefits, but what about using public insurance versus private insurance. We know a lot of states are still considering this and there are a lot of policy makers that are quite interested in this question. What we found, for the 30 outcomes that we looked at, that for almost all of them, it actually didn't matter. What mattered was getting coverage. Getting Medicaid or getting private insurance both produced these significant gains in access, affordability, preventative care, quality of care and self-reported health. And what mattered was, did you get coverage, did your state expand? And if they did it via public or private insurance, that was less important. So both of these approaches seems to be really viable ways to improve healthcare and health for low income Americans.

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So the last slide I'm going to show you is, let's think long term. Well, we are still only in year two, or halfway through year three of the Medicaid expansion or the ACA. But I know that one of the things that many people want to know, is what will happen over the long term with health insurance expansion? We don't have enough data yet on the ACA to have firm conclusions on that, but I want to show you some work that we did from previous expansions in Medicaid, back in the early 2000's, where we do have long term follow up. So in a study that we looked at, of several states that did ACA-like expansions on their own, back in 2001-2002, including Deborah's in New York, what we are seeing is that in the years after expansion, the mortality rate started to go down and in particular, if you can read the small print on this slide, or you can look at the article in reference here, the type of mortality that was most effected were people with healthcare related causes of death. Sorry, healthcare amenable causes of death. So in healthcare there are some things we probably have a lot of influence over – how well do we manage someone's blood pressure and diabetes? How well do we manage their heart disease? Do we treat their infections promptly? Do we get them screened and treated if they have cancer, earlier on in stages? And what we found was that those causes of death were declining. Meanwhile, things that are harder to affect with healthcare like homicide rates, like car crashes, we didn't find much happening there. So this really points to healthcare via health insurance as a potential way to improve population health and I think some of the examples you heard from Gretchen and Deborah point to the ways that Medicaid can be quite flexible in tackling public health crisis and some of this data that we are showing from the earlier part of the last 15 years, points to the possibility that the ACA expansion could also save lives over the long term.

So I am going to wrap up there. I'm eager to hear your comments and questions and to have a discussion with the other members of the panel.

MARILYN SERAFINI: Fantastic, thank you so much, Ben. Thank you to all of our panelists for the very informative presentations. So you may ask, where are these microphones of which you speak? And the answer is, I have no idea. In the Alliance's 25-year history, they are not standing there, so we do have a microphone, it is in the back of the room with Katie Rubinger, one of our staff, so if you have a question, please work your way back to Katie. She is standing by the back doors and she will hand you the microphone and you may ask your question. The other way to ask a question is to write in on the green card and other members of our staff will come around and collect your question on the green cards and of course you can ask questions via Twitter, hashtag #medicaid. So, to start us off while you are all getting your questions ready, I will ask the panel the first question. A couple of our panelists talked about social determinants of health and Medicaid's ability to address social determinants of health and I was hoping that our panelists could be more specific about exactly how Medicaid is addressing social determinants of health. In what capacity? How specific can we get here?

DEBORAH BACHRACH: So I will start and then I think Gretchen should follow because she is doing some of this right now in Colorado. I think there are two ways that Medicaid – or three at least, that can address. The first is, there are a number of optional benefits that states may include in their Medicaid plan. So, the state has to decide it's worth it and then it can provide the service. Now, the first one would be case management, or targeted case management or – just a

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form of care coordination. That can be done at the state's option. Employment supports, housing supports – Medicaid cannot pay for housing, but Medicaid can pay for the supports required to keep vulnerable populations in housing, keeping them, making sure the rent is paid. Not paying the rent, making sure it's paid. How to be a good tenant. Dealing with behavioral issues. Nutrition under certain circumstances. So there is a range of social interventions that Medicaid can cover at the option of the state Medicaid agency. Then, remember, Medicaid is primarily delivered through Medicaid managed care plans, which receive a capitated payment – a fixed amount every month for every enrollee. Medicaid managed care plans can use those dollars to support social interventions, where they determine that there is an ROI. Where it makes sense in terms of improving the health and reducing the cost and they have almost complete flexibility in terms of what they can do. And then a third set can be covered under waivers. So there is multiple ways that Medicaid can step up and the issue always is, and this is something that I know the Commonwealth Fund has spent a lot of time at, which populations, which interventions, which models, produce the health outcomes and the savings to justify the investment. So, Gretchen, talk a little bit about what is going on in Colorado, where I know you are looking at this.

