MACPAC

Medicaid and CHIP Payment and Access Commission

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PUBLIC MEETING

Ronald Reagan Building and International Trade Center
The Horizon Ballroom
1300 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

Thursday, September 19, 2013
10:18 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
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DONNA CHECKETT, MPA, MSW
ANDREA COHEN, JD
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ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S [10:18 a.m.]

Session 2: MACPAC PLAN FOR THE 2014 REPORT CYCLE

* CHAIR ROWLAND: If we could convene, please. I want to call to order this meeting of the Medicaid and CHIP Payment and Access Commission and welcome everyone back to our meetings that now commence in the fall and will obviously run through into 2014 as we work on developing our recommendations and our reports for the coming year.

We had a very successful retreat this summer where we tried to focus our efforts on what are some of the key issues that this Commission will be addressing over the coming years and have focused on five areas that will be the prominent areas for the Commission's work.

One of the key areas will be children's health and the future of the CHIP program. Our work will address how well children are being served by Medicaid and CHIP, how CHIP differs from Medicaid, and what lessons can be learned from the CHIP experience to inform future policy options for children, how well CHIP interacts with Medicaid and with the new emerging marketplace coverage under the ACA, and what our recommendations, therefore, are for CHIP in the future given that its appropriation expires in 2015 and that the ACA now provides new coverage options for families.

We will also be looking, as will everyone, at the implementation of the Affordable Care Act, but especially trying to focus, as you'll hear this morning in our session, on how the new eligibility and enrollment processes are working and how well Medicaid is interfacing with eligibility in the exchanges, how well plans are aligned between Medicaid and the exchange market, and what options could help mitigate churning, and also how state decisions regarding the expansion of Medicaid enrollment and spending are

having an impact on both the beneficiary population, the uninsured population, and the safety net itself.

And, finally, in the area of cost containment, we are always looking at how to improve the delivery and payment systems. You'll hear more this morning on some of the work we're doing to look at supplemental payments and how they interact with Medicaid spending, but we really want to look in this area at how well Medicaid and CHIP provide access to quality and cost-effective care for enrollees, how that varies across the states, how performance is being measured both in managed care and in fee-for-service areas, what impact managed care and new delivery models have on access and cost, and how do we move to a more value-driven delivery system and payment policy that allows us to both constrain Medicaid costs but maintain access for the Medicaid beneficiaries that depend on these services. This is an area where we're going to try to look for targeted recommendations that could achieve savings and also a core set of issues in our mandate.

And, finally, in terms of the populations and the population responsibility we have, we will be looking at Medicaid's role for high-need and high-cost populations to begin to address how Medicaid interacts with the financing and delivery of long-term services and supports, and the role of waivers in that process, the need for better metrics to measure and monitor quality of care for high-need populations, the extent to which the program meets the diverse needs of persons with disabilities, and the implications of the ACA for eligibility for people with disabilities, and the issues and impact of integrated care models for Medicaid-only people with disabilities as well as the dual-eligible population. This is an area where we'll be keying up this afternoon some of our work at looking at how long-term services and supports are provided now and what are some of the challenges going forward.

And because the program administration and accountability are critical issues of how well the program performs and how well federal and state dollars are expended in terms of administering this program, we're going to look at ways to both improve and modernize Medicaid administrative capacity, at better performance measures and accountability, and a great theme of the Commission has always been how do we simplify an already complex program to get more effective outcomes from what we're looking at. This work will include both looking at ways to improve the data and information required to administer the program, how to evaluate performance, also how to look at waivers and how to simplify or alter the waiver process, and begin to discuss what templates or metrics should be developed to provide a framework for comparing states, and what's needed for program accountability and program integrity.

These are all areas that are broad and have a great number of issues underneath them, but in our work we've looked at these as the areas that we should be focusing on, and you will see in today's agenda that the work there is clearly directed at being able to address the many aspects of the five issues I have just raised.

I'm going to turn to Anne and ask her to just give us an update on sort of the building blocks that we've already got in place on these issues and how we've been going forward and building on our past efforts.

* EXECUTIVE DIRECTOR SCHWARTZ: Thanks, Diane.

First of all, it's just very fitting for me to be reflecting a little bit on this this morning since I think my first MACPAC meeting was last year in September. So I feel like we've accomplished an extraordinary amount since then, and I'm looking forward to another great year.

As Diane said, the agenda today reflects each of these areas that the Commissioners focused on. I think we have one session in every area of those five areas today, and we will see more of those as the meetings roll out over the fall. Some of these areas we are further along, in which the foundation has already been built, the Commission's common understanding of the data are there. Others are ones where we're still building the foundation.

We had two recommendations in last year's March report. I think there's an expectation from the Congress that we will be doing more recommendations, and the staff will be here to support you in doing that. We've made significant strides in our internal capacity on data development and data analysis. To do more quick turnaround analyses, we've brought in some more technical expertise on the staff. So we hope we'll be able to do that.

I think the other thing that I would like to be able to do in the future, we would like to be using our website more, to put more foundational work on the website and make it a richer resource for people. We also hope in the near future to make it something that is more navigable and has more content on it so people wouldn't just think, well, I just need to know when the meeting agenda is and last year's report. And so we will be posting more and more content to that website, and so it will be a resource for you in your other work that you do, and I hope to the members of the public and certainly our core audience on the Hill as well.

CHAIR ROWLAND: Thank you, Anne.

David?

VICE CHAIR SUNDWALL: Welcome. Thank you. This is an interesting meeting because of the

timing. My gosh, we're on the cusp of expanding Medicaid, or not, participating in exchanges, or not. This is such an interesting time. We have major health reform in the nation but uneven participation, and we just don't know where we're going to -- what it's going to be. So I think the agenda that we've set for ourselves is very ambitious but very appropriate. I'm really looking forward to the discussion on the factors related to the ACA implementation. I come from a state where they so far have chosen not to expand Medicaid. We don't know if that will hold after the legislature convenes next. But, anyhow, it's a lot going on, and so I think it makes the work of the Commission all the more important.

I agree with Diane. I thought our retreat in July focused us in an important way on these issues that we've highlighted.

I would like to just put in a pitch, as I always do -- I kind of feel like Andy. I keep saying it until the cows come home. Embedded in all of this I hope will be an eye toward improving public health and population health. Medicaid is a great lever to do that. It is very, very important and financing access to services that actually make people better, and that's a public health issue as well as an issue of just individual health.

So we will try and look for ways where we integrate this population health concept throughout our work, but I look forward to the discussion today, but I can't emphasize enough what interesting times we're living in. This is very historic given what we're about to embark on as a nation.

CHAIR ROWLAND: A perfect segue to our first panel. Chris Peterson is going to highlight some of the areas where the Commission will be engaging and discussing ACA implementation issues and analyses. So, with that, Chris, please start us on our work.

Session 3: ACA IMPLEMENTATION: ISSUES AND ANALYSES

* MR. PETERSON: Thank you, Diane. Good morning, everyone. It's good to see you all.

We are now less than two weeks away from when exchanges in Medicaid and CHIP programs in every State begin accepting applications for coverage that will be effective January 1, 2014. And for Medicaid and CHIP, some of that coverage may be effective immediately for individuals who find out they are already eligible for Medicaid or CHIP.

On the other hand, nearly half of the States are not implementing the Medicaid expansion to the new adult group. In those States, poor individuals may find they are not eligible for any assistance.

Yet, every State is required to make certain Medicaid-CHIP changes to their programs, regardless of whether or not they implement the expansion. For example, Medicaid and CHIP must use Modified Adjusted Gross Income, or MAGI, for determining income eligibility for most applicants.

So there are many issues we are keeping an eye on and analyses have begun. I will go through what those issues are that we've highlighted at the back half of this presentation and the analyses that are underway and look forward to your feedback on what the priorities should be and which analyses you are most interested in, maybe where there are some other analyses that are necessary.

So, what I'm going to do today is review our prior work, update you on where things stand in terms of implementation of the ACA with respect to Medicaid and CHIP, talk to you about the MACPAC approach for monitoring implementation, and talk about some of the policy and operations issues and the analyses that we have underway.

So, recall that nearly all of our reports have discussed ACA issues in some way. We have had

numerous sessions in our public meetings on various ACA issues. We have heard from the administration. We have heard from States.

Then, also in October 2011, we provided a comment letter to the Secretary in response to a proposed regulation. The Commission addressed numerous issues. I'm not going to hit them all, but it was focused on aligning Medicaid and CHIP eligibility rules with exchanges in terms of how income was determined, the period of time for which coverage is effective, so in the weeds on some of those things. We also advised CMS to consider a single consistent method on how States and the Federal Government determine who is eligible for the 100 percent Federal match in 2014 for individuals who are newly eligible.

In February of this year, we provided another comment letter in response to yet another proposed regulation, which was published in January. In that letter, we expressed our support of the regulation's effort to simplify eligibility and enrollment processes without diminishing a State's obligation to ensure adequate program accountability and integrity. We expressed our support of moving toward electronic State plans, although it is not clear when that will actually be implemented with everything else going on.

And the Commission also raised the issue of churning. So we previewed one of our recommendations that we used in the March 2013 report on continuous eligibility for 12 months, which is where individuals are not required to report changes in income that occur between their redeterminations.

And finally, in the March 2013 report, we had a chapter entitled "Eligibility Issues in Medicaid and CHIP: Interactions with the ACA." And in that chapter, the Commission made two recommendations to the Congress, one to extend the State option for 12-month continuous eligibility to all Medicaid and CHIP enrollees, since it is currently only available without a waiver to children, and secondly, to fund Transitional

Medical Assistance, or TMA, permanently, while also giving States that implement the Medicaid expansion the ability to opt out of TMA.

There has been bipartisan legislation to address 12-month continuous eligibility. There was also in the President's budget a proposal to address TMA consistent with what the Commission recommendation. But neither of these has, as of yet, been enacted.

So, in terms of key implementation dates, October 1, coming soon, open enrollment slated to begin. January 1 is when the coverage for Medicaid's new adult group, in States where it is offered, that is when that will become effective and coverage through exchanges will begin, as well.

On March 31 are a couple key dates. One is there are individuals who are currently enrolled in Medicaid who, moving forward, their income eligibility will be based on MAGI, and the statute says that if your redetermination were to occur in the first part of the year and you would have been determined ineligible solely because of MAGI, then we will keep you in the program until March 31 or until your next redetermination, whichever is later. In addition, March 31 is when open enrollment for the exchanges ends for 2014.

So, our approach is to gather publicly available information from the numerous Federal, State, and local sources. I just want to mention that on the local side, while we're tracking as much as we can, we are focusing on 12 States in particular that represent geographic diversity and a range of the type of expansions that they're -- the type of exchanges they're using and whether or not they're doing the expansions. So, just for your information, those states are Arkansas, California, Florida, Georgia, Indiana, Maine, Maryland, New York, North Dakota, Ohio, Texas, and West Virginia.

At the same time, we're also getting information and welcome discussions with State, beneficiary, provider, and other groups. And, in addition, we will be conducting focus groups later this year, in the November-December time frame, with applicants to see how their experience has gone in terms of applying. And then we will do focus groups later, in probably mid-2014, to look at applicants once again, and then to also get the provider perspective.

So, this is the map that we put together about where States are in terms of whether they're going to do the Medicaid expansion at this point. We have 24 yeses, they will implement the expansion, and 19 noes, and eight are still deciding. But I think it's helpful to talk about what "yes" and what "no" means, and so the next slides that follow, because, as with Medicaid, it's always more complicated than you want it to be, I'm going to walk you through four different types of States and we're going to look at these four kind of emblematic States, if you will, in 2013, what they look like now, and what they're going to look like in 2014.

We're going to look first at a State that is kind of the stereotypical State that probably was -- Congress had in mind when doing the expansion, where right now, parents aren't covered very high up the income scale and childless adults aren't covered at all. But then we'll look at a State that had already covered childless adults and parents above 133 percent of poverty. Then the third State will be kind of the stereotypical non-expansion State, where there will be a gap in eligibility. And then we'll also look at a State that is not -- shows up as a "no" here, but where there doesn't appear to be an eligibility gap per se.

So, let's just walk through these, beginning with North Dakota in 2013. You see that the blue is the Medicaid mandatory eligibility levels currently for pregnant women and infants, and one- to five-year-olds at 133 percent of poverty, 100 percent of poverty for six- to 18-year-olds, and then parents, of course, that

mandatory level varies by State, but a relatively low level for parents and no coverage of childless adults in 2013.

How does the world change in 2014? Of course, the thing that jumps out at you is the top green part, where subsidized exchange coverage kicks in. But for the lower-income folks, you see where the 133 is with the asterisk.

So, for six- to 18-year-olds, mandatory Medicaid goes from 100 percent of poverty to 133 percent of poverty. And for States that currently have separate CHIP as covering those kids, they will now be in 2014 Medicaid expansion children, so they will receive the Medicaid benefit package, but they will continue to receive -- the State will continue to receive CHIP funding at the CHIP match for those children. Sometimes, they're called stairstep children just because I'm going to go back a slide. You know, you see how there was a stairstep there and the design of the ACA in this provision was to eliminate that stairstep.

And then what appears on here as black is the newly eligible individuals who will be covered in that State among the parents and childless adults for whom the State will receive the 100 percent Federal match in 2014.

So, now let's consider an early expansion State, Massachusetts, who would cover the non-elderly essentially up to 300 percent of poverty for kids and parents and childless adults, and the parents and childless adult coverage was through waivers. In 2014, subsidized coverage comes in and the maintenance of effort that States are not permitted to reduce their eligibility levels for adults expires on January 1, 2014. And Massachusetts is one of these States that plans to roll back its Medicaid coverage to 133 percent of poverty. So this shows you the difference going from 2013 to 2014, that impact.

Note, though, and it is noted on the slide, that -- we've talked about this before, in previous sessions, that the structure of the ACA is such that one cannot have Medicaid and exchange coverage simultaneously, generally, as one always has to say with Medicaid. So what the State is doing in this case is for individuals below 300 percent of poverty who would otherwise have been covered by Medicaid, they are now using a State-funded cost-sharing wrap so that these individuals will not be worse off in terms of their cost sharing.

And then the bottom right-hand corner is -- it doesn't show up as a different color here than the newly eligible, but it is. There will be no newly eligible individuals in Massachusetts, and this is the case for a number of States, and the ACA has a provision for these States so that, okay, if you had expanded by 2009 at some point, then for your already eligible childless adults, we are going to give -- we will split the difference between that 100 percent match and your regular FMAP for that population.

So, now turning to a non-expansion State, Texas, and this looks an awful lot like what North Dakota looks like in 2013, the difference is what happens in 2014. Texas is not planning to do the Medicaid expansion and exchange coverage only goes down to 100 percent of poverty so that there will be that gap there in terms of the coverage individuals will be eligible for.

CHAIR ROWLAND: Just explain why that gap occurs, what the statutory provisions don't allow.

MR. PETERSON: What the statute says is that subsidized exchange coverage is only available to individuals who are not enrolled in Medicaid and who are above 100 percent of poverty. So, in States that do not do the expansion, that exchange coverage thing goes down to 100 percent of poverty. For a State that is doing the expansion up to 133 percent of poverty, that's why exchange coverage then kicks in at 133. Yes.

COMMISSIONER ROSENBAUM: I think it's worth just the added note that that is the chart for citizens, that legal residents, of course, will not have a gap in Texas or South Carolina.

MR. PETERSON: I think, though -- correct me if I'm wrong, but I think that provision is only if the individual would have been eligible for Medicaid --

COMMISSIONER ROSENBAUM: [Off microphone.] If you are eligible, the gap disappears for individuals who meet all Medicaid eligibility requirements but for the fact that they are short-term legal residents. So, if we did a picture of somebody who was a short-term legal resident, the green would go all the way down to meet the blue. But in the case of a citizen, you end up with this white gap.

CHAIR ROWLAND: Because the statute provided that people in the five-year waiting period would have access to the exchange because they were not getting coverage.

MR. PETERSON: On the other hand -- just correct me if I'm wrong, though -- if you're a childless adult, let's say in Texas, because Texas is not doing the expansion, the non-citizens would still not be eligible for exchange coverage below 100 percent of poverty because the State did not do the expansion.

COMMISSIONER ROSENBAUM: No. So, imagine me as an older woman and imagine me as a citizen. As a citizen, this is the problem in the Texas. I'm a childless adult. My income is below the 100 percent threshold. But imagine me as a recently arrived legal immigrant. I fall into the childless adult category. I will be able to go to the exchange and get premium assistance regardless of how low my income is because I'm in the gap period. This is how Governor Brewer convinced her State legislature to expand Medicaid, because, of course, the only people left out were citizens. So, we might just want to make a note somewhere that the gap is not present for short-term legal residents.

[Off microphone conversation.]

COMMISSIONER HENNING: So, basically, what you're saying is that if you are a citizen of the United States, you're actually at a disadvantage in that particular type of State.

COMMISSIONER ROSENBAUM: [Off microphone.] Correct.

MR. PETERSON: Now, looking at Indiana, in 2013, they offer, even for parents and childless adults, some limited Medicaid coverage up to 200 percent of poverty. Moving forward, Indiana says that they are not implementing the expansion. That is to say, they are not going to 133 percent of poverty for parents and childless adults and offering essential health alternative benefit plans consistent with the statute. But, they are going to continue coverage of parents and childless adults up to 100 percent of poverty. So, it would appear there would be no eligibility gap in that State, although I will note that their draft waiver does have a clause where they can cap enrollment for childless adults, so there are some issues that could arise.

COMMISSIONER MOORE: But that is a waiver program.

MR. PETERSON: That is a waiver program.

COMMISSIONER MOORE: So, if a State didn't have a waiver program, this wouldn't be possible at -- or unless they negotiated a new waiver to do this sort of thing.

MR. PETERSON: I think that's --

COMMISSIONER MOORE: I just want to make the waiver point here --

MR. PETERSON: I think that's right.

COMMISSIONER MOORE: -- that this is the way the situation looks in Indiana because they have a waiver, not because they're going under normal --

MR. PETERSON: Correct.

COMMISSIONER MOORE: -- statutory Medicaid rules.

MR. PETERSON: Correct.

Okay. So, what is our approach? We're going to examine issues where Medicaid, CHIP, and exchanges interact, and a lot of that happens to be at kind of those -- at the margins as one moves between eligibility right there on those lines that we looked at.

We're going to assess opportunities to improve consistency and simplify programs for Federal and State governments, enrollees, and providers with respect to eligibility, benefits, financing, and other program requirements.

So, now I'm going to talk through these issues. I've numbered them, but not in terms of any priority, just for convenience sake as we refer to these issues. So, we look forward to your comments, but we want to tell you -- just kind of describe what the issue is as we see it, provide a little background information, and then tell you what we have underway.

So, with respect to churning, of course, this was a major part of our analysis in our March 2013 report. We're talking about changes in program eligibility because of what are often small income changes or changing family situations and other factors. And the research we cited back then, of course, was the Sommers and Rosenbaum piece that 35 percent of low-income adults are projected to experience a change in income within 6 months that would, theoretically, shift their eligibility.

So what are we doing? What are the analyses we have underway?