GRETCHEN HAMMER: Sure. So I think that yes, we have investments in primary case management or case management services and we use an accountable care collaborative model, which isn't a full managed care model in terms of the capitation of the payment, but they also do receive a per member, per month amount of money that allows them to put care coordinators in place. So, there are these sort of approaches to helping people navigate toward the services. But, I guess I would leave you with something a little more direct: One of the major social determinants of health is educational attainment. Kids who can't focus on school because their teeth hurt, don't do very well in school. Adolescents who are struggling with severe and persistent mental illness or even just trying to navigate the tumultuous times of adolescents, do better when they have a health care home to go talk to someone or supports through a school-based health center. So in very direct ways, the Medicaid program plays a role in making sure kids can stay in school and stay focused on education. Parents can get back to work, because they have appropriate oral health services to allow them to compete successfully for jobs in the workplace. So there are these conceptual ways, that I think are really important, but at the same time, just as we see a reduction in mortality because of the availability of true health services, we believe we see an increase in the ability for someone to navigate or to move through and minimize the impact of the social determinants of health through Medicaid services.

MARILYN SERAFINI: Thank you. We are going to turn to the back of the room for a question, but I do want to mention, before we do, we hope you don't leave us till the end, but if you have to, please take a moment to fill out the blue evaluation form. It really helps us to help you.

AUDIENCE MEMBER: Good afternoon, I am Ryan Mandershite from the County Behavior Health Directors. I have two issues, one for Deborah and one for the panel. The issue for Deborah is on the institution for mental disease. The recent Medicaid managed care regulations relieve that problem somewhat for mental health. The 1115 waivers have done that for substance abuse, but I'm not aware that there is a single 1115 waiver that does that for mental health in non-managed care states. So, I would appreciate a comment on that. The second issue, there is a

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huge number of people with mental illness and substance use going into the country jails every night, probably 75% of the population. We still have serious problems with the issue of suspension versus termination of Medicaid. I believe currently 16 states suspend and 19 states terminate. We have been trying to work with the states so they convert from termination to suspension. There is also a bill over in the house that would do that. I would appreciate comment on that as well. Thank you.

DEBORAH BACHRACH: So let me start with your second question and then again, others may want to jump in. The issue that the gentleman raises is, when individuals go into jails, it's generally for short term incarceration. Longer term are the prisons. But in either case, they come in with Medicaid – what can a state do to ensure they go out with Medicaid? So, some states are doing suspension, other states are doing something which actually turns out to be somewhat easier, is they are blocking the billing. But in either case, it ensures that the individual who went in with Medicaid, comes out with Medicaid, which is critically important for this vulnerable population. The third piece is that states are now – and we are seeing this in cooperation with local governments, making sure that whether an individual came in or out with Medicaid. When they leave, they have Medicaid, because as I said, in almost every instance, they are Medicaid eligible. And I do think the expansion has triggered substantially more interest in this and you are seeing states stepping up and doing exactly what you suggest, for very good reason. Individuals need coverage and they need the care. In terms of the IMD exclusion, again, there are two ways to approach it. One is through waivers and the other is through Medicaid managed care, where the new regulations permit coverage for up to 15 days. I can't point to, off the top of my head, specific waivers, but again, it's part of a – what I think is a productive partnership between the Federal and state government to address the issues that are emerging on the ground and figure out ways – I mean, we didn't see any dent in the IMD exclusion until quite recently. Crisis emerges, we figured out a way to make Medicaid work. Perfectly? Nah, but it's moving us in the right direction. I'm going to stop.

GRETCHEN HAMMER: So we agree that this is a critical area of work and we just actually completed a sort of state-wide conversation about this. We are a state that is moving toward the suspension function with a new system that is coming online in the next month. I think that is one thing you should know, is our current Medicaid claims payment system is a DOS based system and so we are moving into the 21<sup>st</sup> century on October 31<sup>st</sup>, to become a Cloud based system, but that has really been some of the struggle, is that the systems have been too clunky to move in order to fulfill that, but we certainly have had the commitment and have a lot of pilots going. The only thing that is really complicated about this issue is criminal justice involved populations is, there is the county jail system, which again, in a big, rural state, is unique in each jurisdiction. There are the different judicial districts and then there is the state prison system. So again, it is not an easy partnership to build. Most importantly though and I think we agree and have actually contractual obligations for our behavioral health organizations to work with individuals as they are being released, to get them reconnected to coverage. But we really are starting to have a conversation about diversion. That we have a sheriff who shared a story with us at this summit that said, if I had someone in cardiac arrest, in my jail cell, I would be obligated to take them to the hospital and the hospital would be obligated to treat them. If I have someone in mental health crisis in my jail, I can take them to our hospital and while I am sitting

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in the parking lot, completing the paperwork, that individual will walk right past my squad car. So we do not have a systematic way to help people who are having a mental health crisis that is on par with perhaps a physical health crisis, get appropriate services so that they are not moved through the criminal justice system inappropriately. So there is an important conversation about reconnection to benefits, but I think more importantly it's our obligation to talk about, how is it that we are treating individuals with a physical ailment, whether it be in the physical health space or the mental health space, differently in our criminal justice system, in ways that is really creating very challenging circumstances for everyone to deal with

RACHEL NUZUM: We have had some good examples, I think – Deborah talked about Medicaid's role in providing social and support services and Gretchen has certainly reinforced that point. We talked about the flexibility, especially in public health crisis. We have got several questions that kind of acknowledge the fact that for many people, this idea of Medicaid as leading in either innovative ways of delivering care or innovative coverage mechanisms is still a little bit foreign. So, I would like to ask each panelist, give us your favorite example. One example. We know it's like picking between children, but one example of somewhere where Medicaid is leading on the delivery system reform space – how they are delivering care, how they are paying for care, or an innovative way that they are doing some coverage linkages that you have seen. Do you want to start, Dr. Summers?

DR. BENJAMIN SOMMERS: Sure. I talked about it a little bit earlier and we have been focusing on it in our work. I think that there is a debate that rages about whether – first off, how much coverage does for people and then also, whether Medicaid is quote, “good coverage” and does Medicaid help people? And the reality in the research world is that we actually have very little data on how good private coverage is for people, and yet, I don't see most of us volunteering to drop our private coverage. So, what I think experimentation like the private option in Arkansas and some of the other waiver programs we have seen go through under the Medicaid expansion, really gives us a chance to assess the impacts of different types of coverage on healthcare use, on costs, on quality and outcomes. And so, I think I would count all of the states that have put through substantive waiver proposals to expand coverage, as doing a service not only that they are potentially finding ways to deliver coverage to their populations that can benefit them, but in giving us a good way to evaluate what works and what doesn't work and that sort of healthy experimentation, I think is really key to improving healthcare and we are seeing that from Indiana and Michigan to Arkansas and some of those states that are still considering different proposals now.

GRETCHEN HAMMER: I guess I will put the concept of “leading” a little bit context. I think we feel an obligation to lead for two reasons. One, we feel we have an important duty to those that we serve. We play a role, as I have mentioned a couple times, in providing health coverage for low income and disabled adults and disabled children as well. For those children with disabilities and adults with disabilities, there is no other source of coverage for many of them. We have a series of wavers, we have 11. We have waivers for children with life limited illnesses that give their parents and them additional services that they would not be able to receive. Children with autism – so there is really an important role that we play and that is part of the reason we feel obligated to lead, is because we have complex people who depend on us to get it

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right. The second reason we feel an obligation to lead is because we have an impact on our state budget and both our governor and members of our general assembly keep looking to us to say, what can you do to help contain the costs of the Medicaid program. Not compromise people's care, but at least begin to contain cost. and we do that in a context of an ever growing healthcare system costs. So all of our hospitals, we have this great thing in Colorado called "free standing Emergency Departments", so they are Emergency Departments that are being built by our hospital systems, fully within their regulatory ability to do so, that charge Emergency Room rates, but are available outside of their connected hospital system. Those are driving costs up in our state and I think there are some open questions about whether or not those are appropriate sources to get care. So those are the – that is the context in which we operate on. So we feel an obligation to lead in part because of the need to also contain costs. So some of the ways that we are doing that, we are trying to make sure we pay for things in the least restrictive setting. We changed some payment rates between what are called Ambulatory Surgical Centers and hospitals, trying to see if we could drive Medicaid enrollees and providers to use those Ambulatory Surgical Centers, which we are confident are equally as safe and effective. So those are the ways in which we are using our payment. We pay similarly for a vaginal delivery and an uncomplicated – or a C-section and an uncomplicated vaginal delivery. We do those so that we can try and make sure that women are treated and have the best option without a financial incentive, in place for the providers to do different things. So those are the ways in which we are trying to lead as a purchaser of health services, but also as a core safety net for individuals who need it.