We are updating the literature review to see what else has come out in the interim. We want to

examine the extent of churning, its reasons and the characteristics of those who churn -- so, look a little bit more into some of the details. And then, of course, states are doing a lot to try to mitigate the churn and its effect, and so we want to track what they are doing in terms of 12-month continuous eligibility, bridge plans, premium assistance and other approaches.

Issue 2 is MAGI implementation. MAGI is the new income counting methodology that will be used for exchanges, CHIP and most Medicaid populations. So states are having to do a lot right now -- converting their current Medicaid eligibility levels, changing their methods to align with MAGI and changing their eligibility systems.

This has big implications for these populations in that there's no asset test. Some income is no longer counted, such as child support. Some income will count. Individuals are now in the household. Plus, there's that 5 percent of poverty disregard.

So there are a lot of changes here. We want to -- we are examining the policy and operational issues associated with the implementation of MAGI, and we want to -- once CMS has released where states' converted MAGI levels are, then we can look at what the impact is on people.

CHAIR ROWLAND: As part of that work, it might be very helpful to have some examples of an individual and what their income was and how they were calculated, in one state versus in another state and now under MAGI, just so that we could get a sense of where the changes are.

MR. PETERSON: Yes.

CHAIR ROWLAND: Andy.

COMMISSIONER COHEN: Are we waiting on comments on things until the end?

CHAIR ROWLAND: Yes.

MR. PETERSON: So, a factor -- sorry.

Issue 3 is talking about multimarket plan participation. Some plans -- this is an issue, again -- and most of these are issues -- we've talked about before.

But some plans are participating in both Medicaid and exchange coverage. That may reduce plan switching as individuals churn. There are factors that affect whether plans decide to go in to both markets, and there are questions about their ability to do that. And sometimes states have said we don't think you can pull that off.

And so the next session is going to delve into this issue, but what we are doing is looking at the factors that affect plan decisions to participate in both markets and what the impact of that is for beneficiaries, for plans, for everybody involved.

Four is eligibility quality control. With the major changes we are seeing, states are having to do new things, and this requires new strategies to promote program integrity and to measure eligibility errors. There has been recent guidance that came out from CMS on what will be happening. And, of course, the vision of the ACA was that a lot of the checks and verifications would happen electronically.

So this is a new -- this is a paradigm shift for a lot of states and for all states in terms of having to interface with this new Federal data hub, which will have information from the IRS and the Social Security Administration and other Federal sources.

So what are we going to do?

We will be -- we are identifying where the existing guidance perhaps doesn't align with the ACA

requirements and to look at what states are doing right now and where there are opportunities, potentially, for improvement.

Five has to do with the reduction of adult Medicaid eligibility levels. And I walked through the example with Massachusetts, but there are several states who have coverage of adults above 133 percent of poverty, and several of them plan to reduce those eligibility levels to 133 percent of poverty and let the exchange pick up the difference.

Again, states are doing things, like Massachusetts, in terms of a cost-sharing -- a state-funded cost-sharing wrap -- but other states are going to maintain those eligibility levels, it seems.

So we will be tracking this, and we also want to look at the estimated number of individuals who are affected by this and what the impact is on them.

So does the state have a cost-sharing wrap so that it is essentially the same in that regard, or not?

Six has to do with the application of the affordability test to self-only employer coverage. Sometimes people have referred to this as the family glitch, and this is really -- this is primarily an issue affecting exchange coverage, but there are potential interactions with CHIP and Medicaid.

So what this refers to is that, generally speaking, if you were going to obtain subsidized exchange coverage, you'd have to be ineligible for employer coverage. However, if that employer coverage -- if your contribution to that employer coverage exceeds 9.5 percent of your income, then you may obtain subsidized exchange coverage. But that test, that 9.5 percent test, only applies to self-only coverage -- the cost of self-only coverage -- not family coverage.

So the example here is that when you look at average out-of-pocket premiums for employer

coverage, based on the latest survey by Kaiser and the HRET, if you look at it at 200 percent of poverty, the average out-of-pocket premium for self-only coverage would amount to 2.6 percent of income whereas family coverage would be 11.7 percent of income.

So, in this case, the individual would be found to have affordable ESI and affordable employer coverage, could not obtain subsidized exchange coverage, and so, if they do not obtain employer coverage, then they could be uninsured.

It could be the case that CHIP coverage is available for the children, and so we will talk a little bit more about that tomorrow in the implications on CHIP in particular.

But I do want to mention that there are some recent regulatory changes, trying to deal with this issue in some way, and that is affected individuals would not be subject to the individual penalty and affected children would be exempt from any CHIP waiting period.

So what are we going to do on this?

We are going to describe the impact on families of various circumstances, some examples, and also try to obtain -- we are working on obtaining estimates on the number of people affected.

So I've hit those six issues and spent some time going through what our analyses are.

These are, at this point, kind of on our watchful waiting list, but if you think, no, these merit -- these are potentially amenable to options for the Commission to consider and we need analyses on these besides just tracking, please let us know.

There are questions about the capacity to handle applicants on October 1st. The capacity -- once individuals have come in and been determined eligible to enroll them in plans and to pay those plans. There

are questions about, is there adequate access to care and provider capacity? And I think a lot of those questions will be difficult to answer until January 1st when we see how things play out.

Another issue -- and this was raised in our June report. There are several states -- I believe it's seven at this point -- who cover for certain -- most of the pregnant women in the state, only pregnancy-related services. And this has some complicating issues for these women about whether they're going to be eligible for exchange coverage, what does that limited benefit package cover, and so that's an issue.

Then there are kind of the split family coverage issues we've talked about before, about differing eligibility periods and provider networks, and always the issue of eligible but not enrolled individuals.

So those are our plans, those are the analyses we have underway, and we'd appreciate any feedback you have in terms of the priorities.

CHAIR ROWLAND: Okay, Trish and then Andy. Sara--well, I'll get you all, but we'll start with Trish.

COMMISSIONER RILEY: I thought you did a great job, Chris, and the charts were especially useful in illuminating into the sort of complexity of this issue.

As I think about priorities, it seems to me the three that jump right out as critically important for our role are the ones about churning, the multimarket and MAGI. The multimarket one, especially, I think is intriguing and begs for a deeper dive on two issues.

One is, what's the oversight? You know, who's the commercial player, and who's -- there will be new players here. Medicaid-only, commercial, and joining forces that they haven't done before -- that raises red flags.

But where's the oversight -- because I think one of the critical question for me is the shared responsibility between the Federal Government and bureaus of the Department of Insurance.

And how does the oversight work on these new plans, and what implications are there for the three Rs -- because, clearly, I think there's a wise provision within the Act that sort of says we've taken account for some of these changes and have the reinsurance and the risk adjustment.

So I think those are areas that are really ripe and where we could make an enormous contribution.

Where I struggled about whether these three -- there are three issues that I'm not sure come to the same sense of urgency for me.

One is maintenance of effort because what's the recommendation? I mean, what would we do, except for those states that are doing wrap -- because I think that's an interesting place where we might be able to afford some change.

The affordability of self-only is an issue I'm totally -- top-tier interest to me, but I'm not sure it's a MACPAC top-tier interest, and I think maybe that's one where I would raise questions about limited staff time and whether we want to do it.

Program integrity -- I get where it's important, but I just think it's not timely. I think we really need to recognize this rollout will have sloppiness. And to think about program integrity until things flatten out and get a little bit more to a maintenance point is unfair. I think we might want to take a look at it, but I think a lot of attention to it may not be great.

I thought the issues you raised on the last slide were important, and I think in the retreat we talked a bit about the need to focus more on costs. So I would suggest that we have to look in two areas.

One is administration. The reality is that this expansion brings new responsibilities for states. And, while we focus a lot on the 100 percent funding for the first 3 years, the fact is that administration is still 50-50.

How are states managing the enrollment growth with the 50-50 reimbursement?

How are they managing Medicaid and exchange eligibility hand-offs? Who's doing what?

How are they doing operating two separate programs -- a MAGI eligibility and a non-MAGI eligibility?

Those are administrative challenges and costs that I think deserve some attention.

The other is the sad truth that we really have a natural experiment here with expansion and nonexpansion states. Given that, I'd like to take a look at how people fare on costs and accessibility in expansion and nonexpansion states, and with full benefits and benchmark benefits, because I think we're at a tipping point for a new way to look at Medicaid. Sara has talked about this a great deal, and it seems to me we ought to really look at what happens to people that just get a benchmark plan versus a full benefit.

So I think those are areas where we might be able to sort of be a little bit more robust, and I'd like to see some more attention. But I thought all in all it's a tough challenge to try to figure out in this huge ACA implementation what we focus on.

MR. PETERSON: Am I right; on the expansion piece, a lot of that information we won't have until it's been done?

COMMISSIONER RILEY: Right.

MR. PETERSON: So, in other words, it's not like a March report issue --

COMMISSIONER RILEY: Right.

MR. PETERSON: -- but it's something we will definitely see later on.

COMMISSIONER RILEY: Yes, yes, but I think we need to get good baseline information that's accurate.

CHAIR ROWLAND: Okay, Andy.

COMMISSIONER COHEN: Also, I thought you did a great job, Chris, laying out the issues and thinking creatively about where MACPAC can really most effectively kind of weigh in on these issues.

A couple of just quick reactions -- one is on the sort of operational issues that are undoubtedly arising and going to arise as this program is rolled out. I think we just need to think extremely strategically about where MACPAC can really play a role there.

We know there are going to be glitches as there have been in every single major new program that has rolled out in health care and everywhere else in the country. And so to the extent that we can actually play a meaningful role, either as a sort of early warning alarm -- I don't even know if it's a system, but you know, as an early warning alarm -- in a March report or actually come up with some creative recommendations, I think that's great.

I think, otherwise, there will be many, many people kind of watching and finding circumstances where there are glitches. Many of them will be resolved eventually, which doesn't mean there won't be pain along the way.

But I just think we really need to be strategic about that. We're not in operations. We really like to stick to where policy can really make a difference.

On the broader point around alignment and churn, alignment of markets -- and that relates to churn for individuals -- multimarket plans, I think that is the perfect sort of policy area for us to really be digging into.

I would kind of add maybe to the analyses some work around individual cost-sharing because I think one of the things that we should be looking at over time is whether or not one way to address churn issues is more flexibility around individual cost-sharing between the programs so there is sort of not such a cliff at the end of Medicaid and at the beginning of the exchange, depending on how your state is aligning it. So I'd really like to add that to our sort of areas of exploration.

Thanks so much.

CHAIR ROWLAND: Okay, and then I had Sara, Steve, Denise. Okay.

VICE CHAIR SUNDWALL: Judy, too.

CHAIR ROWLAND: And Patty and Judy.

COMMISSIONER ROSENBAUM: It was a great job.

I'd like to second the motion -- I guess third the motion now maybe. I've lost track of the motions.

Understanding cost-sharing wraps because of their tremendous importance to people who now show up in the exchange, who previously showed up in Medicaid, and particularly because I think there's going to be -- based on some work I've done in Massachusetts, I would say there's going to be a lot of pressure on enrollment to sisters and families, for families to think about using their premium subsidy to buy a bronze plan so that they can afford the monthly premium.

And what, of course, shows up as a result is that there is no help with cost-sharing assistance unless

the state provides it.

And because the premium assistance is pretty limited, I would imagine we're going to see a lot of families and individuals making, or being encouraged to make, that choice in order to be able to enroll.

And so, understanding how states are using a cost-sharing wrap and the policy implications of a higher supplementation on the wrap I think would be very important. That's number one.

I think also the other issue that is sort of in this weird space that Andy put her finger on, between mechanics and policy, is this issue where I think we can be -- maybe one of our most important roles is this pass-off between exchanges and Medicaid.

Again, based on some work that we've been doing, it's quite clear that even where there's been a fair amount of experience -- and of course, Sharon can speak to this in the CHIP context -- there are mass confusion and long breaks in coverage. And the original vision of sort of a single point of entry with a flawless trajectory of income, making for seamless financial transactions is just not going to happen, not for a long time.

And the last point is that on the adults losing Medicaid I just wanted to flag again an issue that's been on my mind for a while, which is that I think we need to watch not only, as we call them, the childless adults on Medicaid but adults with disabilities who are over the 138 percent level and for whom states are paid at the normal FMAP rate and for whom most of the expenditures, ironically, may be acute care services.

And so the question is, will states begin to start thinking of those adults as exchange candidates?

And that, of course, brings us to this question of, when can Medicaid serve as a supplemental

insurer just as it does in Medicare?

Treasury and HHS already have some policy on this. It's quite early on, and it's quite limited, on when they will recognize Medicaid as a supplemental insurer versus a primary insurer. And I think that's a place we want to be as we watch the trends for adults with disabilities.

COMMISSIONER GABOW: I, too, really like these graphs and what you've done. One thing that I think would be useful is the numbers of people in the bins, because when you look at a state like North Dakota, not to say anything against North Dakota, but the number of people in the bins are going to be radically different than a state like Texas. So I think understanding not just where the bar graph goes up to in terms of poverty, but what's the implication for the number of people, although obviously every person is valuable.

I think on the issues I agree with what people say about churning and also early warning signs about how the plans are doing, since, as we talked about, people are going into this space who may not have experience either with Medicaid or with commercial, depending on where they're coming from, so thinking about that.

There is one other issue that I may be wrong about, but I think I'd like to put it on the table. I think a lot of the poorer individuals are going to go for the bronze plan, and that's going to leave a lot of uncovered expenditures. So I think another thing to think about following it -- I'm saying this obviously with a past provider hat -- is what's this going to do to the bad debt for hospitals. Because, I mean, it's like the old story about, you know, people adding co-pays, but then, of course, the patient doesn't have the co-pay, so what are you going to do about the service?

So I think, look, while I think tracking most of this from the point of view of people and the patients is very important, which are what most of these bins are, there is a bin about providers that I think may not be -- I think may be important, particularly if the DSH cuts come in at the same time, we may find bad debt particularly in safety net becoming a substantial issue. And again it's another early warning kind of message, I think.

COMMISSIONER HENNING: I just want to make a plea for your Issue 5. I'd really like to take a look at what happens to people that have coverage through their employer for the worker but have families that the coverage through the employer is so expensive that they really can't afford it, because if the intention of the ACA was to provide health insurance for citizens and that was really the intention so that everybody had insurance, so that they hopefully have access to health care, then if we make it so that, yes, because you work and you get insurance through your employer, your spouse, who doesn't work, isn't allowed to buy exchange coverage when you can't afford to provide it through the employer-based coverage. There's something wrong with that. It just doesn't seem fair.

So I think that that would actually be an area where we could make a recommendation that Congress or HHS or somebody take a look at can those rules be changed, does it need legislation to be changed, in order to make it so that the spouse could be covered in some fashion at a reasonable level.

COMMISSIONER WALDREN: So I agree with everybody. Chris, great job getting this together. When I think about churning, I agree with you, Trish, it is a high-priority issue. But I'm trying to figure out how high a priority. So I could see three potential issues for folks. One is that there's a gap in coverage, that notion of, you know, they may be eligible without a gap, but are they enrolled without a gap. The other

issue is, you know, the administrative burden. So do I have a big burden to jump from plan to plan where there's no gap, but I got to do the work?

And the final issue is the continuity of care. So am I switching care teams? You know, so when you get to Issue 6 -- or not 6, the factors affecting multi-plans, one of my questions is: Do we know anything about the provider makeup in those plans, either the Medicare kind of network versus the exchange type of network? If they're the same, then the issues kind of get back to the issues around administrative burden and gap, not much continuity of care, which would make it a lower priority, quote-unquote, for me than if those are completely different, then I think that becomes a bigger issue.

And then the issues around the capacity, I don't see those as a potential. Those are given, so I think those are later issues that we need to deal with after we get closer to a steady state.

Thanks.

COMMISSIONER MOORE: Thanks, Chris. This is a nice way to lay out these issues for us so that we can kind of weigh in for you. I'm actually just as a matter of record high on the churning and MAGI implementation stuff with some attention to the administrative and operational aspects of it, which to me always become policy at some level. But, in any event, the other thing I wanted to mention is -- and we can get into this perhaps a little bit more tomorrow, but the CHIP interactions with the exchange, I just don't want to let that go. I know it's on your list of other things that we could consider. But I think it's really important to focus on in our overall work on churning and MAGI too.

And then, lastly -- and I know you all do this quite regularly -- I think it's important to know what the congressional priorities might be, and they could be, you know, weighed in with this as well, and also

what CMS -- if CMS has tracking plans or if there's any information about what the Department's going to be looking at. I know ASPE has got a fair amount of money that they're going to devote to some of these kinds of things, and it would be useful for us to sort that out so that we don't end up duplicating other folks' work.

But this is really helpful. I'll give you my funky little notes later.

COMMISSIONER CHECKETT: Just a couple of quick comments, and, again, really great work. I actually found the state slides where we saw the colored population, pre and post, incredibly helpful, and I would really hope, Anne, that we'd be able to get those on our website at some point. I have never seen that anyplace like that, and it actually made me think of my very basic question, and maybe you can just clarify here. But in those -- I didn't fully appreciate that the pregnant women in an expansion state who are now covered at 185 percent of poverty for Medicaid will actually drop to 133; and if you're from 133 to 185 in an expansion state --

MR. PETERSON: I don't think they're doing that for the pregnant women.

COMMISSIONER CHECKETT: Okay.

MR. PETERSON: They're doing it for the parents and the childless adults.

COMMISSIONER CHECKETT: Okay. Then I read that chart wrong, and that concerned me because I thought we would wind up having people not be able to --

MR. PETERSON: Yeah, that's a good point, though. I mean, I need to double-check on that.

COMMISSIONER CHECKETT: That's how I read the chart.

MR. PETERSON: My understanding is that -- and I don't think the pregnancy levels changed in

that chart. They stayed where they are. But that's an important point that we need to be sure of, as we talk about what states are doing and the rollback, are they doing that for pregnant women. My understanding is it's not so.

COMMISSIONER CHECKETT: Well, and I saw -- and here would be where I'm going with it, just to dig in on this, because I actually saw some language in a state who's looking at an expansion for 2014, and they actually were saying we're going to take those women from 133 to 185 and they have to buy on the exchange. My concern not only was what you said about potentially different benefit packages, but if you're -- the exchange has -- people forget this. There's an open enrollment period for the exchange. You can't just get on the exchange all year round. So what happens to someone who is pregnant and it's August? Well, the enrollment is January through -- well, October 1st through March 31st.

So it's really technical, but I just wanted -- let's dig in on that one. So thank you, and really the start of some great work.

CHAIR ROWLAND: Donna, I think that perhaps one of the themes we ought to develop here is Medicaid's substantial role for pregnant women and how, just going through the lens of pregnant women, how the ACA changes that, because clearly, even though we're showing their income eligibility level, they're often only eligible for coverage until 60 days postpartum. So in an expansion state, they would kick over to get full coverage, but in a non-expansion state, they might not.

So maybe one theme as we look at people and the impact on different people would be to really try and follow through on what the issues are with regard to coverage for pregnant women.

COMMISSIONER CHECKETT: I think that's great, as long as Commissioner Henning does not

object.

[Laughter.]

COMMISSIONER HENNING: No.

CHAIR ROWLAND: Okay. Any other comments?