DEBORAH BACHRACH: I want to reinforce what Gretchen said. I'm sitting here debating which example to give and I think that the point that she made is that we deal with the most vulnerable population, so we deal with the people in crisis, the homeless – people who are homeless. Those are our people. Individuals coming out of jails and prisons. Those are our people and our responsibility. So it's incumbent on us – I haven't been a Medicaid director in five years, but it's still – I still think of it as "us". But it's incumbent on Medicaid to think about, how do we cover – how do we use social interventions? So it's the debate now, right? 40% of health outcomes are determined by non-clinical factors. What do we do with that? Well, it's our enrollees who are most effected by non-clinical factors, so we are out front thinking about what can we cover, how should we cover it, when should we cover it? So I really reinforce what Gretchen said, it's about the population Medicaid serves that pushes us out front. Let me give now a much drier example, which is, state Medicaid agencies have been testing Medicaid managed care since the late '90s and states have been putting into their Medicaid managed care contracts, metrics. Quality metrics. They have been putting network adequacy standards into their contracts. Isn't that exactly what we are building on in terms of our certification requirements for qualified health plans? So I would say, look at all Medicaid has done in terms of its contracts with Medicaid managed care plans and I think we are starting to borrow them and I would suggest we should be aligning them across our Medicaid managed care contracts and our QHP certification. And I do think Medicaid has been out front and done a lot of learning in the last 20 odd years.

MARILYN SERAFINI: Question in the back?

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AUDIENCE MEMBER: I'm Dr. Caroline Poplin, I am a primary care physician and my question builds on what you have been talking about. The first lady had a slide that led up to population health. That is a term you hear all the time now in health policy circles and it sounds like people are sort of using the healthcare system to achieve population health at a high responsibility for population health is being built into the healthcare system. Where as we know, that medical care is only a very small part of the social determinants of health and I was wondering, when you said "population health", what you were thinking of.

DEBORAH BACHRACH: I share your frustration with the term "population health" because I always say, which population are we talked about? Is it the community or the population that is enrolled in my health plan or in my service area? So I share your frustration with the term, despite using it. But I think that when it's used – and the reason we bring the discussion of population health or more particularly, those non- clinical factors, into our Medicaid discussion, is because we are a nation that under invests in our social safety net, if you will, and social services. And we put far more money there than most developed nations and far less in socials and far more in healthcare. So we look at healthcare and we look at Medicaid as the potential funding source for the non-clinical interventions, because the funds don't exist elsewhere and I think that is why it is a Medicaid issue and that is why it has become a healthcare issue, because its where the dollars are and the facts drive us to look for a solution and we go where the money is.

RACHEL NUZUM: So we have got lots of questions, we have tried to group them and get at all of the issues that you all have raised. Lots of news lately around pharmaceutical drug pricing. About the spikes and the access to them and still the need to kind of keep things innovating and moving forward. So, would love to hear your thoughts on both the impact that some of these trends are having on Medicaid programs – are there innovative things that Medicaid programs are doing to try to get a handle on this and both ensure access and affordability to patients, then if you have seen any of this manifesting in the data that you have done. Thoughts about the role of Medicaid and the pharmaceutical drug pricing issue?

DR. BENJAMIN SOMMERS: Let me talk about the broader question of the role of prescription drugs in healthcare and Medicaid and then maybe in the terms of the specific approaches states are taking in dealing with prices, I will defer to other members of the panel. So, we do know that when you look at where patients are price sensitive and where their behavior has changed by their ability to pay for their care, that filling prescriptions and taking the amounts prescribed and not skipping doses, is clearly one of them. There is evidence from Medicare Part D creation and other studies that prescription drugs actually help offset other types of healthcare. That if you get people to stay on the prescription drugs that they are supposed to be on, it does actually reduce some of their other spending, hospitalizations and the like. So sometimes in Medicaid, going back 15-20 years, we have seen experiments that were intended to try to control prescription drug cost, but had the unintended effect of driving up total spending. So there are studies from the '90s where there were caps on the number of prescriptions that people on Medicaid could fill and what happened was, we saw that among low income elderly beneficiaries who are medically frail, their rates of nursing home admissions went up because they couldn't stay on the medications they needed to stay in good health. So we have to be careful about carving out

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specific solutions that just look at one segment of healthcare such as prescription drugs, and not look at what they are doing overall. But that said, there are some real pressures that are unique to Medicaid, in part because of the clinical and demographic features of patients in Medicaid. So for instance, Hepatitis C, is one of the obvious examples where there are some pressures that are just much high rates of patients who would need those high cost drugs that are quite effective and while there are some programs in place to help Medicaid to get a more advantageous pricing, we have seen that this has been, in some places, a real crisis of affordability and I will leave it at that and see if the other panelists want to comment on that.

**GRETCHEN HAMMER:** I think we would reflect that yes, prescription drug prices are going up and yes, it is impacting our state budget. So it is something that we are wrestling with as well. There are a few levers, but perhaps not all the levers that we could use to manage that. So, it's an area that is, like frankly some of the other things – hospital administrative costs, other costs within the healthcare system, that we have, we believe, some ability to impact. But not a complete ability without first of all, a multi-payer approach. So all payers in the system. So as not to create unintended consequences. Also, a federal and state regulatory infrastructure that allows for options for states.

**DEBORAH BACHRACH:** I will just briefly add to the conundrum that has been discussed by the first two, Ben and Gretchen. Federal law, 1927, requires that Medicaid, if you cover drugs and all states do, that beneficiaries have access to medically necessary prescriptions. And price is not supposed to be a factor. As Gretchen said, the reality is, the budget. So how do we assure that the Medicaid beneficiaries have access to which they are legally entitled and clinically need, consistent with the state budget? This is the conundrum that we face and I'm going to stop, because I don't have a good answer.

**MARILYN SERAFINI:** Let's go to the back of the room for another question?

**AUDIENCE MEMBER:** Thanks, I'm Sean Griminger with America's Essential Hospitals, we represent large urban safety net hospitals around the country including Denver Health, Boston Medical Center among them. I have a quick comment and then a question. First of all, I just want to say thank you to Dr. Sommers for your excellent research and in particular the findings that the variation in the type of coverage between traditional expansion and a non-traditional expansion state, is slight. I think it's helpful because it helps to debunk some of the thoughts on both sides of the aisle. I remember when Arkansas was first negotiating the waiver, I heard concerns from a lot of my liberal friends saying, no, CMS shouldn't do this, we need to push harder to push for a standard Medicaid expansion. And we found that that might not have been necessary. And then a lot of my friends on the right have long claimed that Medicaid coverage is inherently inferior to private insurance and I think that your study helps to show that that's not the case. On an unrelated point and my question, very much appreciated the health affairs article, which was in today's packet, which comes to a policy recommendation as much as health affairs ever does, that Congress should consider delaying Medicaid DSH cuts. As you all know, Medicaid DSH have been delayed for four consecutive years due to the infinite wisdom of Congress. The conclusion of the health affairs article is that it is still probably not time to be making substantial cuts to Medicaid DSH. I would be interested in hearing your thoughts and

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particularly from Ms. Hammer as to what the impact might be in a place like Colorado, which has had a very successful Medicaid expansion, but continues to see high levels of uncompensated care in many hospitals.

GRETCHEN HAMMER: I can speak in general terms. I am one of six Deputy Executive Directors at my department and I have a chief financial officer who could answer your questions a lot better than I could. So I can speak to some extent. I think you are right, we are still seeing a settling out, if you will, of the coverage landscape as we have gone through expansion and we will, I think, continue to see changes as the health system goes through these years of hopefully improved costs and value. The piece that is important for all of us to remember is that health insurance coverage is not a steady state. It is not static. For many individuals, it is. You join a company, benefits are available to you, you work in that company for three to five years, perhaps longer, you move to another company that provides health insurance. For individuals who live at the income levels that Medicaid covers, it is a much more tumultuous time of coverage. There may be coverage available through a seasonal and part time job, if you work in the ski industry in Colorado, as an example. If you work someplace else. So this notion of, there are times in people's lives when they are covered and have the full array of benefits, and there are times in people's lives when they face a period of uninsurance. It's still a reality and so I think there is still some recognition both for our federally qualified health centers and other safety net providers, as well our hospitals that, until we better understand those patterns of coverage, at least in our states, which do move seasonally because of some of the economies in our communities, there is an important piece to think through before we start making changes to some underlying payment mechanisms.