COMMISSIONER GABOW: One other thing in determining where we look is your assessment of how real time the data is going to be on these various points and how valid you think the data you're going to be able to get is going to be, because we know that ordinarily there's a lot of lag in the data and a lot of digging that you have to do to clean up what you get. So I think that should be a lens to look through. There's no sense going down a path where you think it's going to be really hard to get the data and it may not be good.

I think the other lens is the one Judy mentioned, if we know someone else is really going to dig into one thing, maybe we could collaborate with them or think of a way not to both use our limited resources to begin to solve it.

CHAIR ROWLAND: Just as we are with the duals by working with MedPAC.

Well, thank you, Chris. I think you've gotten a lot of guidance here, I hope, on moving forward. And we're now going to really delve a little deeper in this next panel into that issue of market alignment and plan participation in Medicaid and the exchanges. So if I could have the next panel come forward, that would be helpful.

Sarah and Kevin. And we're going to have -- Veronica will provide the introductions and set up this panel, and I want to welcome both Sarah and Kevin and thank them for joining us today. And we are now

at Tab 4.

Session 4: ACA IMPLEMENTATION: MARKET ALIGNMENT AND PLAN PARTICIPATION IN THE MEDICAID AND HEALTH EXCHANGE MARKETS

* MS. DAHER: Okay. Good morning. So we're going to look in more detail at one of the issues that Chris Peterson just brought up, which is alignment between the plans on the exchanges and Medicaid managed care. And we're interested in that because it has been estimated that as many as 50 percent of people below 200 percent FPL will be possibly churning between Medicaid and the exchanges. So that's almost 29 million people, so this level of churn can be very disruptive to the enrollees, to the plans, and to their providers.

Now that we're getting very close to October 1st, we're actually able to see more about what plans are either already accepted to participate in the exchanges or have applied and whether they are in both markets.

Over the past several months, the staff has explored this issue of market alignment, and we've investigated the number and types of plans that are participating in both markets, the factors that are affecting their decisions to do that, which include the federal requirements for QHPs and Medicaid managed care, state strategies for encouraging participation, and business and strategic considerations.

So we found that about 17 percent of the plans that have either announced their intention to participate or who have been accepted to participate in the exchanges are also in the Medicaid market.

We also found that while there are some differences in the federal regulations surrounding each market, the QHPs and Medicaid managed care, those don't seem to be creating a barrier for plans that want

to be in both markets.

We also found that state variation is obviously, as always, an issue. States that are operating their own exchanges have the ability to customize many of the requirements on the plans that can be a concern for a plan -- for a provider that wants to be in multiple states. We have to look at what each state is doing, and it could differ.

So we have also found that many of the states that are operating their own exchanges have actually taken steps to encourage plans to participate in both markets. But when we look at the 27 states that are having a federally facilitated exchange, we're not seeing as much direct encouragement of plans either to participate -- to participate in both. And so what we really saw is that business and strategic considerations seemed to be one of the most important factors in a plan's decision to either stay out of the exchanges this year or to enter.

The plans that are deciding to stay out for the time being are looking at issues like the administrative burden, the time and investment that would be involved, and with the potential return on investment that they're not sure about.

The plans that are deciding to enter are looking at the ability to maintain enrollees who are going to be churning, to capture family members of people who are already in one of those plans, and to retain people as they move between the two systems.

So as part of our inquiry, we encountered the extensive research that's done by our two guests, Kevin Lucia and Sarah Dash, and their colleagues at the Center on Health Insurance Reforms at the Georgetown University Health Policy Institute. So we've invited them here today to share their insights and

discuss the extensive research that they have done into state exchange design.

Kevin Lucia is a senior research fellow who conducts legal analysis on how states and the federal government regulate private health insurance. He focuses on the implementation of the ACA. He previously led the state market rules compliance team at CCIIO.

Sarah Dash is a research fellow who leads a comprehensive review of state health insurance exchange implementation. She was previously a senior health policy aide to Senator Jay Rockefeller and Congresswoman Rosa DeLauro during the implementation of the ACA.

I'll now turn it over to the guests.

* MR. LUCIA: Thank you. First of all, thank you for inviting us to be here today. We generally spend 90 percent of our time studying private health insurance and have done so for the last 15 years, so --

CHAIR ROWLAND: You might need to pull the microphone a little closer.

MR. LUCIA: Sure.

CHAIR ROWLAND: Thank you.

MR. LUCIA: It's exciting to be here to be talking about Medicaid and this folding over between private and public coverage.

Today's discussion is mostly going to be informed from the work that we're doing on two projects -- one that's being funded by the Commonwealth Foundation, which is a 50-state ACA implementation monitoring project. We're watching what states are doing both to implement the market reforms inside and outside the exchange, and we've written extensive papers on this over the last three years now. And we're also working with the Urban Institute with an RWJ-funded project, which is tracking state implementation

in 11 states, and it really allows us to take a deep dive into those states, often with site visits and informed with discussions with informants in those states about how implementation is taking place.

So at this point, I will just point you to two papers that we have published recently. One is just implementation of the state-based exchanges and all of the different decisions that have been made, the critical decisions that have been made in those states, many of which affect which issuers will participate, and then also a paper that I worked with John Holahan at the Urban Institute on that specifically looked at what state action was influencing issuers in their decision to play in the state-based exchanges.

So at this point, I'll turn it over to Sarah, who is going to kick off the discussion.

* MS. DASH: Great. Thanks, Kevin. Thank you so much, Commissioners, for having me. It's certainly a privilege to be here. I'll just give a quick overview. Veronica did a great job. Basically we're going to talk about some of the key design decisions that state-based exchanges have made so far, focusing on plan participation and market alignment. And I feel like I need to stop here and just say that I've already -- you know, in terms of sort of vocabulary and terminology, when we are talking about market alignment and I think so far when a lot of the states are talking about market alignment, they're kind of talking about aligning the markets inside and outside of the exchange and kind of focusing on the commercial piece. And obviously with the Commission's interest in market alignment between Medicaid and commercial coverage, that's another component there.

Then Kevin is going to talk about some of the early indicators on plan participation and competition, issuer concerns and strategies from the interviews, and then we'll try to talk through some of the considerations for Medicaid and CHIP, which Chris has already covered many of.

This map is pretty familiar, I think, to many by now, but it really shows the patchwork quilt that we have as far as states' decisions on whether to run a state-based exchange, defer the federally facilitated exchange, or take on the plan management functions. And I think the importance of this slide for today's discussion is that the model really matters, that there are some key differences between the state and the federal exchanges, and then in between, where you have 14 states that have chosen to take on -- actually, I'm sorry, 15 -- the plan management functions. Utah is also doing plan management for its individual exchange.

Some of those key differences -- and this is based on, you know, some of our research and also interviews with state officials -- are: Where is the locus of the plan management decisions and the standards for qualified health plans? With the federally facilitated exchanges, even if the state is doing plan management, you still have that CCIIO, you know, the QHP issuer letter setting out the standards. That's really kind of forming the basis. You have your state-based exchanges that have the most flexibility to make plan management decisions and add standards for the qualified health plans that go beyond the federal requirements. The state partnership and marketplace plan management exchanges, again, also have that ability, I think, perhaps somewhat more constrained by politics, depending.

Coordination is also a critical issue, and coordination both within a state, between the state Medicaid agency, the exchange, the Department of Insurance. There's been a lot of activity certainly in the states in terms of that kind of coordination. But when you go to the federal exchange model, obviously there's that additional layer that needs to happen. And I guess I would add here as well the fact that if you're a Medicaid managed care plan, you now are dealing with not only the Medicaid agency but also potentially the exchange

and the DOI. So there's that added layer for the Medicaid plans.

IT, I'm not going to pretend to be an IT expert, but those who are can certainly come up with some of the real details here, but, you know, that's going to be a really important area as well. And then certainly outreach enrollment, consumer assistance, making sure people are not falling through the cracks, that they're getting into the right plans, as some of the Commissioners have already pointed out.

So in our latest study, we looked at just the state-based exchanges and tried to take the many, many design decisions that they have within the context of the Affordable Care Act and put them into some of these buckets that we felt are important to policymaking. And I'm going to talk about just a couple of these here, mainly the competitive marketplace and what we call the meaningful consumer choice piece.

This slide provides some more detail on a little bit more of what were the domains that we looked at within each of these categories.

And just to kind of quickly give an idea of where the exchanges were in terms of structure, because, you know, as some of the Commissioners have already pointed out, the administrative details are going to really matter. Most of the states established their exchange as what they call a quasi-governmental entity, a private or an independent entity with governmental functions. Most are overseen by governing boards, but others, mainly the ones that are established within a state agency, are relying on advisory boards. So there's more room for transparency and stakeholder involvement within the state-based exchanges.

Financing mechanisms, most of the states are assessing individual small group insurers offering through the exchange. And then the IT piece, the ones that have a state-based exchange, are capitalizing on the federal funding to create a more integrated system, and I think that, again, as I said, offers more

opportunities for coordination.

So just to go to the measures to encourage insurer participation, states have taken quite a range of approaches. Some states have proactively decided that they need to create some requirements to get insurers to participate, so one of those is to create a single marketplace or closing the non-exchange market. D.C. and Vermont are requiring eventually that all individual and small-group plans be sold through the exchange.

Two states, Massachusetts and Maryland, are requiring insurers to participate in the exchange or to bid to participate in the exchange. That's Massachusetts.

Five states have set waiting periods or lockout periods for insurers. If they didn't participate this year, they would have to wait until in some cases 2016 to participate again.

California didn't have a specific waiting period or lockout period, but kind of informally wasn't really planning on bringing on any new issuers in the next year.

And then, in addition, a couple states have a waiting period if a plan withdraws from the exchange.

On the more informal side, what a lot of states told us is that they felt that they could encourage plan participation basically by placing as few regulatory requirements or restrictions on the plans as possible. Informal negotiations and discussions are certainly taking place behind the scenes all the time. And while we didn't see very much formal action to encourage specifically Medicaid plan participation, some of those could include easing some of the legal and regulatory requirements. Obviously the market signals, the big elephant in the room--you know, is Medicaid going to be expanded, are there going to be affordability programs and things like that--also important to the plans.

So the market alignment strategies we looked at -- and, again, this is the market alignment between the inside and outside market. But it, I think, points to some of the ways that you could get to some of the market alignment issues with the Medicaid plans.

The states are really looking to reduce adverse selection at this point and better choices for consumers and competition. So some of those include requiring insurers to offer certain types of plans inside and outside of the exchange. For example, in California, the issuers have to fairly and affirmatively market the plans inside of the exchange. They also have to offer them outside of the exchange. Or, conversely, for example, in New York, if a plan is offering what they call an out-of-network product, so a plan with out-of-network benefits outside the exchange, it also has to be offered inside the exchange for that same county and market or individual exchange. So, again, to try to avoid that adverse selection problem.

Eight states and D.C. have required insurers to offer coverage levels beyond the silver and gold that's required by the ACA. And then, you know, in general, wherever there's an issue of rules being different potentially inside and outside, you know, I think the states are being pretty mindful of that, and network adequacy is a good example of that.

This just shows graphically where the states have required additional coverage levels beyond the silver and gold. I'll just note that we'll get a little bit into the bridge plans, but in California's bridge plan legislation, they actually exempt the issuers that would offer a bridge plan from this requirement to offer at every coverage level.

And, you know, the point here is really that the exchanges can use their plan management capacity

to provide more affordable, attractive options to consumers, including potentially Medicaid beneficiaries.

So I just want to focus a little bit on the network adequacy piece since this is certainly going to be critical to beneficiaries keeping their same provider networks as they potentially churn between Medicaid and the exchanges.

As far as 2014 -- and we focused, I should say, more on whether there was a level playing field as opposed to what was really in the network adequacy standards. So I'll just that from the outset. But in 2014, ten states decided to apply the same standard inside and outside, so marketwide. Six states just applied the standard to the qualified health plans. And then two had existing HMO standards that they chose to apply to their qualified health plans, but then those will also still apply to the HMOs outside of the exchange as well.

It's an evolving issue for many states, and there I think is an opportunity for better alignment with the Medicaid standards.

So on to what we call meaningful consumer choices. This is an effort to help facilitate consumer choices of plans on the exchange. You have about, you know, a third to half of the state-based exchanges taking some kind of action to shape plan choices on the exchange, so either limiting the number of plans that issuers could offer, requiring them to offer standardized plans, applying a meaningful difference standard, and just here I want to point out, on the standardized plan piece, I think that's particularly an area that may be interesting to the Commissioners as you're looking at benefit alignment between the two programs.

Quality and value was also an important value for the states. Eight states still are planning to display

quality measures in 2014. Ten told us they were developing a state-specific quality rating system. And then, in addition, there's the quality improvement strategy that the exchange plans have to have, and the states had various approaches to that. A lot of them were just requiring the plans to attest that they had a quality improvement strategy. But that could be another potential area of alignment as you're getting beyond some of the eligibility enrollment and sort of coverage issues as far as, you know, aligning the quality metrics. So it's definitely an emerging, though. I think a lot of states felt like quality is something they like to continue focusing on as they have more time and get this up and running.

We talked a little bit about the affordability wrap-around pieces, so I won't really belabor this other than to say Vermont is also using state funds to further subsidize premiums. New York, they have their Family Health Plus plan, so those individuals are transitioning into the exchange. And the bridge plan -- California passed bridge plan legislation. They're waiting for HHS approval to go forward. But when we asked states about this, a lot of them really didn't have any concrete plan. They really felt that just dealing with the Medicaid plan participation, getting those in was sort of the first step and that this is an issue going forward. And the same with things like the basic health plan, obviously, because there are no regs on that.

And so I'm going to now turn it over to Kevin to talk about his deeper dive into the smaller number of states.

MR. LUCIA: Thanks. So we went out to six states under the RWJ project, and to really understand what the states were doing, to encourage participation and foster competition. I would just say that this took place early in the spring when I think the exchanges were really interested in, you know, getting ready to turn the lights on. So it was a complicated series of questions when I think maybe their focus might have

been in different places. But there's certainly some lessons to be learned.

Some of the key observations that we made is basically states were very nervous about putting up too many barriers for all issuers, commercials, and any other new entrants, and so they were not necessarily setting a bar across the states, and I think you'll see that from Sarah's work in the discussion. And, also, the key areas of flexibility that we heard directly from the issuers were the service area requirements and network adequacy. There was great concern about going beyond the federal standard or going beyond the state standard. And I would just say, you know, to be honest with you, most states on the commercial side, they don't have rigorous network adequacy standards. And so to the extent that exchanges were starting to contemplate going beyond those, I think it raised flags for many commercial carriers, and as a result, we saw that backing down.

And, generally, states were referring to the standard review process that was taking place prior to the ACA, and actually which continued under the ACA, but there wasn't, except for a few states, this idea that rates were actually being negotiated. Most of them just deferred back to their typical state rate review process.

So, generally, what we heard was, you know, the dominant insurers were playing because they couldn't afford not to join the exchange. And as we know, there's a lot of exceptions to that. There are a number of large carriers that aren't playing, but I think for the most part, if you're maintaining a decent market share in the individual market, in most states the larger carriers are participating in the exchange.

Medicaid plans, we consistently heard that they were concerned about churn, that they were able to -- they were interested in helping this population that they were already involved in, and that there was

potential profit to be made.

Again, just piggybacking off what Sarah said about bridge plans, it just seemed like there wasn't a lot -- that they weren't necessarily appealing, and if you're going to jump into the market, then it seemed like why not jump in completely.

Certainly all issuers that we talked to were really concerned -- except, actually, the Medicaid plans -- were concerned about -- or were unaware, or at least they were telling us, of the health risk of the enrollees for that expansion population.

So, generally, states, at least in the spring, and I think, you know, they're still going through -- it's hard to believe, but we're still finding out we don't know exactly who's playing in these exchanges. But states expect, you know, a robust number of issuers to participate, many commercials. In the states that we went out, at least one Medicaid plan in each of those states is playing. Some of them, for example, New York, will have many.

And then also -- and you're probably aware of this -- there will be -- I think in 28 or 24 states there will be co-ops that will be entering into the market. Many of the co-ops have to -- as new entrants are going to be, you know, renting networks, but -- so they'll look a lot -- I think their networks at least will look a lot like their commercial partners. But, yeah, and at least these states will have new entrants.

On the competition side, I think states expect the markets to be fairly competitive, and for this competition to improve over time, as issuers become more familiar with the risk mitigation programs, the federal risk mitigation programs. So what we wanted to know after that, since you have benefits and cost sharing largely standardized, how are they going to compete on price? And consistently we heard issuers are

going to be looking towards their networks. Medicaid plans, you know, may have the advantage here, and at least the few that we talked to were talking about slightly broadening their networks to appeal to a larger population, that they want to expand beyond their traditional population. And as I mentioned before, co-ops have lots of flexibility and generally are renting their networks from their commercial partners, but their commercial partners are narrowing those networks possibly, at least for some of the plans offered through the exchange.

So this was a much more complicated piece of our paper, but we found that, you know, for the Medicaid plans to be competitive, it really would -- well, one, it changes from region even within a state, so upstate New York, a smaller number of hospital systems, the larger Medicaid plans are already expanded up there. If you're downstate, a larger number of hospital systems, possibly more competition. But certainly also the provider market share, for example, in Rhode Island, there's only two major hospital systems, so I think the commercials and the Medicaid plans are both competing for the same piece of the pie there, and it's going to be hard negotiations.

And then, of course, existing contract arrangements that are in place, you know, will Medicaid plans be able to maintain their rates that they have with providers, or are those providers going to push back and ask for higher rates? And at least, you know, when we were doing this study, we were hearing that the Medicaid plans were going to, of course, try to maintain their provider networks, but already providers were pushing back and felt like, look, if you're going to be selling a commercial product in the exchange, then maybe we should be getting paid a little bit more money.

I think this has been out in the news. You know, it's interesting. Premiums are coming in at levels

that I think we are calling reasonable, and -- except, you know -- and Sarah and I have been talking a lot about this. It's reasonable except if you're coming off of Medicaid, and suddenly you're getting hit with a $280 premium, and you're also facing cost sharing that you hadn't faced before. And it's not necessarily a small amount of cost sharing. It can be significant. And so it's something to watch.

I would say, you know, I tried to go back and figure out like in what state will the second lowest cost silver plan be a Medicaid plan. But as you know, the second lowest cost silver plan is going to change from county to county, service area to service area. So it was beyond my talents, at least for the last week. However, I think this is something that we all need to figure out, like what role are Medicaid plans playing in being the lowest cost silver plan -- or second lowest cost silver plan, and also how are they shaping or influencing the pricing in those states.

I'm going to hand it back to Sarah for the big picture, and I'll offer a couple of thoughts at the end.

MS. DASH: Thank you. So, you know, everyone likes the 1.0, 2.0. I don't know if you like it, but --

MR. LUCIA: I like it.

MS. DASH: That's what we're calling it. So as we look, you know, not only to this year but to next year, because -- I'm sorry. This wasn't on. What are some of the big-picture items to look at? And so one is going to be certainly are states going to modify their exchange model at all in 2015 or are they going to take on new functions or, you know, are state politics going to, you know, even perhaps make them let go of some of the exchange functions, and sort of how is that whole model going to change the Medicaid expansion clearly, and then how are states going to handle those Medicaid transitions. So I forget which number that was on Chris' slides, but the issue of states moving some of these populations to exchange

coverage. I think those will be some big-picture items.

And then more specifically, how are states and the federal government going to promote continuity of both coverage and of care? And I think there are a number of levers here, and one certainly, again, is the plan participation strategies. You know, really not that many states at the end of the day did anything too formal to encourage plans to participate, and that was just on the commercial side. And then the same with the federal exchange as well. Will more states adopt affordability initiatives? Then certainly, as Commissioner Rosenbaum was saying, you know, what are the details there? How is that going to work? And is it going to just be premiums, cost sharing, et cetera? How will the standards be aligned in terms of networks, benefits, cost sharing, you know, and quality as well? Will the qualified health plan standards for the states include any kind of requirements for continuity of care? I know Deborah Bachrach has written about this, and others, but, you know, the plans -- I'm sorry. The states and the federal government, they have the ability to set additional standards for the qualified health plans. So will they require that, you know, someone coming in from a different plan is going to let someone get their prescription filled until the end of the month or, you know, those kinds of things to make sure that plans of care are continued.

And then the role of outreach enrollment, eligibility, and consumer assistance. You know, I didn't talk about that much here, but that's another critical area, especially when you look at the pretty big disparity in resources between the state-based exchanges and then the state partner exchanges that did take on consumer assistance functions. And then the rest of the states, where the federal government is using what resources it can to do the navigator and in-person assistance programs.

So, with that, maybe I'll just leave this slide up and welcome any questions or discussion, I think.

Kevin, I don't know if you had anything to add.

MR. LUCIA: Just, I think it is important to understand, you know, to really figure out what plans participated, why they didn't, why they did participate and what were the factors.

And then, actually, I mean, many Medicaid plans didn't participate. Why not? You know, what were the factors that drove that decision?

I do think we need to better understand the network adequacy on the commercial side, state to state.

I think that you can look at the statutes and the laws and think that you have a picture of that, and then you realize, well, that might not actually be happening on the ground within the state. And so we need to have a better kind of understanding about what the game is in each state on network adequacy and how that evaluation is taking place.

And then just to -- you know, the last discussion ended with how readily available will data be. I would suggest that it's going to be difficult to -- it may be more difficult than we think to actually collect all the data that we need in regards to certainly on enrollments.

And I think we have a lot to learn on what the state-based exchanges are going to release, first of all, and then also what the Feds are going to release in the upcoming months. So that might influence the way that you think about how you want track this stuff.

CHAIR ROWLAND: Thank you.

Patty, Sarah, Trish, Judy.

COMMISSIONER GABOW: I have three technical questions that I probably should know the answer to, but I don't.

How are failures to pay premiums being handled in terms of continuity of care, and what are the implications about that, and is every state doing that differently?

The second is -- I'm sorry to ask this question because I should know it, but -- are the risk-based capital requirements that are generally by the insurance commissioners going to be the same for these subsidized premium plans?

And sort of a similar thing -- what's the reinsurance part of this? How is that going to work?

I think those are all important in terms of the sustainability of plans, but I don't -- somebody, I'm sure, knows the answer to those questions, but I don't.

MS. DASH: Very good questions, I agree. I think all are really important, and this is one where there are probably others who are much more expert at those questions than certainly I am.

The failure to pay premiums -- there's a grace period there, but eventually, someone -- I believe it's a 90-day grace period, but someone could end up not getting coverage and losing their coverage.

The risk-based capital --

COMMISSIONER GABOW: But on that premium piece --

MS. DASH: Yeah.

COMMISSIONER GABOW: -- with a 90-day grace period -- so say you're a person who needs major cardiac surgery in that 90-day grace period, who's holding the tab for that?

MR. LUCIA: That's a great question.

MS. DASH: Yeah, that's a really -- I think that -- and again, I think there are others who have looked into this more closely from the consumer side.

But someone could end up -- at least in terms of like repaying the premium tax credit, there are certainly some major implications for that.

If they are getting care during that 90-day grace period, you know, who's paying for their actual care?

They should be covered, but there are implications as far as the premium tax credit, and they may have to then repay a bigger piece of that.

So I think to what Commissioner Rosenbaum was mentioning, though, as far as the bronze plan and people kind of picking up a bronze plan because it has a cheaper premium because they think that's more what they can afford, that's going to be -- that's a really important implication for this population because they're not necessarily thinking about the cost-sharing, or they don't even necessarily know that they don't get the cost-sharing assistance unless they're in the silver plan.

And so they could lose out on that cost-sharing assistance if they pick the bronze plan even though their so-called liability for their premium is capped at a percent of income, but they would still wind up paying a lower premium if they're in the bronze plan. So those affordability programs, I think, are pretty critical.

You asked about the risk-based capital for the premium wraparound?

COMMISSIONER GABOW: The plans that are in the subsidized premium group, who are participating in that, in the exchange, do they have the same risk-based capital?

You said most of the states are using the same criteria. But is that being the same, and how does that interact with the reinsurance pool that was created for this plan, which I'm confused about?

MS. DASH: In terms of the state requirements for licensure solvency, the plans all have to meet

those kinds of state requirements. And it doesn't matter if it's an exchange plan or not an exchange plan; they still would have to meet all those requirements.

MR. LUCIA: Yeah, I mean, we are not aware of any state that did not ask the Medicaid plans to come up with the commercial license, but -- you know, New York, for example, didn't require them to get a new license, but they still had to meet the same solvency standards.

COMMISSIONER ROSENBAUM: This is one of these issues that makes my head explode.

So I realize that everybody on both sides -- the exchange side and the Medicaid side -- has been living in a foxhole for basically a couple of years.

I mean, you know, who can worry about anything sort of elegant-like, whether people will have continuity of care, when they're trying to do what they need to do to just get their requirements up and running?

Much of what you presented -- and it was great information -- is really about the market dynamics between exchanges and the world outside the exchanges. So, obviously, what we're really concerned about is this market dynamic between two sponsors -- between the exchanges and the Medicaid program.

And I'm wondering whether in your larger survey work and in your specific state travels you had any advice for the Commission on states that look like they may be closer to being ready to having Medicaid officials and exchange officials and even some insurance regulators popping their heads out of foxholes and say we ought to talk because this is one of these issues that's not -- I mean, we're going to have to figure out -- and the Commission staff has started to do some really good background work, but -- and those people on the Commission, those commissioners who are themselves health care executives, will have more feel for

this.

But, if you were trying to figure out where people were maybe closer to having these kinds of fundamental but more nuanced discussions, where would you be looking?

MR. LUCIA: Well, I would say, first of all, on most of the boards they do have ex officio, you know, folks. So they often have some -- they have Medicaid representatives, right.

But Oregon is probably a state that you want to start with, which was already well ahead of the game, I think, in regards to implementing the whole idea of an exchange, but they -- you know, even recently they started figuring out how they could align their Medicaid. I mean their network adequacy standards between both Medicaid, the commercial carriers and then their mix of plans.

So I think it's, you know, like that's a state that I see as like they're taking one piece of these market reforms and trying to figure out like how do we get a standard that works for all. But I would say they're ahead of the game, and they're just starting.

And then I would also just -- you know, I think everybody here is aware of what happened in Washington, right?

You had a number of -- well, first of all, Washington State is one of the few states that we've come across that has real -- they take network adequacies very, very seriously -- the whole department of insurance -- and they have for years.

And so you saw this issue of plan new entrants coming into the commercial markets and really bumping up against this higher standard, which their commercial carriers are ready for.

And so, ultimately, I don't know exactly if every Medicaid plan that applied got in, but I think that

certainly will prompt a discussion in that state about how to align at least that market reform.

MS. DASH: If I can maybe add -- I mean, I think this goes back to that whole, you know, the model matters.

In our conversation with the states, just the ACA in general has sort of forced these conversations between the different agencies in a way that, you know, in a lot of states had never happened.

And certainly Washington State is where they -- some of it just has to do with the philosophy, obviously, of the officials who are involved. But they call that the critical interdependencies between the different programs.

In some it's just -- it's almost like personality or personnel-specific, where you have the exchange director who used to work at the DOI, who also used to work at Medicaid, and so you have kind of three in one there.

But I think, again, the challenges between -- for the federally facilitated exchanges, I think, are much more significant, yeah.

COMMISSIONER ROSENBAUM: [off microphone.] [Inaudible.]

MS. DASH: Right, where -- or maybe they thought about it, but as one official told us is not on the East Coast, but -- you know. So I'm a Medicaid director. I'm going to be talking to the Feds and trying to coordinate when, you know, instead of kind of going across town or down the hall, or that kind of thing.

MR. LUCIA: Yeah, you know, one of the major findings of the early RWJ state work was really this kind of interagency collaboration where -- you know, I was in Rhode Island, and you had the commissioner of insurance and the director of Medicaid sitting down in a way that they even described as never happening

before in the history of Rhode Island to create their new IT system.

So I think on your state-based exchanges you're going to see this new kind of frontier of collaboration between the agencies.

But I would agree; in the FFE states -- I mean, we haven't had the chance to kind of explore that, but I doubt it's there.

CHAIR ROWLAND: Okay, I have Trish, Judy, Sharon, David and Mark and Richard.

COMMISSIONER RILEY: This issue of the Federal exchange with its less reach in the state is enormously important and challenging, and I hope somebody will give you a grant to do that work too.

But I just had a quick question for Sarah on, I thought, the chart. The graphic on the exchange coverage level requirements was interesting, but it raised a question that I don't -- that I need to ask, which is so in some nonexpansion states there's been the suggestion that people below poverty could afford a catastrophic plan. Whether or not that's true, it's a suggestion.

But all these states aren't offering catastrophic plans. Where did they -- how do they get offered?

MS. DASH: Yeah, that's a great question, and I should have mentioned this at the outset -- that this only really covers what's actually required on the exchange.

Certainly, that doesn't mean that's the only thing that's going to be offered, but it's the minimum requirement from the state -- that the issuer offer coverage at, at least, those levels.

So, in other words, you could have a state where they didn't require it, but they're still going to have every coverage level.

But, right -- I mean, conceivably, there could be states that don't have the catastrophic offered on

the exchange. The issuers are only required to offer silver and gold.

MR. LUCIA: Yeah, I think it's unlikely, though, that there will not be catastrophic plans being offered and available in every state, and also bronze plans too. A number of states actually take the steps to require that platinum be offered. And I think I was surprised actually by the number of states that required bronze plans to be offered because that seems like a no-brainer for issuers.

COMMISSIONER RILEY: But there's a provision, isn't there, in the ACA that if you can't afford coverage -- the 9.5 trigger. You can buy a catastrophic plan?

So there's no assumption that a catastrophic plan must be offered?

MR. LUCIA: That's a good question.

I think every state-based exchange will have a catastrophic plan being offered.

COMMISSIONER RILEY: But what about the Federal?

That will be interesting. I'm not an advocate of that, but I think it's an interesting question.

MR. LUCIA: Right. MS. DASH: It's a good question.

COMMISSIONER MOORE: I want to step back a little bit because one of the things we've talked a lot about in MACPAC is kind of an overall philosophic, big-picture, best-of-all-possible-worlds scenario where there would be more standardization and less complexity and more simplification across Medicaid.

And what I hear and what I see and the little I know about all of this -- it strikes me that there is huge complexity and variation with regard to exchanges and that we're building another silo in many, many states that will in 30 or 40 years be just as crazy as Medicaid is.

And I guess I'm asking, does that make sense?

I mean, is that not what we're looking at here -- is the development of yet another way to provide health financing that will not necessarily be coordinated, will not necessarily be very transparent or consistent across states?

MS. DASH: Um --

COMMISSIONER MOORE: That's really negative. I'm sorry.

MS. DASH: Yeah, Commissioner, I would agree.

You know, I showed the patchwork quilt, and that was just for exchange models, and that doesn't count all the variations in Medicaid expansion and then certainly, as we've seen just with the state-based exchanges, quite a bit of variability.

I mean, even -- and we'll be coming out with a paper on sort of more of the consumer choices with a little more details on the standardization of plans and things like that.

But you have some states that require 3 standardized plans and some that have 17 different standardized plans. So it really is quite a bit of variation and variability, yeah. And then, obviously, when you had Medicaid into that, it's even more so.

MR. LUCIA: Yeah, you know -- and I would also say when you look at the state-based exchanges -- I mean, there's a balance at least in this first year of making sure that there's choice, right?

So, in D.C., for example, where they are unifying the market, they're talking up that there will be over 300 plans that are offered to people who enroll through the exchange.

So I think the states struggle with this balance between standardization and offerings -- you know, making sure that there are enough offerings.

And I think we -- again, this is why data are going to be important, to understand exactly how people experience this level of choice within the first couple of years and then for states to make the important decision about do they want to somehow use some of the tools that they have available in regards to meaningful difference and standardization and limiting the number of plans. And I think that's to come.

COMMISSIONER MOORE: And just a quick -- given that, where do you see opportunities, maybe particularly between Medicaid and the exchange world, if you will, to forge more simplicity, standardization, transparency, continuity of care, et cetera -- the kinds of things I think the Commission would be -- I mean, if you -- and you might want to think about this and get back to the staff, but I think it would be useful for us to be thinking where we'd like to see this come out that would address some of those principles that I think we have shared in the Commission, at a frustrating level obviously, but in the past, with regard to Medicaid and now would think about with the exchanges.

MS. DASH: Thanks, and we'd certainly be happy to think through this more and get back to the staff.

I think one area to consider is the fact that, again, the Federal Government will be putting out that QHP issuer letter for all the issuers participating in the Federally facilitated marketplace. And so even though 14 of the states, again, are doing the plan management and can make variations on that, I mean, that's the basis.

So as far as when you're thinking about those levers, I mean, that's one where CMS, when they're talking about Medicare Parts C and D, they've put some of those requirements in for the C and D plans in terms of meaningful difference or encouraging them to drop plans with low enrollment or duplicative plans

or things like that. So that's certainly one area.

And it's timely as well because the last QHP issuer letter came out in April of last year. So that's one that's kind of upcoming.

And then the other thing I would say about that is the state-based exchanges -- you know, I think they look to that as well. They're not really operating in a vacuum. So they make take what the Feds decide to do for the Federal marketplace, and they may just apply those standards whole-cloth, or they may change or tweak it a little bit.

But that, I would say, is one big area as well as the Federal Government has -- even though every state Medicaid plan is different, they have more of the ability to do that kind of analysis where they can and make some of the changes.

MR. LUCIA: Yeah, and I would just add; back to the whole transparency, especially on the data side, it's coming up with those data points that matter, that can tell the story in the early years and really encouraging both the Federal Government and also the states to collect and publically release this data.

I think the Feds have done, actually, a decent job on MLR and rate review numbers and made that accessible, and that's been helpful for researchers out there. But I think they have some powerful tools in the ACA, specifically 2715(a) which gives them broad authority to collect basically any data that they want, and this is carried over to the states that are enforcing the Public Health Service Act and certainly state-based exchanges.

So having a uniform way to collect data that's useful, to tell the story -- the exact story that you were talking about -- and doing that early in the first couple of years, I think, would be a powerful addition to this

discussion.

CHAIR ROWLAND: It could be an area where the Commission might choose to weigh in.

All right, Sharon, then David, Mark and Richard.

COMMISSIONER CARTE: In our state, we recently had -- we had two carriers in the individual market, and one of them withdrew. So we now have one.

They went down just like that.

We now have the one. I imagine that's not really uncommon for small, rural states, but I wonder after 2014 what you see are the opportunities to do something better there for consumers. Would there be an opportunity for regional markets?

MR. LUCIA: What state is that?

COMMISSIONER CARTE: Would there be -- do you see Medicaid bridge plans as the strong possibility, or might we not even see basic health plans starting to emerge, which haven't been talked about much?

MS. DASH: I can speak to the regional piece of it. I think that was one where a lot of states -- they just weren't there in terms of the option, which they had to do like a regional exchange.

I think you'll see some states, including West Virginia, which is looking at potentially partnering with other states in terms of some of the back-end functions, potentially consumer assistance, things like that. But I don't know that that's going to be something in the immediate future, especially given all the complexity and state-by-state variability.

The entry of the co-ops and the Medicaid plans into the exchange, I think, maybe Kevin can speak

to.

We haven't even talked about multistate plans in this discussion at all. Obviously, that will remain to be seen -- which states get one of those and how that piece plays out as well.

MR. LUCIA: Right. I think multistate plans is -- you know, it could be the underdog in this story, right?

At least during -- in our paper, we were hearing from states already that they were going to have a multistate plan, and I think it's pretty well known that it will probably be one of the Blues.

But, you know, there's potential for OPM to really recruit other issuers to participate in the multistate program and to reach into some states. So that's something to watch and maybe encourage.

And then on the co-op side, I keep thinking that if any of these co-ops are successful then they will be looking for other opportunities in regional states.

For example, we had one. There's a co-op that started in Maryland, and I think there's certain interest in having that co-op also look toward the D.C. market in future years. So that might be something.

VICE CHAIR SUNDWALL: Well, thank you, I think, for this presentation. It is so sobering to really hear this layout of the complexity.

I will just say ditto to what Judy said. I have the same misgivings about this whole policy move.

However, having said that, it's what we have. And so I think MACPAC and you and others who are doing research on this have a very, very serious responsibility to track how it unfolds.

I need a clarification on something. I'm just perplexed by this concept that states are doing supplemental funding already to build -- they're giving more public money to beneficiaries of these

supplemental plans.

I don't understand how -- what do you call it? The New York Family Health --

MS. DASH: Oh, Family Health.

VICE CHAIR SUNDWALL: -- Plus Plan and some of these others. What are they trying to achieve?

I mean, we already have increased eligibility. We're giving more Federal money. What is the purpose of this? Are they wraparound plans?

MS. DASH: Sure. Thank you.

So the issue here was that this was for states. So, in Vermont, they had the Catamount Health and pretty generous kind of insurance affordability programs for people going up to 300 percent of poverty; in New York, this program for individuals going up to 150 percent.

And then -- so it's not that they're already providing it, but the plan is for them to basically provide additional assistance so that as people move from those programs into the exchange, that they analyze sort of the differential between the premiums -- or if people are even paying premiums now -- that they're paying now and what they would be paying and wanted to --

VICE CHAIR SUNDWALL: So they have the same level of coverage they had previously.

MS. DASH: Exactly. The idea is to hold them harmless --

VICE CHAIR SUNDWALL: Okay.

MS. DASH: -- or make sure that people don't choose not to enroll --

VICE CHAIR SUNDWALL: I see.

MS. DASH: -- or are able to enroll and that affordability isn't a barrier.

And it's really, again, just in a few states.

I think a few other states might have considered something like that, but clearly, since the state budget is involved and they had to pass -- you know, it has to go through their budget process.

VICE CHAIR SUNDWALL: Right.

MS. DASH: I think in Vermont it's somewhere around $10 million that they're spending on this.

VICE CHAIR SUNDWALL: My last question or comment is you just at the very end mentioned navigators. I think that's an important thing to look at, as to their impact or influence or effectiveness. This is a brand new thing. I know that they're, I guess, in every state.

But I would just, I guess, make the comment that I'm not sure it merits MACPAC study, but we really ought to know if this new kind of helper-outer is going to make a difference in expanding coverage or getting people covered that didn't have it.