MARILYN SERAFINI: Do we have a question back there?

AUDIENCE MEMBER: I'm with the National Association of State Mental Health Directors. Deborah, you said that one of the ways we have been able to get states to cover various services is by mandating that the managed care plans cover that within the contract. The IMD managed care regulations prohibit a state from mandating that a plan or a provider provide IMD services. So I'm wondering how that has impacted that and Gretchen, I would like to hear your thoughts too, on how successful states have been in negotiating with plans to cover IMD services I guess, beginning in January.

DEBORAH BACHRACH: First of all, I don't think states negotiate with plans. States enter into contracts, they are the state and the plan once the contract – these are our terms. I agree with you that the way the managed care regulations are drafted, the states can authorize the plan to provide IMD services, but not require the plan to do so. I have not – so this a new provision in how plans are using it. We will have to see. But if a plan has an individual who requires in-patient or residential care, that is otherwise covered by the plan contract and they are authorized to use an IMD, which would be an in-patient psych hospital, an in-patient substance abuse hospital, a residential treatment – that is service that they are entitled to. What the site of the service is, will be a choice the plan will make, the physician will make and now we have more choices and more sites. So I see this only as a positive and I'm not seeing any resistance by plans to use alternative

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residential or in-patient facilities, so long as the state in the contract, as it must, authorizes them to do so.

GRETCHEN HAMMER: And I will just be brief, because I think we have another series of questions. So we don't have capitated physical health services in Colorado, only on our behavioral health side. So this is a piece that we have been working through. We use a 1915 waiver to allow us to operate our behavioral health plan, so they are technically PIPs, not MCOs, so we are still working through some of the details with them as we sort through the new regulation to come into compliance with that, but it is a slightly more complicated picture in Colorado.

RACHEL NUZUM: We have a series of questions talking about and wanting to know about work force and what incentives states are either successfully or not successful employing to incentivize providers to participate. Some of the headlines that we hear that is just harder and harder to find Medicaid providers real and we know from our own Commonwealth Fund, survey and work, that it obviously depends on where you are. It depends on how your Medicaid program is structured and it depends on what region, potentially, even of the state that you are living in. Would appreciate thoughts on steps that states are taking and are there innovative things that are happening or that even folks here on the federal side could be thinking about in order to support states, really be able to ensure that there is someone on the receiving end when you do get folks Medicaid coverage.

DR. BENJAMIN SOMMERS: Let me start with a broader lens and also wearing my economist hat here. We have to think about where the offsets come from or the funding comes from to pay for coverage expansion, right? And this relates to the question about DSH cuts as well. In a world of unlimited funds, we never cut DSH, we would pay providers in Medicaid huge amounts of money and we would expand coverage, but obviously that is not practical and so the question becomes, where are the tradeoffs? Here, I think the evidence is helpful. We saw that Medicaid expansion does cut hospital uncompensated care costs, so in the overall levels, that becomes a reasonable way to try to fund some of the coverage expansion. The challenge is that it's not – every hospital doesn't see the average effect. And so, what becomes really important is, well, how do states target their DSH money? Do the hospitals that still have high numbers of uninsured patients, because they have low participation rates in Medicaid or more immigrants who are ineligible, or other factors, trying to figure out ways to make sure that states are spending the DSH money where it most needs to be spent. Similarly, when we think about providers, when I sit in front of medical crowds, which I do sometimes, the expectation is that we should all be saying, Medicaid needs to pay doctors a whole lot more. And I would say the conversation is a lot more complicated than that. In our own data, we actually looked within our state – in those three states we studied – and we compared people who lived in counties that are shortage areas versus non-shortage areas. Primary care shortage areas and non. One of the really interesting findings was that expanding coverage actually produced big benefits to beneficiaries even in shortage areas. And so sometimes you hear the notion, it doesn't make sense to expand coverage because we have problems with provider capacity. Our study says, even in relatively poor states, in poor counties, with shortages, it turns out that giving people insurance is much better than leaving them uninsured. So it's not an either/or and also we have to kind of think how