MS. DASH: Thank you.

COMMISSIONER HOYT: I think the average health plan is probably interested in growing its market share -- the number of people they cover in a state -- and improving their risk profile.

One of the things that we discussed around outreach and navigation and educational things -- I think the plans would feel have sort of an internal bias towards reaching the people who are higher risk. If I'm at a health plan, I want to know how are you going to drive people who are better risk out into the exchange.

Do we know much about how the mandate per se is going to be enforced, state by state?

There are so many different touch points where you could check -- when you file your taxes, try to get a driver's license, register a car, a marriage certificate. You know, you can list off a bunch of things.

How does it vary state to state? Do we know that?

MR. LUCIA: Yeah, Mark, thank you for that question.

No, we haven't really followed that, state to state.

MS. DASH: If I could add, I think that in the background that you all had there were some interesting points about marketing.

And I'm not the expert on this, but in general, there aren't that many restrictions in terms of marketing of the Qualified Health Plans.

And with everything else that the state departments of insurance have to do, I don't think there's going to be a whole lot of oversight of what the marketing efforts are for those commercial plans. So that's a potential area to look at as well.

And I guess if I could just add on the navigator piece, I think whether or not it's a MACPAC issue -- you know, certainly that would be in your court.

But I think it's interesting that you have some states like Minnesota, for example, that drew on an existing Medicaid sort of consumer assistance program to build its in-person assistance program. So one question, as people look at those programs, is what experience did they have before with the Medicaid population, and things like that, from state to state.

MR. LUCIA: Yeah, and I would just add it's probably -- you may already be aware of this, but a number of the states that are not setting up their own exchanges have passed legislation that places a

number of barriers that go beyond Federal law on their navigators. And so in a few of these states I think that it will be hard to judge the success of the navigator program in part because there is concern on the ground level about what they're allowed to do and what they're not allowed to do.

I don't think this was experienced by the outreach program that we saw during CHIP implementation, and so it's really an interesting dynamic. When CHIP was rolled out, I think that was part of its success, right -- was this ability to be on the ground.

Gosh, I was in Arkansas for a site visit, and the outreach effort in that state was simply amazing. That probably will not be the case in many of these FFE states in part because the funding at the Federal level probably is not as high.

But then also, I think navigators on the ground, because of these new legislative initiatives, are really kind of, at the least, not going to be able to do -- I mean, at the most, not going to be able to do their job and, at the least, are going to be nervous about what they can do.

COMMISSIONER HOYT: I had one other question I wanted to ask that I forgot. Do we know how many states have thought about doing competitive bidding to get on the exchange?

You mentioned a large number of plans in some places.

I used to work for a consulting firm, and I know that everybody hates to lose and there's a lot of hassle involved in competing for this and jumping through all those hoops. But when they win they really want to win, and they also hate sharing.

MR. LUCIA: Sarah will answer this question, but I'll just start it. One thing is whatever rates come in -- you know, are you talking about on rating or just participating?

COMMISSIONER HOYT: [Off microphone.] Participation in the exchange itself, that somehow -

MR. LUCIA: Oh, okay.

COMMISSIONER HOYT: Participation in the exchange itself. We don't need 45 plans to cover this geographic area, but whatever that is. Eight or ten would be sufficient if they met these criteria. So we're going to have -- we're going to set up a scoring criteria, you know, to evaluate proposals, and then we're going to pick the eight or ten best plans, however the State or exchange board defined that.

MS. DASH: We did look at that and that kind of plays into the question of, you know, which States are more active purchasers or clearinghouse States, and we used the term "selective contractor." It's kind of hard to put States into boxes, but really, only four States. We looked at sort of what we called three categories.

One was just the clearinghouse, how many States just accepted any plan that met the criteria, and that was seven States and D.C.

And then the next sort of level up, we used the term "market organizer." So, that was plans that -- I'm sorry, States that tried to sort of shape what the offerings to the exchange might be, but without necessarily adding sort of an extra layer or review. So that is things like saying, you know, the insurer can only offer five plans per coverage level, per service area, and we call those market organizers, and that was six States.

And then only four States really took a more proactive approach and added that additional layer of review, so that even if they met all of the criteria, that there were some additional sort of State-specific criteria that they would look at when they were evaluating the plans. It wouldn't necessarily accept every

plan on the exchange.

I know of one State that -- I don't know of any that sort of did that based on the number of plans per service area or something like that, but, you know, for example, in New York, they had the requirement of offering the catastrophic plan, but if they felt like there were enough catastrophic plans in an area, then they could maybe go back to the issuers and tell them, you know, we don't need this plan or that plan.

But that's -- it gets pretty murky when you try to put them in boxes and they don't like to be put in boxes, but we tried to the extent we could for this year.

COMMISSIONER CHAMBERS: Thank you. I'd like to compliment Staff and Sarah and Kevin. Great reports.

A couple comments and then a question, and I'll start by saying as a little disclaimer, because I'm head of Molina Healthcare in California, which is one of the participants in the California plan, and just the last discussion about how the State did it. California originally was a much more proactive, selective State. There originally in the solicitation were 33 plans that had put in requests to either serve the entire State or parts of the State of California, and through the process, selection process, ended up with 13 of those 33 being selected to cover the State of California.

The thing is, I think they -- in the applicants, as far as who they ended up selecting, of the 13, seven of the 13 today participate in the Medicaid program in California. So it really was trying to push for having a balance of larger plans, like a Kaiser or Anthem Blue Cross, Statewide or large commercial players that have Medicaid. And five of the seven plans that today do Medicaid that are going to be in the exchange, five of the seven are exclusively Medicaid. So this is a first. Like, our plan is the first, really, foray into

commercial business.

But it was a decision, I think, as you talked about, is plans, Medicaid plans' decision on whether to jump into -- especially in States where there was more of a selective process as opposed to just an any willing provider could get in, is what you talked about, all the administrative challenges. California required all the plans to do, you know, meet essentially, as the business expansion requirements that are in any kind of commercial product.

But a lot of the plans, at least in California, were distracted with other things going on, Medicaid expansion, which they had a plan for. In California, the dual eligibles demonstration, many of the Medicaid plans were involved in that. So it was a lot of things happening in January 2014 in which they decided not to go forward.

But there were other things, too. It was jumping into new business lines. It was taking on additional risk. It was, you know, and they were looking for, is there a possibility that there would be a bridge plan or basic health plan, and you mentioned that in this. There was State legislation passed in which California was supposed to be implementing sometime next year is a bridge plan, but they're still working through all of that and what it's going to mean. You know, the State and the plans themselves are not sure, even if a basic -- or, excuse me, the bridge plan actually does happen, is whether they want to jump into the bridge plan, because you have to jump through all of the same requirements to actually do it.

So, as that went on, I think there's the issues of, you know, why. For us, it was the obvious things about trying to protect membership and churn, getting parents of children. But it's the focus on serving low-income communities in which the Medicaid plans have the experience, the cultural competency, have

the networks. Our network essentially is our Medicaid network, and we targeted through the bid process, is to try to produce a cost-effective product, because we were concerned is what's going to be the take-up rate, particularly in the low-income communities, of having a cost-effective product, be able to do it.

In doing that, we also had, as Mark said, is looking at, you know, is trying to blend the risk across multiple plans of being able to do that. So I think there's different motivations on why folks did it. But I think you've captured, and I hope you'll continue to do it, because it has been one of my personal things of raising with this Commission, is making sure that there's opportunities for Medicaid plans to participate, because I think there's going to be, as time goes on, a requirement as to be able to have that as a mix in what's going on.

Just, after all that rambling, was more comments than really any kinds of questions.

One thing, just quickly, is you mentioned about the whole issue about quality ratings in the plans. There's been a struggle in California is trying to figure out for 2014 what to do. So the exchange board has been struggling as to whether they should use existing ratings, you know, for plans, and certainly puts Medicaid plans to real disadvantages because of the kinds of rating systems, or lack of rating systems, that there are.

So, have you seen this across other States? I'm just curious as to where that's going and certainly would appreciate staff also following that, because we think that's a big challenge going forward.

MS. DASH: Yeah. I think on the quality side, there are a lot of really important challenges. I mean, one is just the data challenges, where you have a whole bunch of basically plans that haven't existed before that are going to be offered on the exchanges and then how do you kind of rate the quality. So, I mean, in

large part, you're kind of talking about rating or displaying quality metrics, like HEDIS or CAHPS, from the closest possible match that's currently offered. And so, yes, that would put sort of new entrants at a disadvantage. I think how the Federal sort of national quality strategy plays out, that's also going to be really important.

I mean, the thing we definitely heard is an enthusiasm among a lot of States for doing this and for not sort of waiting on the Federal Government to come out with the quality rating system or those kinds of things and not to wait until 2016 to display the quality metrics. But there are a lot of data challenges. There's a definitely numbers challenge as far as what's the enrollment in each plan even going to be and then how do you measure the quality.

So, that's just on the commercial side. And then, obviously, the point, I guess, I was trying to make is that, you know, you have the Medicaid adult quality measure piece and so how does that whole thing align. So if you have a diabetic going back and forth, is their doctor literally reporting on different things for the same person? And I think there's a really, really long way to go.

And then, in addition, you build in the accreditation piece, as well. That also gets really complex. So, I think it's a real emerging area and one for certainly a lot of thought.

The quality improvement strategy, I just want to mention again, because as was reading the background material, if Medicaid plans have to come up with a quality improvement strategy and, again, the QHPs also have to come up with a quality improvement strategy, that might be an area that's a little bit more flexible and offers a little bit more, perhaps, of an immediate opportunity. and I would leave it up to the people who are more well versed in quality than I am to sort of speak to that. But in a lot of the States,

they're just requiring the States to attest that they have a quality improvement strategy and not really asking them to go any further than that. Maybe they're requiring, like, a written narrative of what the quality improvement strategy is. So there could be an opportunity there for States to do a little bit more of an alignment between whatever they're requiring of the Medicaid plans and the qualified health plans.

MR. LUCIA: Yeah, and I would say I think a number of States are really -- you know, they took a somewhat -- a step back this year and they're monitoring what happens in their own exchange and what other States are doing. So, I would agree with Sarah. There's a lot of opportunity to education in this first year in the hopes that States may put in place, you know, measures that really do align better.

COMMISSIONER CHAMBERS: Because I know the exchanges would like -- I know the exchanges would like to give consumers information to make choices, so it's not just a blind, I'll pick it by name or reputation. But, it seems like it makes sense in the long term is to measure apples to apples is, like, for exchange populations is to measure the quality and be able to rate plans equally across that. So, I mean, that's just sort of soap box talking --

MR. LUCIA: No, it's also just -- I mean, it's measures that consumers -- well, let's face it. There's going to be an outside market and it's going to be you, and so consumers -- I mean, it's going to be one of the factors that drive people to the exchanges is having access to this information about how good this plan is performing for them, that they won't have access on the outside market. So I think State-based exchanges and certainly the Feds have to get this right.

CHAIR ROWLAND: Yeah. We're coming to the end of our time, so I have still Denise and Norma who had questions.

COMMISSIONER HENNING: This isn't so much a question, but we were talking about navigators, and, of course, I'm from Florida. Our Governor won't let the navigators in the health departments, which is kind of the obvious place where you would want to sign people up, because that would be the people that would be falling off of Medicaid and would be eligible for exchange coverage.

So the good news is that I work in an FQHC and we see that as an opportunity to grow our business. So we already have Medicaid workers on-site, so what we're going to do is get them more versed in signing people up for exchange coverage so that we can be a one-stop shop when it comes to insurance brokerage-type things. So that's helpful.

There are also using librarians in the State of Florida to help people, because so many low-income people that don't have their own computer access at home use library internet services. So they're using librarians to help navigate that.

And also, the Democratic organizations, the Obama for America folks are actually organizing to get out to low-income communities to help navigate and get people signed up for the exchange. So it actually might end up backfiring on the people that don't want the people to sign up for exchanges because they'll have more contact with them between now and the next election cycle.

CHAIR ROWLAND: We'll go to the State of Texas.

[Laughter.]

COMMISSIONER MARTINEZ ROGERS: [Off microphone.] I am from the State of Texas and I actually met with about 40 social workers that worked for Medicaid and CHIP [inaudible] not about this but about other things, and they brought the issue of [inaudible] not knowing what was going to happen

because there is no communication between the social workers and Medicaid, though they know that they exist, or are going to exist. It's just kind of a comment and food for thought [inaudible] is that in Texas, because it's such a large State, to get from point A to point B could be 100 miles in between [inaudible].

My mic is dead. I'll move closer. Thank you. Oh, it was really dead.

[Laughter.]

COMMISSIONER MARTINEZ ROGERS: And so I guess my concern is that even though my Commissioner friend over here, Denise, is talking about the librarians, using the librarians, there are no libraries in some of these areas, and I actually went out to a couple of the very rural communities to check out what the library had and they had one computer and it was one of those that had the big box at the end, so it's quite outdated.

I'm concerned how we're going to -- for the consumer. I'm concerned about the consumer not having enough knowledge to make wise decisions for what they need to do, because at the end of the day, it really is about the consumer. We can talk about all these other things administratively and management-wise, but at the end of the day, what is the quality of care the consumer is going to get based on what it is that they need?

MS. DASH: If I could offer a quick thought. I know you all have lunch, so I don't want to hold you up, but perhaps just one other piece as we're talking about helping consumers making the right choices and apples to apples. Quality is going to be an important piece, but I think first is almost getting over the hurdle of having people understand the differences between their benefits and their cost sharing.

There are some new tools in the Affordable Care Act on the commercial side. The plans have to

offer the Summary of Benefits and Coverage, which is the standardized format. So there -- but the Medicaid plans don't have to offer that.

And also, when you're talking about this population, I think that there is more that could be done in terms of language access and making sure that that's offered in different languages. So not to belabor it, and maybe that's something we can share with the staff later, but just another thing to keep in mind.

CHAIR ROWLAND: Well, this is clearly an area where there's a lot of interest and it's very important to try and figure out how to align these incentives and to make sure that the churning, which is a great concern of this Commission, be minimized and that people really can get the kind of continuous care.

I want to thank our two guests for coming to be with us today, and we'll be drawing on them in the future. But I especially also want to thank Veronica and Lois Simon, who isn't here because she's on jury duty -- and it's a grand jury for six weeks -- five weeks -- so that otherwise Lois would be with us -- for the excellent piece that you've pulled together, which I think raises great issues about not only the State exchanges, but the additional complexity when we get into the Federally facilitated exchanges and the rules there. So I think this is clearly an area where the Commission will continue to probe and, hopefully, be able to come up with some guidance as to how some of these areas can be better managed and integration facilitated.

But I thank you for, really, a very stimulating and informative discussion and we look forward to continuing to work with the staff as well as with our guests on these issues. Thank you.

So, we'll adjourn until 1:30.

[Whereupon, at 12:39 a.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION [1:38 p.m.]

CHAIR ROWLAND: Okay. If we could please reconvene. We are going to turn now to looking at one of the complex issues in the Medicaid program, which is the non-federal financing and supplemental payments and the role that these play in trying to figure out what the actual payment levels are in the states. So we're asking Jim Teisl to provide us with some background on this discussion, and I'll open it up to Jim.

Session 5: NON-FEDERAL FINANCING AND MEDICAID

* MR. TEISL: Thank you very much, and hello to everyone.

So first I wanted to start out with a little bit of a review of what the Commission said back in our March 2012 report when we covered these issues in some depth. Here on the slide are some of the conclusions that we drew, which is that health care-related taxes and supplemental payments make it very difficult to compare payments or to conduct payment analysis in the Medicaid program.

The net payments are effectively reduced by the amount of financing that providers contribute. The lump sum supplemental payments can't necessarily be tied to individual services or enrollees, and the effect of health care-related taxes and supplemental payments on net Medicaid payments can't be discerned from the Medicaid claims data that we get, such as through MSIS.

Some of the reasons we might want to know more about the factors that contribute to net payment include some of the things that are in our charge: understanding the effects of payment on access to and utilization of services, studying the effects of policies and the incentives that they create, and then to allow us to sort of benchmark and compare across states, across providers, even across payers.

UPL supplemental payments -- and you'll recall that supplemental payments fall into both DSH and

payments made to fill in what we call the upper payment limit, or UPL. UPL supplemental payments are a big part of payment in the Medicaid program, particularly to hospitals. CMS 64 data from fiscal year 2012 show that they account for more than 20 percent of total fee-for-service Medicaid payments to hospitals, though, of course, we see a huge range among states. Some report no UPL supplemental payments while in others they account for about half of the total amount of fee-for-service Medicaid payments to hospitals.

In the nursing home world, UPL payments are a lot less common, though we are seeing in recent years in a couple of states that they can account for about 20 percent of total Medicaid payment.

And just as a reminder and sort of a routine plug for our MACStats, these results can be seen on a state-by-state basis in Table 20 of our March report.

As for health care-related taxes, you'll all recall that these are statutorily authorized taxes on health care providers that are commonly used by states to finance the non-federal share of their Medicaid programs. At this point, as of fiscal year 2013, according to Kaiser survey data, every state but Alaska has at least one health care-related tax. Most have more than one, and these taxes are most commonly assessed on hospitals and nursing facilities.

So the previous work that we did and what we presented in our report in March 2012 was largely illustrative. What we wanted to see if we could do was use some actual state-specific real state data to demonstrate the effect of both health care-related taxes and supplemental payments on the net payment amount that providers were actually getting from the Medicaid program.

It's important to remember that the goal was to see if we could determine the effects of these things on net payments. We were not trying to conduct a payment assessment or any sort of payment adequacy

analysis. We are merely trying to see if we could demonstrate what would happen if we sort of backed out taxes or added in supplemental payments.

We requested data in a common format. Our ability to get it in a common format was actually pretty challenging. So this took a lot of time and effort. We worked with five states who agreed to participate anonymously because, again, you know, we assured them our objective wasn't sort of to point out payment levels in their state compared to anyone else. We asked them to participate based on factors including their use of these things as well as the size of the state. We tried to get diversity in terms of the geographic region.

I do want to emphasize that our scope was limited to five states, and we picked them because they had these things that we wanted to study. So clearly these results aren't necessarily generalizable to every single state, but we think they fairly represent the sort of things we would expect to see if we could collect these data nationally.

And I should also mention that we worked with a consulting company that's experienced in these things, Burns & Associates, to help us both collect and analyze the data.

We conducted interviews with Medicaid leadership in each of the states to better understand each of their individual payment and financing methodologies, and then again we asked that they provide provider-specific payment and financing data, including claims data, supplemental payments, and then the non-federal share that providers contributed not only through health care-related taxes but to the extent they used other things, like intragovernmental transfers and certified public expenditures, we asked for those data as well. Then we tried to use these data to determine net payments as well as to estimate what the net payment-to-

cost ratios would be in these states.

Of the five states that participated, we were ultimately able to get usable data from four of them in the sort of time period that we've been doing this. There are a lot of limitations to the data, which, you know, we realized going in was going to be the case. There are inconsistencies between claims and cost reporting time periods. The claims data that we used are for Medicaid payment. The cost reports that we had to use were for the Medicare program. We aren't necessarily able to standardize payments for case mix, which may vary across the states, and we can't adjust the payments for underlying characteristics like differences in eligibility levels, the extent to which they use managed care, the extent to which they control utilization one way or another, all of these sorts of things.

So some of the things that we found, first of all, the base payment methodologies that the five states used, four used DRG-based systems, though I should mention the extent to which they used DRGs was different in each of the four states. One paid based on a per diem methodology. We thought that was fairly reflective of what we think we see nationally. In the outpatient hospital arena, we saw a mix of cost-based, fee schedules, some use of ambulatory care groups, and I should mention we saw that mix even within individual states. They would use four or five different methodologies, depending on the types of providers and things like that.

Nursing facilities was a little bit more consistent. All five use -- they pay per diem with case mix adjustment, which we suspect is pretty common nationally, though, again, there were big differences in the way that states actually set their payment levels, differences in the ceilings that they apply to each of their cost centers, the costs that apply to each individual cost center, whether they have some sort of settlement

process, how they pay for capital. So sort of the takeaway point here is even though the base payment methodology may look the same between two states, there are a lot of underlying details that actually result in some pretty significant differences.

Four of the five states reported making significant supplemental payments to hospitals, and only one actually makes significant supplemental payments to nursing facilities. Again, sort of similar to the CMS 64 data we looked at, you know, not unexpected, I guess. And I should mention once again we actually asked these states to participate because they largely use a lot of these things.

Four of the five used health care-related taxes. The other didn't, though, interestingly, used a larger amount of intragovernmental transfers as part of their non-federal share. And nursing facilities, all five had health care-related taxes.

For this and the next slide, I just want to point out that we are still working through some of these numbers, so sort of what we found is preliminary. But we don't expect sort of the high-level findings to change; that is, you know, we think we were able to demonstrate the effect of these things, and while we're still working through some of the finer details in the numbers themselves, we still think we were able to demonstrate that these things mattered.

Among the states that make significant non-DSH supplemental payments, they accounted for between about a third to more than half of the fee-for-service payments that states made. As I mentioned, only one state makes supplemental payments to nursing facilities.

So comparing claims-based total payments, by which I means claims-based plus supplemental payments, and net Medicaid payments, by which I mean the total minus any provider-contributed non-

federal share, we saw, not surprisingly, a lot of differences. For hospitals, again, supplemental payments were an important component of total payments in three of the four states for which we had data. As I mentioned previously, these supplemental payments accounted for about a third to a half of the payments that went to the hospitals. So looking at that another way, claims payments reflected anywhere from half of what the providers actually received in Medicaid payment to 99 percent in the one state that barely made any supplemental payments.

For nursing facilities, in three of the four states the claims were the total payment. But in the one that made supplemental payments, the claims were closer to like 90 percent of the total payment.

When we backed out taxes and IGTs and certified public expenditures, it resulted in net hospitals payments that were in the realm of 60 to 90 percent of the total payments that we saw.

So the bottom line here -- and I know I'm sort of throwing all kinds of numbers and different factors at you. The bottom line is when we looked at just claims, we saw a different picture from when we added in supplemental payments. And when we backed out taxes, we saw a different picture from using just claims or the total payment. And it's important to keep in mind, as we've said before, that the data for supplemental payments and for the non-federal share through taxes isn't something that we commonly have at the federal level and was a huge amount of time and effort for us and for our contractor and for the states who very generously contributed their time to help us understand these.

I'm going to hammer this point home over and over. Supplemental payments and health care-related taxes are, in fact, important components of net payments to hospitals and nursing facilities. The data related to the supplemental payments, as I just said, aren't routinely available at the federal level. I would

remind everybody that there is now a requirement for states to demonstrate their compliance with upper payment limits on an annual basis. Part of demonstrating that compliance will include reporting supplemental payment data. It remains to be seen sort of, first, whether we can readily access that data and then how easy it will be to tie those data to what we see through the claims payments.

I should also mention that after accounting for both supplemental payments and health care-related taxes, the net payments that we calculated, we still think we're seeing pretty big differences among the states in the net payment amounts. So whether we use claims or total or net, the amount of payment -- we did per unduplicated recipient -- varies quite a bit. And it's clear, again, based on these case studies, claims data alone don't provide a complete picture and likely aren't sufficient to do a good job of Medicaid payment analysis, at least among those providers where supplemental payments and health care-related taxes are an important part.

We feel like what we've done raises some policy questions, and some of these are familiar to you because they're similar to what we raised back in March 2012, and that is, you know, we still don't necessarily know why states choose specific payment and financing approaches and what effect these choices have on their providers, on the enrollees, on the states themselves.

We also sort of posit the question: What do policymakers need to know to assess Medicaid payments, to conduct Medicaid payment analysis, to oversee the Medicaid program? And then what's the balance between state flexibility and achieving their payment objectives, but then assuring accountability for the federal level?

With that, I open it to discussion.

CHAIR ROWLAND: Jim, why don't you put the previous slide back up?

MR. TEISL: Sure.

COMMISSIONER CHAMBERS: Jim, good work. This is a really tough issue, and I think it's been -- for some of us who have worked at the federal level in previous lives, it's something that has always been a challenge of just getting, you know, appropriate data from states to understand expenditures in programs like this. I think as you say in the policy questions, we have a lot of work to do, and I think you're highlighting the right questions to at least get to a common data set so we can look at it and understand more clearly, because, you know, payment has such a big impact on access, and it would be great to understand, you know, what are states' objectives in the use of supplemental programs and paying providers? It's significant on the hospital side, as you said, the range of -- when you back out supplemental payments and taxes, how much is that component of that?

So I think you're on the right path, and I think the Commission needs to continue to look at the information if we can -- even if we get to recommendations of having better information so that both CMS and the Commission can analyze that, I think is on the right path.

COMMISSIONER ROSENBAUM: Your work in the area is great, and these issues are obviously so fundamental to the program. I still feel -- this came up for me back when we were doing the early work that led to the March 2012 report. I still feel that we are conflating two issues, and we have to figure out as the Commission how to talk about them differently. And here you give us a glimpse of a point at which the issues may meet up, but it's by no means the -- it's by no means inevitable that they're going to meet up here. What we don't want to do is leave Congress with the idea that somehow it's a totally closed world.

So, on the one hand, there is the question of where states derive the revenues from that they need to run their Medicaid programs, and from the very beginning of the program, it was understood that a minor -- meaning less than 50 percent -- a minor portion of the money was to come actually from the state at all, and furthermore, the statute said nothing about whether that would be general revenue or specialized taxes, you know, maybe it would come from property taxes, come from the sale tax, whatever. And so I think that putting the provider taxes into the broader picture of where states derive their financing from is always very important in these discussions. We've done this before, and I think we need to keep doing it.

Then there is the question of how Medicaid programs pay providers, and I think in some ways this is -- you know, it's an issue that's sort of reached a strange point in the life of the program, because in so many states now it's really not the Medicaid program itself often that makes a lot of the decisions. It's the managed care system that a provider may be part of. So it's more complicated than just states paying providers.

There are points at which those two inquiries meet up. But I think that it's better for us to disentangle the two inquiries in our reports to Congress so that they see if the provider tax base forms some percentage of a provider payment, that that tax base nonetheless goes way beyond potentially the provider payment.

And so I think as you continue the work in this area and as we continue to work in this area so that we do not leave anybody with the idea that there is -- I will say it -- a quid pro quo going on here, when that's not what we have. What we have is questions about how Medicaid is financed, and we have questions about how Medicaid pays its providers. And I think unless we are extremely careful, we will create a wrong

impression about how states raise their Medicaid funds and how they invest then in health care systems, in eligibility, in benefits. And it's going to be a real struggle for us to get there, but I think it is in some ways the most important issue we're going to deal with, the financial base for Medicaid

COMMISSIONER HENNING: Well, I'm not sure, following Sara, whether I really want to suggest what I was going to suggest, but what I was going to ask for was kind of a flow chart, you know, idea when this is all put together, just because I'm kind of a visual person anyway, and, you know, I was thinking taxes on providers plus the state contribution, and then matched by the Feds, and then it would come down back to the state and then go back out to the providers. But what you're saying is that's not really the case. So maybe my flow chart needs to be axed before we even start it.

COMMISSIONER ROSENBAUM: There were times when it was that way, and those issues have been dealt out in the statute. I mean, they were dealt with in the 1990s. But I think now it's a much more complex, nuanced picture, and I'm not sure, other than discussing generally, how any state, you know, generates the revenues it needs to run the Medicaid program. I mean, at heart what's going on here is that the burden of Medicaid on states is very high, and so they can't ask for it all from a general income tax. Many states don't even have an income tax to raise the money from. So, you know, whether the deepest, deepest policy issue is that the federal contribution to Medicaid should be adjusted I think is a question for us to grapple with, but that's not -- you know, I think we're a long way from that.

COMMISSIONER MOORE: Jim, this is really an amazing paper. You and I talked about it earlier this morning. It's beautifully done given all of your constraints. And I think it actually will be useful as a background document, regardless of where else we go with it, and particularly with some of the emphasis

that other Commissioners have already mentioned.

One of the things that I'd like to see stressed or maybe in an opening section -- and it is here, but I'd like to see it more explicitly stated -- is the idiosyncratic nature of each state's situation which has grown up over many, many year and which in many cases has responded to political situations and what was going on with regard to waivers and other kinds of individual state problems, because I think that sets the context for the complexity that's important, and we've done a little bit of this before, and here. But I just want to sort of emphasize this.

And then, again, in 2012, we talked about the need for more transparency and better data that's comparable across states. And I guess I'm not sure where we go from those very general views, but I think that's where we need to go over probably a period of years.

COMMISSIONER RILEY: I, too, think this is really difficult and important work, but I think, to Sara's point, it's not how the money is generated but how it's spent, and what it seems to me the headline of this work may be when we get further along may be that the widely held belief that Medicaid programs profoundly underfund hospital care may be incorrect, and that the cost shift that has been going on and believed to be going on may be incorrect. And that's very important to make sure we get this right. But it seems to me there's enough in Jim's work to suggest that we're on to something terribly important, as long as we stay focused on the payment strategies.

And to that end, I don't know if this is a real question, but I wonder if there's a difference in hospitals that have significantly engaged in the purchase of physician practices and owning physician practices versus those that don't. I don't know if that would change the payment structure, but it's also a

good question in terms of how hospitals then pay their provider networks and the physician practices they own. But I think this is really extraordinarily significant work that we ought to take carefully, and the notion of the need for better -- this is one place where the need for better data couldn't be more significant.

COMMISSIONER COHEN: I echo the compliments, Jim, on your work. Sort of along the lines of what Trish was saying, I wondered if there wasn't -- besides sort of getting to what I think you would sort of characterize as the gold standard of sort of knowing what every provider, what every hospital in the nation is actually receiving from Medicaid on a service-by-service basis, which Medicare has the benefit of, and MedPAC has the benefit of; on the other hand, we also have a single -- in that program, sort of a single payer from the federal government, which we don't have here, and we can't make sort of payment recommendations in the same kind of way that MedPAC does for Medicare. So I think we need to be very -- you know, think very carefully about what do we need how much data for.

I did wonder if there was more value in separating out both the categories of supplemental payments -- I mean, they're not all the same. DSH has a specific purpose, which federal regulations are making more specific. UPL is very different. And I think what we do want to understand is why they're used rather than, you know, other kinds of payment methodologies that are more transparent, and maybe understand -- maybe we can look at things, besides knowing what each hospital is paid hospital by hospital, look at different categories. So one great suggestion from Trish is to look at differences between hospitals that own their physician practices or not. Is that what you said?

I'm also really interested in the question of where public hospitals sort of make a difference in the use of this. Obviously public hospitals is one area where the point that Sara raised comes up a lot. Public

hospitals are frequently largely financed by a locality, either a county or a city or something else. So IGTs are used all the time, maybe not -- and DSH and UPL I think are frequently used heavily. My guess would be if you look around the table, people wouldn't see that as sort of inappropriate or a scheme. But we would want to understand how big a portion of these kind of mechanisms are really driven by that, just a historical county-based public hospital serving the most underserved and getting potentially a disproportionate -- as compared to sort of, you know, their market share of all patients, a disproportionate amount of supplemental payments.

COMMISSIONER CHECKETT: Well, again, very interesting work, well done, complicated. And I actually have to say I think Sara's comments really caused me to think, because it is an important distinction, is that we need to make sure we don't mix, you know, what is the right or wrong amount to be paying the provider with how the money with which we were paying them was raised. And I think we as a Commission and in our reports, we need to really separate those issues, because, on the one hand, you know, I think there is that juxtaposition, Jim, when you're saying, you know, and because of this mixing we can't necessarily easily tell how much a hospital is receiving. But I actually know that in the end the state could tell you that. I mean, they really do know, and it probably just requires more digging on the part of MACPAC, and we have to ask, you know, do we actually need to know that or not? That would be another question.

But I think depending on where we go next with this research, you know, one of the points I've made -- and as someone who's a state Medicaid director who was very involved very early on, you know, doing everything we could with taxes and IGTs and DSH, that it would be interesting to actually see if we

could get some -- perhaps a survey from the states, you know, when you did these different -- made these different decisions, you know, what were the things? Were you using it for an expansion? Were you using it as a general revenue substitute? Were you doing both? Which is, I think, what you're going to hear a lot. And it would just -- I think it could be very interesting to give some historical perspective on the decisionmaking behind the intention of these programs, too.

So very interesting work. Thank you.

COMMISSIONER HOYT: I'd like to suggest you just say a little more on managed care. I think a number of us can probably read between the lines and figure out what some of the issues are, but maybe just what some of the complications are for states that are using managed care contracting and how these two sort of stand side by side or integrate or not.

MR. TEISL: Sure. Well, the first thing I'll say is just sort of a reminder that our goal here was to demonstrate the role that these things play and our ability to analyze payment. So it wasn't necessarily to sort of evaluate the policies themselves so much as to better understand how what we don't know actually affects what a provider receives from the program. But managed care is an important point, and just to remind the Commission, we heard from some folks last year when we were doing some of this work about the challenges that UPL payments -- about the challenges that they've caused when states have looked to expand their managed care programs. And we specifically heard from Billy Millwee, who at the time was the Medicaid director in Texas, and the UPL supplemental payments that the state of Texas was making were sort of so important to the program and to their providers that the only way that they were able to expand managed care in their Medicaid program was to get an 1115 demonstration that would allow them to

preserve UPL supplemental payments while expanding managed care.

The reason they had to do that is because the upper payment limit itself is based on fee-for-service Medicaid days, so managed care days can't be counted toward that upper payment limit. So as you expand managed care, you begin to reduce the number of days that build that UPL and you sort of begin to squeeze down on the amount of room that you have to make supplemental payments.

CHAIR ROWLAND: I think the explanation you just gave would be well served to be in some of our documentation, because I think it really is another piece of the issue of how you transition from one system to the other.

VICE CHAIR SUNDWALL: Well, thanks, Jim. As I told you this morning, this was really one of the highlights of our copious materials. I mean, I didn't read them all, but I did pay attention to this and think it's very helpful.

I have a discomfort with this idea that we're just reporting on this with the idea that we're describing something that the Commission understands is important for running hospitals, but still, the complexity just boggles the mind. I don't understand why these various ways to supplement payments to Medicaid should be required. I guess if there were maybe, as Sara said, a more appropriate payment from the federal level, it wouldn't be. But I also think I'd like to go on record as saying that I don't want us to imply that these things are fine and should continue on and be not evaluated, because -- do any of us -- I mean, I hope some of you share my concern about federal expenditures for health care. We can't just keep going on with more and more. And the idea that the providers of care are determining the amount of money they need, isn't there something a little peculiar about that, the fox guarding the chicken coop a little bit? I mean, it's really -- it

doesn't seem to me to be the right way to go about determining payment for the services under Medicaid.

So I have a lot of misgivings about the supplemental payments, however they're categorized. And I understand why they're done, but I do think we need to also be aware that we can't just keep condoning ever increasing amounts of federal money for health care.

COMMISSIONER GABOW: Well, to sort of respond in part to David, it would be wonderful if we had a completely logical, simple, non-complex health system in America, and I would say "Amen" to that. But I don't think the issue applies simply to supplemental payments.

I hadn't really thought about what Sara said before, but I think that there's a lot of wisdom in that. We should try to separate out what is the -- how the state is financing their Medicaid program is one piece. And why are they doing it the way they're doing it? And how can we have transparency about that and be able to compare apples to apples? I think that's one line.

I think the second line is: How do states decide to pay their providers? And what are the sort of decisions? You know, you have some of them listed, access to certain specialty care, supporting health care systems that might not otherwise be able to make it. So I think making that delineation that Sara raised is a very important one.

The second, I agree with Mark that we really do have to include the managed care piece in there, because it would be interesting to know -- and I'm sure you may know this, Jim -- what's happened to UPL if you take out the waivers as managed care has gone in? And it sort of fits to our waiver chapter. Why do people go to waivers because of this issue? So I think there's a bridge there.

The third thing sort of relates a little bit to Trish, is that as people are trying to develop ACOs and

integrated models of care, there is a movement not just to physician practices but to incorporating federally qualified health centers because they are serving a lot of the primary care needs of this. And once you start to do that, you do have to think about the special payments that are related to that group of providers as well, because they're critically important in constructing the actual Medicaid payment for ambulatory care in the system. So maybe we do not want to tease it out in this report, but I think it's worth mentioning that they have their own supplemental payment in wrap-arounds that are an important piece of the ambulatory payment, which otherwise might not be clear and simple claims data.

But, again, this is very complicated territory, and thank you for trying to help explain it. Good luck.

[Laughter.]

CHAIR ROWLAND: Well, I hope we've given you a little bit of guidance on how to structure our thinking going forward, but I do also think that what the current system means for future transitions as we look at -- we just had that panel on trying to figure out how to have plans that are in the exchange market also be in the Medicaid market, how do we move forward to Medicaid managed care, and what does this all imply, are really important features of what we're tasking you to do, Jim. But it also involves kind of thinking through some of the waiver issues, which is a good transition and bridge to our next panel. But I join my other Commissioners in complimenting you on a chapter that is extremely well done for a highly complex and difficult-to-disentangle issue. So thank you.

MR. TEISL: Thank you.

CHAIR ROWLAND: And in that context, we have, of course, been discussing the role of waivers in the Medicaid program. We've looked at all the various kinds of waivers. We've tried to look at some of

the key issues. And so I'm pleased to have Ben Finder now join us to present some of the staff work on trying to pull together the themes in our analysis of the Medicaid waiver authorities. Welcome, Ben.

Session 6: ANALYSES OF MEDICAID WAIVER AUTHORITIES: EMERGING THEMES

* MR. FINDER: Thank you, Diane. Thank you for the opportunity to speak today. The purpose of today's session is to synthesize some of the work that MACPAC has done on waivers and to home in on some of the themes that have emerged from our conversations and our analyses.

We'll start by reviewing the work to date, and for this, we'll draw on some of the information that we presented at our April 2013 meeting in which MACPAC staff presented background and context information. At that meeting, we also mentioned that we had conducted ten semi-structured interviews with current and former state and federal Medicaid officials and some other Medicaid thought leaders, and this information has informed our analysis of the themes.

We'll also review some of the information that came out of our May 2013 meeting that featured two panels, one that represented federal perspectives and one that represented state perspectives.