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we spend our money most effectively. Our goal should not be that 100% of providers take Medicaid. When you look nationally at studies, 100% of providers don't take Medicare and don't take private insurance. None of us can see any doctor we want, anywhere in the community, with our insurance – or very few people can. Whether you have high quality private insurance or otherwise. So I think we have to weigh the tradeoffs of paying providers more and focus on where are the real barriers and actually, some of the nice work that has come out of MACPAC has shown that it is actually specialty care, where Medicaid beneficiaries are more likely to experience differential barriers and that primary care access is reasonably good in Medicaid. For children it is even better, but specialty care, especially for adults, tends to be a problem area. So if I were trying to pick where I'm going to spend those scarcest resources to improve participation, I would look at specialty care and I would also look at some of the non-financial factors, because it's also the DOS based payment systems. It is recertification processes that make it difficult for providers. These are things that can be done that don't necessarily cost as much money, but do take some upfront investment. So, just as the voice of saying, it's not always more money is the answer, when you don't have that money. We can still do a lot of good in Medicaid, but think about how to spend money for providers in a more effective way that benefits beneficiaries.

DEBORAH BACHRACH: I have to jump in. I agree with everything that Ben said. First of all, the non-financial factors. When I ran New York Medicaid, one of the factors that discouraged providers from enrolling in Medicaid, from taking Medicaid, is we made them produce their lease for their space, to make sure there wasn't any fraud going on in their lease. I mean, we made it so damn hard for providers to enroll and we assumed they were going to defraud us. Once we made it normal, we got more providers to enroll. So it is partly non-financial factors. I want to say something about the DSH cuts, which sort of follows on Ben's point, because we are cutting DSH, we are not eliminating DSH. So again, targeting becomes absolutely critical. When DSH cuts go into effect, assuming they do, what that cuts is the federal share of DSH. The state share is still there and that becomes a question, what does the state do with it? What I keep saying to states is if you take that state share and you use it in expansion, you are going to get a 90% match or 95% match for it. When you use it in DSH, you get a regular match. So here is another way to think about how we use our money and now if we use it for expansion adults, we use, it, let's take it for increasing rates of substance abuse services – increasing rates of payment for substance abuse services. We bring in more substance abuse providers, that same dollar has gone much further and it's our safety net hospitals that are really the mainstay in many cases of the substance abuse system. So I think we have to be smarter about how we use our dollars. Finally, I'm fortunate to do a lot of work in Arkansas and one of the things that is going on in Arkansas in the early evaluation, is we are finding better access to care in the so-called private option. Not so much because there are more providers enrolled with the QHP's, but because the Medicaid beneficiaries enrolled in QHPs are getting better access to the same providers, because they come with a slightly higher rate of reimbursement than they would come if they were in regular Medicaid. So again, there are lots of ways to think about how to use the money to assure access and as Bens says, the bottom line is, even in shortage areas, it's better to have coverage than not.

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RACHEL NUZUM: We talked about different innovations – behavior health, substance abuse, I was particularly struck by your comment, Deborah, about folks being released from prisons or from jails and the impact that you see in ERUs and linked to other sources of care. In many situations, the linkages are not that clear and it takes much longer to see the impact. As we are starting, as we are assessing the innovations that we are seeing across the country, they come in all different shapes and sizes, they have different names, how do we distinguish? How do you distinguish between promising and successful innovations? When do we say, we tried this, it was great, good-bye, your time is over and what is a reasonable time frame for expecting to start to see some sort of savings for health change?

DEBORAH BACHRACH: So I will just say, we have seen this economic savings already. I mean, I don't mean from improved healthcare, I'm talking about on the state budget. So the first thing that we have been able to access – then I will turn it over to Ben, because he started to move us into some of the access and clinical issues. But we can see savings in state budgets, savings because Medicaid dollars can pay for the in-patient care of prisons. Savings because every state has state-only dollars funding mental health and substance abuse services. Medicaid comes in and those same individuals are now ensured and Medicaid is paying for that coverage. We are seeing the savings in multiple buckets of care, where Medicaid dollars are coming in. So I could go on and on, but Medicaid is producing savings in states that have expanded and that can already be documented. That is the easiest to document. I want Ben to pick up, because then we are starting to see it more on the access and outcomes side, slowly but surely, right?