I'll describe some of the themes that have emerged from our section 1115 waiver analyses, and some of these themes have brought to light policy questions. The goal of today's presentation is to prompt a discussion of those policy questions and get your feedback on some of the next steps.

This slide is probably a little familiar. It's a crash course in the primary types of Medicaid waivers. Section 1115 waivers are sometimes called demonstration waivers or demonstration projects because waiver authority allows the Secretary to waive Federal requirements for any experimental, pilot, or demonstration

project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of the Medicaid or CHIP program.

As discussed at previous meetings, there's a lot of variation in the comprehensiveness of these waivers. On the one hand, you've got waivers that states use to really wrap their entire Medicaid program, and on the other hand, you've got small discrete waivers that states use to provide a certain set of benefits to certain categories of people.

It's also worth noting that some states operate programs under 1115 waivers, but the program is essentially the same as what the state would provide under State plan authority. For example, a state might use 1115 waiver authority to implement a managed care program that provides the same benefits available under state plan authority.

One of the policy requirements, which we'll discuss later in greater detail, is that 1115 waivers must demonstrate budget neutrality, which basically means that they cannot add to federal expenditures.

Section 1915(b) waivers are often called Freedom of Choice Waivers. They're used to waive enrollee freedom of choice of providers to mandatorily enroll populations in primary care case management or managed care plans. And here, it's worth noting that states also have the authority to do this under state plan, as well, but the state plan authority is limited to certain populations.

And the 1915(c) waivers are often called Home and Community-Based Services Waivers. States may limit home and community-based services to certain populations or target groups. These, just like 1915(b)s, must demonstrate cost neutrality or cost effectiveness, and most states offer more than one 1915(c) waiver.

The Commission will also recall that as further context, our May 2013 meeting featured two panels

representing the Federal and State perspectives. For the Federal perspectives, we had Cindy Mann from CMS and Katherine Iritani from GAO. And for State perspectives, we had Tom Betlack and Valerie Harr from -- Tom Betlack from Arizona, Valerie Harr from New Jersey, and Robin Cooper from the National Association of State Directors of Developmental Disability Services.

And, in addition, I just remind you that we conducted some interviews with current and former State and Federal Medicaid thought leaders and officials, and much of the feedback that we've heard from these interviews and from the panels in May was really focused or concentrated on 1115 waivers. So, for the rest of this presentation, we'll be focusing primarily on 1115 waivers.

So, with that being said, I'd like to shift gears and talk about some of the themes that have emerged from these conversations. They generally fall into three categories. One is the waiver approval and renewal process. The second category is budget neutrality. And the third category was the reporting and evaluation requirements.

Some States and interviewees expressed frustration with the lengthiness of the 1115 waiver approval process. New Section 1115 waiver applications, unlike State plan and Section 1915 waivers, lack some parameters around the timeliness. I think you'll recall that 1915 waivers and State plan authority often features a parameter or a guideline called the 90-day clock in which CMS has to respond to waiver application. Section 1115 waivers generally don't feature this same clock.

It's been noted elsewhere that the lengthiness can be an impediment to program innovation. And the lengthiness really results in uncertainty about the approval and can make it difficult for a State to predict when an application might be approved, which can limit their ability to plan for implementation.

On the other hand, there's a lot at stake in these waivers. The scopes can often be broad, waiving provisions like comparability or freedom of choice, which can affect the coverage that enrollees receive. The broad scope also means drawing on different subject matter experts for their review, and this warrants additional time to allow me CMS to perform due diligence in order to ensure that waivers are used in a way that's likely to promote the goals of Medicaid and CHIP programs without imposing additional Federal costs.

Given these concerns and considerations, the questions that arise is whether changes could be made without compromising the integrity of the process. For example, would providing States with time lines make the process more predictable for States? Could the approval process be bifurcated somehow for comprehensive and discrete waivers? Or could the approval process be expedited for States that are proposing a waiver that is similar to an approved waiver in another State?

Another issue that emerged was that some States report that they would like a mechanism to consolidate multiple waivers more easily. You'll recall that some States are operating multiple waivers and they've reported that this results in increased complexity and additional administrative burden. At our May meeting, Valerie Harr spoke about New Jersey's experience in consolidating nine discrete waivers into one global Section 1115 waiver. She mentioned that this enabled staff to better coordinate certain benefits, like physical and behavioral health services, and that the consolidation allowed New Jersey to streamline reporting requirements. So, before they consolidated, they had nine discrete waivers. They were completing nine different sets of monthly reporting requirements. And after moving into this one global waiver, they now have one monthly global reporting requirement, significantly reducing their administrative burden.

On the other hand, in some of the interviews, some states preferred to administer separate discrete waivers for target populations. They mentioned that this enabled them to better manage their administrative burden and financial liability.

So, this feedback raises the question of whether the waiver approval process should be changed to allow states to more easily consolidate while continuing to meet federal requirements and assurances.

For example, would it be possible for a state to apply to add an additional population to a current 1115 waiver? Other questions include, is the current process actually an impediment? Are there compelling reasons for states to maintain multiple discrete waiver authorities? And what implications might this have for CMS's ability to provide oversight?

Another theme that emerged was that there's not an administrative method for existing waivers to become permanent. There are some states that are operating waivers that they've had for years, and every couple of years, they have to come back and renew, or submit a renewal application for the waiver. For example, Tom Betlack explained that Arizona has been operating their program under a waiver since 1982, and during this time, the waiver has been evaluated several times. In fact, in 1996, an evaluation found that the waiver had saved over $500 million since its inception, and other evaluations had found that consumer satisfaction levels were high. At the same time, Arizona is still required to reapply every couple of years.

So, on the other hand, we have several examples from history of when waiver authority led to changes in statutory authority. Cindy Mann talked about in the 1990s, Medicaid agencies were looking for a method to implement managed care. They were following commercial plans which had already done this, and so they had to use section 1115 waiver authority and section 1915(b) waiver authorities to implement

Medicaid managed care programs.

In response, this authority to implement managed care was added to the Medicaid statute, allowing States to enroll certain populations into managed care plans. Some other examples are alternative benefit plans or benchmark benefits and eligibility for low-income childless adults.

Another development is that the Patient Protection and Affordable Care Act created a new waiver authority known as 1115A, under which certain program innovations can be made permanent. Under 1115A, the Center for Medicare and Medicaid Innovation can test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to enrollees. These are structured a little bit differently than section 1115 waivers. CMMI decides on an initiative it wants to pursue with its funding and then permits states to apply.

So, on the one hand, we have the criticism that there's no administrative method for existing waivers to become permanent, and on the other hand, we have these historical examples and this new example of new waiver authority that's designed to really create a path to permanency for some things.

So, this raises questions like what lessons might be learned from CMMI authority? Should there be a path to permanency? And if a path to permanency were implemented, what requirements would waivers meet?

Another theme that emerged were concerns about the process for calculating budget neutrality, specifically, that that process lacks transparency. You'll recall that under waiver authority, states can receive Federal funds for expenditures that are not typically allowed under statute. These are called Costs Not Otherwise Matchable, or CNOM, which typically are for certain services or certain eligibility categories.

Budget neutrality is intended to ensure the flexibility or authority does not result in increased Federal spending. So budget neutrality, you'll also recall, is not a statutory or regulatory requirement. It's a policy requirement.

And again, the interviewees and States reported concerns to us that the process of calculating budget neutrality lacks transparency. States typically report that specific factors are overlooked, like recent enrollment trends that are State-specific or cost trends that are specific to their State, as well. And GAO has expressed similar concerns about the lack of transparency.

On the other hand, in our May meeting, Cindy Mann noted the complexity inherent to calculating budget neutrality in light of unique and changing State-specific factors.

So, some of the key questions regarding budget neutrality policy is, is it possible to issue guidelines or publish methods to make the budget neutrality process more transparent? Or could budget neutrality be replaced by some other mechanism that would ensure no new Federal spending?

And some of the last themes that emerged were centered around reporting and evaluation requirements. As background, it's worth noting that the Affordable Care Act added additional reporting and evaluation requirements. The final rules were published in February 2012. States are required to submit periodic reports to update CMS on the status of each Section 1115 waiver. These regulations require at least annual reporting, but reporting requirements are often agreed to in the special terms and conditions that States have to agree to during the waiver approval process, and as a result, States are often faced with quarterly reporting requirements.

In addition, States are required to design and conduct an evaluation of each Section 1115 waiver. So

they have to submit an evaluation design plan for CMS's approval that details what hypotheses they're testing, some of the methods they plan to use, or some of the data collection methods that they plan to employ. And upon completion of the waiver, States have to conduct or hire an independent evaluator to conduct an evaluation of the waiver.

One criticism of reporting and evaluation requirements is that the reporting requirements were said to be onerous and misaligned with State needs, and by misaligned, we mean that States reported that they have separate reports that they use to monitor the operation of a waiver, and often the State-used or the State-specific reports don't overlap with the reporting requirements that they're agreeing to in their special terms and conditions.

Another criticism was that the information was poorly disseminated, making it difficult to learn from other States' experiences.

So, some of the key questions that these issues raise is whether or not there's been enough time to see if requirements are meeting their intended goals. Could reporting and evaluation requirements be better aligned with the information States need to operate waivers? And how could waiver evaluation findings and lessons be better disseminated?

So, these were some of the themes that our analyses have sort of generated or raised, and the goal of the session, like I mentioned, was really to raise these questions for your discussion. So I look forward to your feedback and thoughts and any questions you might have.

CHAIR ROWLAND: Mark.

COMMISSIONER HOYT: Sort of linking -- and good job on this. Sort of linking this to, I think,

the next chapter or presentation on the LTSS, I was wondering if we have a loose end we need to wrestle down tied to HCBS. In your presentation, you correctly stated that HCBS waivers, of which I believe there are hundreds, are required to demonstrate cost neutrality, and I think in the LTSS chapter, it says there's no way to do that because of the problems that are highlighted there with the data. There are some pretty strong statements that it's next to impossible to truly prove out the cost effectiveness of HCBS, if I'm remembering that right.

So you've got that unresolved conflict of, well, so which is it, then? Are they cost neutral, or what's going on here? So you guys need to circle the wagons, I think, and --

CHAIR ROWLAND: Figure it out.

COMMISSIONER HOYT: -- figure that out.

CHAIR ROWLAND: Sara and Donna.

COMMISSIONER ROSENBAUM: I wonder whether we might think about -- obviously, we're a long way from formulating recommendations, but in 1115A, in the new demonstration authority, the Secretary actually has the power once she pilots a model and evaluates it and determines that it is meeting its objectives, to take the model to scale, to make it an open model to anybody at that point.

And I wonder whether -- you know, once you see things like 47 states have a home and community-based waiver, you say, there's got to be an easier way to deal with this. And so I wonder whether, similarly, we might not think about -- rather than going piecemeal through the statute and saying, well, this should be an option, that should be an option, that should be an option, to reformulate 1115 itself to give the Secretary similar powers. Once you do, you know, 27 waivers of the same issue, that you would then

formulate a new policy that would give states an option to fall within the range of whatever was demonstrated on a State option basis.

So, looking at 1115A, we might think about ways to deal with 1115, because otherwise, once we unpack all these demonstrations, they probably represent 100 amendments to the Medicaid statute, and the Medicaid statute is already a sufficiently interesting statute so that I'm not sure we want to recommend 100 new amendments. So, therefore, you know, whether we think about an innovation in her demonstration authority similar to what we've done now in 1115A.

CHAIR ROWLAND: Donna.

COMMISSIONER CHECKETT: This is a just incredibly interesting topic to me and, I think, to many others. One thing we need to remember is that despite the problems with waivers, there are many aspects of waivers states love. For one thing, they really let you try ideas out. They let you control and get special services to special populations. Sometimes they give you a way to say no. And so I think we just need to keep that in our minds, and we might even want to, as we work on the paper, write about that, as well. I mean, they are very, very useful tools.

But one area that I would really like us to explore, and it's really following, actually, on what Sara has raised, is that there really needs to be a process for which HHS just says, we don't have to keep demonstrating this anymore. I mean, the Arizona example is, you know, just -- it's really, it's ludicrous. It's just all -- it's enriching consultants who are going to do the analysis for the States to prove this demonstration, which is probably the best run Medicaid program in the country, over and over and over again.

And we need to -- you know, I would love to have the Commission really come forth and say, here's a recommendation. We're just going to stop this. You know, stop the madness, as they say.

[Laughter.]

COMMISSIONER CHECKETT: And, I think, the same thing, too, for some of these HCBS programs. When 46 States have kind of like the same waiver, then there has to be a process to just say, this now becomes a plan amendment, and I think that we could really contribute to just the whole program and its beneficiaries and efficient and economic administration if we made some recommendations along those lines.

But it's really fascinating and, I think, really important. Well done, Ben.

COMMISSIONER GABOW: Again, I would say, well done.

I want to take Sara's observation and ask a broader question. Is it legal for the Secretary to use the new waiver authority that was CMMI from the old demonstrations to say, well, we actually -- we didn't need to do a CMMI on home and community-based services because, as a matter of fact, we have 200 of these data points. So we are going to, under the new waiver authority, say we've already done the pilot, we've already done the work, and now we're going to make this generalizable.

Now, you know, to a logical person, that would be possible. But I think it's important to pose the question. Can you use data from previous demonstrations under the new authority to create it becoming generalizable? I mean, I think that's worth asking the question because it would get around a lot of the things we're talking about.

CHAIR ROWLAND: I think that's a good broad question. I think we have to be a little careful on

home and community-based services because there are all these waivers, but they also did provide a State plan option for home and community-based services and there are reasons that the States have chosen to stay with the waiver authority rather than going to home and community-based services. So I think that kind of a balance has to be reflected here, too, to pick up on Donna's point, if there's some reasons why they'd rather a waiver than a State plan.

COMMISSIONER GABOW: Well, maybe it's not the good example, but I think the principal question --

CHAIR ROWLAND: I think the principle is a different issue.

COMMISSIONER GABOW: [Off microphone.] -- is it worth --

COMMISSIONER RILEY: Actually, my point was your point, and to remember that in a waiver, you can cap your expenditure and I think you can control your spending and put on waiting lists and do things that you can't do in the Medicaid program. So we ought not to be too quick to think States want to move away from that. It's a management tool.

COMMISSIONER COHEN: Following up on this, thanks, Ben, for very good work.

But I do think we're sort of toying around with, I think, some directions to moving towards recommendations, and I, for one, perhaps since my law degree I'm coming back to bite us all, but --

[Laughter.]

COMMISSIONER COHEN: -- you know, I feel like there's a lot we don't know about some things that are feeling intuitively like they are silly, like the fact that Arizona has to reevaluate their waiver every five years, but can -- I mean, we have not yet done an analysis, to my knowledge -- maybe you have, Ben, but I

don't think the Commission has been presented with more detailed information about, well, what does that evaluation look like? Has it really not changed at all in each of those times? And is there any value at all to that evaluation requirement?

I'm inclined to say, likely not, but I don't think that we have done an analysis of the specifics of some of these waivers enough to know that it's just silly to do it every five years when the Arizona program that we know, just to use an example, is the Arizona program that we know and why are we sort of going through this exercise every five years. I think that we need some more detailed analysis of some specific waivers, and they are, to go back to our theme, incredibly complicated, I mean, in many cases, and incredibly specific to the infrastructure that they're sitting on within each State, which is really different.

So, I do feel like we need to get to the next level on a particular area that we want to explore, and I would agree that one that seems intuitively to make a lot of sense is this idea of, over very long periods of time, continuing to have to sort of re-up a waiver and not make it permanent, but I'd really like to know what the potential counters are to that and what the real details are in this sort of evaluation process. I feel like we haven't quite gotten to that level yet and I think we have to get there before we get close to being able to make a recommendation on this. As much as I do think there may be some low-hanging fruit, I feel like we have to prove it.

CHAIR ROWLAND: Okay. Well, Ben, I think you've given us a very good piece of work here. I think it has some nice balance. I think adding in some of the points that were raised today, especially with regard to sort of the reasons why States do use waivers and like waivers over their State plan amendments and what, as Trish points out, what they can do with them, and then just a few of the historical examples of

the way that a waiver did lead to a progression that became a State plan would be helpful. So I thank you very much.

So, now we'll take a break and then we'll reconvene to get into an area in which waivers have been the way, home and community-based services, and in the interim, I know Molly and Angela are going to be trying to figure out how to answer Mark's question. Thank you.

[Recess.]

CHAIR ROWLAND: Okay. If we could please reconvene.

Somehow, it's always interesting that long-term services and supports often comes after a full day of discussing health insurance coverage, waivers, supplemental payments. But it's not that it's not one of the most important topics and one of the most important pieces of the Medicaid program.

And we've also, of course, been waiting and now have a release of a report from the Long-Term Care Commission and we will be hearing from some of the Commission members at our November meeting. But for today, we wanted to have a real briefing to begin our work on long-term services and supports, and we have a very long chapter here, but I know we're going to get a great presentation of it from Angela and Molly. So, with that, start us in on our discussion of long-term services and supports in Medicaid.

Session 7: MEDICAID LONG-TERM SERVICES AND SUPPORTS

* MS. LELLO: Thank you, and as Diane mentioned, I'm Angela Lello and I and my colleague, Molly McGinn-Shapiro, have prepared a briefing for you today on Medicaid LTSS.

We have included in your binder a background paper that contains detailed information about

Medicaid LTSS policy, and during our presentation today, we will review with you some of the key points from that paper in order to lay an informational foundation for MACPAC's work going forward. We've also included some information in that paper and accompanying appendices about the many complex and nuanced elements of Medicaid LTSS policy, those that influence service use and quality, expenditures, enrollment, and other important aspects of Medicaid long-term services and supports. We realize that this is a lot of information, but our goal today is to cover the basics so that in future meetings you can have focused discussions on some of the major policy themes that we'll highlight for you today at the end of the presentation.

So, to begin with, there are many different definitions of long-term services and supports. The exact definitions of what is considered LTSS is determined by the context for which the services are provided and by the payer. Generally speaking, Medicaid LTSS are those services that help beneficiaries manage chronic conditions, accomplish everyday tasks like bathing, and live independently in the community. LTSS can be provided in an individual's own or family home, in a residence that they share with unrelated people, in community settings, such as job sites or day centers, or in congregate settings where they live and receive care alongside other similarly situated people.

LTSS is used by many different people. It's not just the elderly who need it. About five percent of the U.S. adult population receive LTSS. This includes individuals over the age of 65 with age-acquired functional impairments and working-age adults with disabilities, and about 1.3 million children were disabled enough to qualify for Supplemental Security Income, or SSI, which in most cases enables them to receive Medicaid LTSS.

And as you can see here, Medicaid is the primary payer for LTSS. It counts for more than half of all total LTSS spending in 2011. Other public payers, such as the VA, account for a much smaller percentage of LTSS spending. Private long-term care insurance also accounts for a small portion of LTSS spending, and next to Medicaid, out-of-pocket spending accounts for the second-largest share of spending on LTSS.

Medicare does not by definition pay for long-term care. It pays for a time-limited set of acute and post-acute skilled care services, for example, post-acute stays in nursing facilities or post-acute home health care. For that reason, the total LTSS spending in this figure does not include any Medicare expenditures.