DR. BENJAMIN SOMMERS: Yeah, so when you talk about coverage expansion and savings, you really have to be very specific about whose perspective are you talking about? So I think Deborah's team has done some really nice work showing that in the right setting and the right circumstances, states can either recoup most of their expenses on expansion or even save money to the state budget. Now that is different than saying that coverage expansion saves society money. This is an important question, because there are those who advocate – well, if we do coverage expansion, we will make all of that money back in five years by keeping people out of the ER. Well, there is really no evidence that that is true. You might keep people out of the ER in the right circumstances – some studies like ours show that you do, some studies show that you don't. You still don't generally save money. The cheapest healthcare system, if you look at all payments from Federal, from state, from out-of-pocket, the cheapest healthcare system in the world is the one that locks its doors to all of its patients, but that is not a good healthcare system. So, if we expand coverage, we should expect to spend more on healthcare, but hopefully we are spending more on the types of care that are cost effective like prevention, like chronic disease management. So even as we spend more, we get more. Patients feel better about their health. They are better able to continue working if they want to work. They have better functional status, they have better educational outcome for children. They live longer. These are the goals that we hope we are investing in. So most areas of the economy, we expect that when we spend money, that we are making investments. We don't expect that we are going to spend a million dollars on highways today and then tomorrow get a \$1.2 million check dropped off that says, hey, the highway saved us money. That doesn't work in healthcare either, typically. We are investing in better healthcare and hopefully better health from that. It's different from the federal/state tradeoff and so I think that is an important thing to keep in mind. And we have to always decide,

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what are we spending money on and what are we getting for it and I think the evidence that I showed today, hopefully gives you some feeling that this is an investment that does produce real benefits for people, particularly some of the lowest income Americans.

MARILYN SERAFINI: We have time for one more question and I am going to ask it. But before I ask it, I just want to make one final plea to you all to fill out the evaluation cards before you leave. So I'm going to ask all of our panelists to answer this: What is the one thing Congress can do to help promote value and innovation in Medicaid? So you can leave our – especially our Congressional staffers in the room, with one wish that you have, what would that be?

DEBORAH BACHRACH: Oh, I'm so upset you started with me. I don't think I have the answer. But what I'm going to say is, the minute I leave this room, is if you could provide for three more rooms of 100% matching rate for any state that expanded after 2014, so enabling more states to expand or triggering greater interest in expansion in the 19 states that have not yet taken up the option.

GRETCHEN HAMMER: I'm not sure I'm fully prepared to answer. I think one thing we know is, we value our relationship with CMS, our sort of federal regulatory agency and we know that they are working incredibly hard and that they perhaps – I don't want to say more staff and resources, because I know that my general assembly doesn't like it when I suggest that to them about our agency, but I do think there is probably some important federal infrastructure investments that could be made to ensure that as these programs have grown, and as the options and the challenges grow, that the federal infrastructure to help administer the programs grow on par with that.

DR. BENJAMIN SOMMERS: You didn't save the softballs for the end. So I would echo Deborah's comment that I think the 100% match could make a real difference in some of the states that are on the fence and would like to do this. If you look at the distribution of states that haven't yet expanded, they are disproportionately states that have lower tax bases, they have higher poverty rates and so keeping that 100% match could be a difference maker. The other thing I will point to is, I believe Gretchen mentioned the dynamics of coverage. People come in and out of coverage much more frequently than we want both at – whether you talk to people who run Medicaid managed care plans, you talk to physicians and other clinicians, you talk to patients. They move in and out of Medicaid because they lose eligibility. They don't complete the renewal process and one simple solution to that is something we have seen adopted with good success in children but not for adults yet, is to give people 12 months of continuous eligibility in Medicaid. That is only available right now via a waiver and to my knowledge only one state so far is doing it for adults. So, there is a bill that has been floated, I believe it's every couple of months I hear some conversations about it, that would make that 12-month period of eligibility, so even if your income goes up a little, goes down a little, you get divorced, you move to a new house, you don't lose Medicaid mid-year. That makes better continuity of care, its again, and effective way to invest in people's health and seems like a sensible approach that most of us take for granted in other types of health insurance, that you are not going to drop in and out every three months.

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MARILYN SERAFINI: Thank you, you all did great for being put on the spot. So we have come to the end of our program. First, thank you all for being here, thanks to the Commonwealth Fund for their partnership and support in this program, and please join me in thanking our panelists for a very informative discussion.

[applause]

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