In terms of LTSS eligibility, statute only requires States to serve individuals eligible under SSI-related pathways, meaning that either they're receiving SSI, or in 11 States, they qualify under 209(b). There are several optional eligibility pathways States use to serve beneficiaries who need LTSS but who have incomes above the SSI limit, and those are listed here for you on the slide.

The income and resources limits vary for each of the optional eligibility pathways, and Table 6-2 in Appendix 6 of your materials lists the income and resource limits by the different eligibility pathways for each State. Each of these pathways require an individual to either meet the SSI disability criteria or a State-defined functional eligibility criteria, which is also known as level of care criteria.

Appendix 3 in your materials discusses some of the variations in level of care criteria, the assessment processes, and the protocols, and Table 6-1 in Appendix 6 lists the eligibility criteria by pathway. And as you can see, this varies both by State and by eligibility pathway.

And in 2010, the majority of LTSS users came in under the mandatory SSI pathway. A little over one-third of LTSS users came in under either the special income rule or other pathways, which would

include the 1915(i) Medicaid buy-in and Katie Beckett pathways.

How the various eligibility pathways relate to available LTSS is described in detail in your paper, but in general, a State chooses which services are included in the benefit package that is linked to a given eligibility pathway, and Table 6-1 in Appendix 6 also shows whether or not a State must offer full Medicaid benefits, institutional LTSS, or HCBS waiver benefits under each of the eligibility pathways.

So, for example, in one-third of the States with the medically needy pathway, HCBS is included in the medically needed benefits, and as a result, the majority, or 63 percent of individuals eligible under that pathway use institutional services.

Another example is where many States use the special income rule pathway to provide access, either to HCBS waiver services or institutional LTSS. And, accordingly, almost all, 87 percent of beneficiaries who enter under that pathway receive either of those two services. And this is an example of how LTSS use may not be purely driven by beneficiary need.

As you know, the Medicaid statute includes optional and mandatory services that States include in their State plan, which can also be called full Medicaid benefits, and Appendix 2 lists the mandatory and optional Medicaid LTSS and the ways in which those services vary by State. The only LTSS States are required to provide to adults are nursing facilities and home health services. Statute also requires States to provide all medically necessary services to children under EPSDT, and this could include LTSS. EPSDT would apply to children who receive full Medicaid benefits under any eligibility pathway.

However, even within the mandatory services, there is considerable variation. Specifically, what is included in the home health services benefit. It can include home modifications, durable medical

equipment, or home health aids. Also, the nursing facility level of care criteria and how it's assessed, and what constitutes medical necessity are all determined by the States.

Optional LTSS that a State may include in its full Medicaid State plan are listed here for you. State plan HCBS would include personal assistance services under 1915(i), self-directed personal assistance services under 1915(j), and community-based attendant services under 1915(k). States can also include other services in their State plan so long as it's approved by HHS. Optional LTSS definitions also vary by State and States can determine the amount, duration, and scope of all the benefits available under its State plan.

Another type of optional LTSS are the 1915(c) HCBS waiver services, which are separate from any State plan HCBS. The variation across 1915(c) waiver programs is significant. States can include just about any service within an HCBS waiver so long as it's approved by HHS. Typically, waiver services include in-home support, out-of-home residential services, and any other services needed to help participants remain independent in the community.

In one recent review of less than half of all current 1915(c) waivers, researchers identified around 1,800 separate different service definitions, and Appendix 1 describes the variation in HCBS waiver services and a current effort by CMS to develop a standardized taxonomy of those services.

In addition to the optional financial eligibility pathways, States have other mechanisms by which they can extend Medicaid LTSS to individuals who have higher financial resources that are not adequate to cover all of their LTSS expenses. States have the option to allow LTSS recipients to retain some income, as well. For example, residents of institutional LTSS may retain a personal needs allowance which can be used for things not provided by the facility, such as clothing. For HCBS recipients, they can retain a monthly

maintenance and needs allowance to use for basic necessities, including housing expenses.

As a result of this flexibility, how much income an individual may have in order to qualify for Medicaid LTSS varies within and across States. Appendix 6 lists the different income limits and income protections by States. One of the mechanisms States use in counting income include institutional and spousal impoverishment rules that a State may use under certain optional eligibility pathways to disregard the income of a beneficiary's spouse, or for a child, their parents.

Another of these mechanisms is special needs trusts. Box 1 in the background paper describes some of the special needs trusts that individuals may use in order to obtain Medicaid LTSS while retaining some income or assets. Most of the time, however, income or assets in these trusts must be used to pay for the care of the beneficiary, and in some cases are payable to the State upon the beneficiary's death.

In conjunction with the special income rule and a Miller trust, a State may effectively have no upper income limit for Medicaid LTSS. The medical spend-down requirement of the medically needy pathway also enables higher-income individuals to become eligible for Medicaid LTSS if their expenses are high enough.

Each of these tools are used by States to serve individuals who cannot afford to pay for their long-term service and supports needs but who either earn or have incomes too high to qualify for Medicaid. Federal policies, however, regarding asset transfers and estate recover ensure that wealthy individuals are not able to game the system by either transferring or sheltering assets in order to obtain Medicaid-funded LTSS. These rules also prevent individuals with substantial home equity from obtaining Medicaid, and research has shown that individuals who apply for Medicaid LTSS do not have substantial home equity or assets.

CHAIR ROWLAND: Just for clarification, these rules are not affected by the Affordable Care Act's MAGI income determination.

MS. LELLO: Correct.

* MS. McGINN-SHAPIRO: So, Medicaid enrollees with long-term care needs are quite diverse in their demographic characteristics, the types of services and supports they use, the eligibility pathways in which they come through to obtain Medicaid coverage, the amount of Medicaid spending on their LTSS, as well as the services available to them based on specific State policies. However, collectively, Medicaid enrollees who use LTSS overall use more services and have higher costs than Medicaid non-LTSS users.

In 2010, just over four million Medicaid enrollees, or about six percent of all Medicaid enrollees, used LTSS, accounting for 45 percent of total Medicaid spending. And as you can see from this figure, almost half of these enrollees were Medicaid enrollees aged 65 or over. Forty-two percent were individuals under age 65 who qualified for Medicaid on the basis of a disability. Non-disabled adults and children accounted for nine percent of Medicaid enrollees who used LTSS in 2010. And just to note, this is a group of enrollees who are individuals who qualify for Medicaid and, therefore, are entitled to certain long-term services and supports, but they did not qualify for Medicaid on the basis of an eligibility, and that's why they're separated out.

And as you can see from this figure, the types of long-term services and supports used by Medicaid enrollees differ by population. The share of individuals age 65 and older who used LTSS in 2010 was evenly split, at 47 percent for both those who used only institutional services and those who only used home and community-based services.

COMMISSIONER ROSENBAUM: Can I just stop and ask you one question?

MS. McGINN-SHAPIRO: Sure.

COMMISSIONER ROSENBAUM: On this -- sorry, it's -- I'll wait. I'll hold my question. It's the next table.

MS. McGINN-SHAPIRO: Okay.

UNIDENTIFIED SPEAKER: Did you read ahead of the class?

[Laughter.]

MS. McGINN-SHAPIRO: And just for individuals with disabilities who are under age 65, you can see as compared to the individuals age 65 and older, their primary type of long-term service and supports was in the community-based services rather than institutional-based.

COMMISSIONER ROSENBAUM: I'm sorry. It is this table. I just realized, it is this table, but who are the 376,000 people? Are they people with catastrophic injuries who need some sort of rehabilitation? They're non-disabled people --

MS. McGINN-SHAPIRO: Right, they're --

COMMISSIONER ROSENBAUM: -- so I assume they would be children and adults who've had some sort of, like a car accident or something --

MS. McGINN-SHAPIRO: Right. Yes. I mean, we haven't gone --

COMMISSIONER ROSENBAUM: -- that requires rehab.

MS. McGINN-SHAPIRO: -- too far into who specifically makes up each group, but I would guess that, yes.

COMMISSIONER ROSENBAUM: Okay.

MS. McGINN-SHAPIRO: So they have access to the State plan --

COMMISSIONER ROSENBAUM: Of course.

MS. McGINN-SHAPIRO: -- long-term care.

COMMISSIONER ROSENBAUM: All right.

CHAIR ROWLAND: But these are people who come in through the more traditional eligibility groups.

MS. McGINN-SHAPIRO: Right. Yes.

CHAIR ROWLAND: So, in the future, these people are going to probably come in through the new MAGI income determination system, whereas the people coming in on the basis of their disability would come in --

MS. McGINN-SHAPIRO: Right.

CHAIR ROWLAND: -- under the rules that Angela just went through.

MS. McGINN-SHAPIRO: That's correct.

COMMISSIONER COHEN: Although you could -- I mean, this could be point in time, right, like they could be on their way to a disability determination or something.

CHAIR ROWLAND: Correct.

COMMISSIONER COHEN: I mean, but they would still come in through MAGI and then have to get your disability --

COMMISSIONER HOYT: Can actuaries interrupt, or just lawyers?

[Laughter.]

COMMISSIONER COHEN: Just lawyers, actually.

COMMISSIONER HOYT: Because I had a question that relates to this graph that I asked you before. It's in the tables, too, in the report. Like, I'm looking at Table 4-4 right now, but it appears a bunch of places.

Can you tell me again, what are the -- these are, like, discrete sets, and the fine print up underneath the header, both institutional and non-institutional, and then it's institutional only, and then the two other groups. Who's in those groups again, especially the first two?

MS. McGINN-SHAPIRO: So, 4-4 or 4-dash-4 -- so that's among the spending, I believe, right? So --

COMMISSIONER HOYT: But they're discrete sets, I guess was my point. None of them --

MS. McGINN-SHAPIRO: Right. So we're looking at by the enrollees. They're all Medicaid enrollees. And so, then, the first set, the 4-1, would be their utilization among LTSS types of services. And then the LTSS spending would be for these types of enrollees. And so institutional only users would be people who are only -- in that 2010 would be only in institutions like nursing facilities or ICF/IDs. And then we divided the non-institutional for the community-based types of services, either the ones that come in through the waivers or those that only use State plan HCBS. And then there are some individuals, enrollees, that during that year used institutional and home and community-based services. So, they're in a separate -- is that helpful?

COMMISSIONER GABOW: So, now a doctor gets to ask the question. This is about a diagnosis.

I know we've talked about this many times and I keep getting confused about it. Is there a qualitative or quantitative difference between home and community-based waiver services and home and community-based State plan services, or is it just the mechanism by which they're funded and instituted, because if the services are the same, it's fine to do this from a financial point of view. But if it represents the same core services, it might be worth somehow clarifying that these are not either qualitatively or quantitatively different, if that's true, which it may not be. I may completely misunderstand it.

CHAIR ROWLAND: It now represents which option the States have chosen to use and --

EXECUTIVE DIRECTOR SCHWARTZ: It could be the same --

CHAIR ROWLAND: It could be the same or they could have --

MS. McGINN-SHAPIRO: Different --

CHAIR ROWLAND: -- a slightly different package, depending on how they put it together.

COMMISSIONER GABOW: But it's more about the financing than the care provided, correct? Or no?

EXECUTIVE DIRECTOR SCHWARTZ: The label is strictly determined by the financing mechanism, but it's sort of an overlapping piece. There could be some things that are very similar and there could be some things that are different. You would have to go do another exercise in there to actually look and see the specific items, which, as Angela pointed out, under the waiver was 1,800 different types of things, which there can't be 1,800 actually different things --

CHAIR ROWLAND: What year did the home and community-based services State plan amendment come into effect?

MS. LELLO: Which one? Nineteen-fifteen (I) was --

COMMISSIONER ROSENBAUM: Two-thousand-six.

MS. LELLO: With the Deficit Reduction Act. And then 1915(k), which is the Community First Choice Act, was included in part of ACA.

CHAIR ROWLAND: ACA.

MS. LELLO: And I do not recall when 1915(j) was introduced, but we can get that for you.

CHAIR ROWLAND: But, so what we're seeing here is a progression from waiver only as the way you could get these services --

MS. LELLO: Absolutely.

CHAIR ROWLAND: -- to new options under the State plan as, what, as recently as 2006 was when they really --

MS. LELLO: Yes, but I would also point out that other optional services that are considered home and community-based services, such as just personal care services, were, in effect, before 1915(i). Nineteen-fifteen (I) is a different set of -- so other of the optional services have been in existence longer.

CHAIR ROWLAND: And home health.

MS. LELLO: And home -- yes.

MS. McGINN-SHAPIRO: Can I move on? And I just wanted to move on from -- as you can see, a group of --

[Off microphone comments.]

MS. McGINN-SHAPIRO: Right. Exactly. So, a group of Medicaid enrollees that have a particular

interest to Congress and the Commission are the dual eligibles. Over two-thirds of the Medicaid beneficiaries both under and over age 65 who used LTSS in 2010 were dually eligible for Medicaid and Medicare. About three-quarters of dual eligibles who used long-term services in 2010 were age 65 or over, and 29 percent were under age 65. And just to note, almost all of the dual eligibles who used Medicaid long-term services and supports were individuals who qualified for full Medicaid benefits in their State, which also includes LTSS, and so we generally refer to them as full benefit dual eligibles.

So, when taking a closer look at the Medicaid spending for long-term services and supports, we find there are a couple different distinctions by population and types of services. Medicaid spent $123 billion on long-term services and supports in 2010. The majority of this spending was for institutional care, at 56 percent, and home and community-based services accounted for 44 percent of Medicaid long-term services and supports spending.

Although there are fewer total LTSS users with disabilities under age 65 than those age 65 or over, they accounted for the same share of Medicaid long-term services and supports spending, around 49 percent. The majority of the long-term services and supports spending for individuals with disabilities under age 65 was for adults rather than children with disabilities.

Non-disabled children and adults under age 65 accounted for two percent of the Medicaid spending on long-term services and supports in 2010.

When looking among the individuals age 65 and older, almost 70 percent of the Medicaid LTSS spending for this population was for institutional services, totaling over $43 billion in 2010. On the other hand, for individuals with disabilities under age 65, the majority of the LTSS spending was for non-

institutional services, which was around $37 billion total in 2010.

So, when looking at the share of Medicaid LTSS spending for home and community-based services, for example, across States, you can see that it varies substantially. And just to keep in mind when looking at this map, the LTSS spending amounts displayed are for fee-for-service payments and, therefore, some States with managed long-term service and support programs, like, for example, Arizona, could possibly reflect lower percentages of LTSS here if their payments are reported as capitated payments instead.

So, this variation in spending across the States can exist for several reasons, including the types and amounts of benefits that a State chooses to cover, the enrollee case mix in a State, and the State policies regarding provider payments and care management, which can all impact State variation in service spending. And when compared to other types of Medicaid benefits, you know, for example, physicians or prescription drugs, Medicaid spending for long-term services and supports varies even substantially more across States than these other types of services.

As with most other Medicaid services, States have flexibility to determine payments and amounts within broad Federal guidelines. Institutional-based LTSS, such as nursing facilities, are generally paid on a per diem basis, as Jim has mentioned before, meaning that they are paid a rate for each day that a person spends in the facility. Specific methods for determining the per diem rates are determined by each State and comparing rates across States is complicated because States vary in what they include within the nursing facility payment, as we've discussed.

So, just as Jim had mentioned, for example, some States' per diem rates include payment for therapies or medical equipment, and in others, they are paid separately. And some States use health care-

related taxes and lump sum supplemental payments, making it difficult to determine net Medicaid payments to the nursing facilities.

HCBS payment is typically based on a State-specific fee schedule. Fees are established for each type of provider and service and based on the number of units of care delivered. So, for example, personal care services in most States, the unit is equal to around 15 minutes. For adult health services, on the other hand, payment may be made for half- or full-day units. There is no current standardized source of Medicaid payment rates for HCBS, and comparison of the rates is complicated by the fact that the States do not define HCBS in a consistent manner.

States are increasingly turning to managed care models for their long-term services and supports as a method to control costs and provide a level of predictability to Medicaid total spending. Managed long-term services and supports, or MLTSS, are services that are provided via managed care contractors who receive capitated rates and are held accountable for the delivery of their long-term services and supports. MLTSS programs are very diverse and range from fully integrated programs to more limited models.

In 2009, MLTSS accounted for ten percent of total Medicaid LTSS spending in the ten States with programs that provided data. Reported MLTSS expenditures increased more than 25 percent from 2008 to 2009, and as of 2012, 23 States have or are planning to implement MLTSS programs.

And as we have been discussing, the types of services and settings in which Medicaid enrollees receive long-term care have evolved over time, yet the measures used to determine the quality and effectiveness of such services has not kept up at the same pace as the development.

Among LTSS, quality measures for institutional-based services tend to be more established than

those for services provided in the community setting. Federal law and regulations exist that define specific quality standards for Medicare- and Medicaid-funded institutional-based LTSS. However, absent standardized Federal requirements for HCBS quality measures, States are generally left to set the quality measures used for providers that deliver these types of services.

There is, however, activity at the Federal and State levels as well as by non-governmental organizations to identify and develop standard quality measures applicable to LTSS, particularly for home and community-based services. Much of this work, which is outlined in your background paper as well as in Appendix 7, is in the developmental stage and can provide the basis for the much-needed effort to assess and ensure quality of care for Medicaid enrollees with LTSS needs.

So, now that we have provided a very high-level overview of the different aspects of Medicaid and LTSS, we'd like to lay out a series of policy questions and issues that we think stem from examining Medicaid's role for LTSS. A more extensive conversation of these issues are raised in the last section of your background paper, but we would like to go through several questions, which we have divided into three major themes, the first being LTSS payment and access; the second, LTSS innovation; and the third, variation in Medicaid LTSS.

So, first of all, one of the major policy themes that emerges from the discussion of Medicaid LTSS are the issues around payment policies and access to such services. Some of the key policy questions that are raised when examining such issues include what types of data are needed to determine access to LTSS? What are the State payment policies for these services? How are these types of Medicaid services coordinated with other payers or programs? And what types of providers are there for delivering Medicaid

long-term services and supports?

For the second theme that emerges from the discussion of Medicaid long-term services and supports are the numerous LTSS innovations that have developed over the years in the attempt to reduce costs and improve beneficiary satisfaction and quality of care. Key policy questions included in this policy theme are what do we know about what examples of service delivery initiatives that work or have not worked in the past? How do enrolles with long-term care needs learn about available services? What can we learn about the development of LTSS quality measures? What is the effect of MLTSS in terms of utilization, provider payment, and participation, beneficiary satisfaction, and quality? And how have the ACA provisions affected Medicaid long-term services and supports?

MS. LELLO: And so the third theme that we identified is the variation in Medicaid long-term services and supports and the ways in which this variation impacts Medicaid LTSS as a result of the interaction between eligibility pathways and benefits and State flexibility and benefit design. This variation is evident in terms of the use of services, how income and assets are determined, and the mix of HCBS and institutional LTSS available across and within States.

And from that, we've identified key policy questions that can help guide MACPAC's work on this topic going forward. For example, how does the definition and availability of LTSS vary across States and how does that affect access, utilization, quality, and cost? And what is the relationship between eligibility criteria, both financial and functional, to access and utilization costs? Does this variation in income and asset determination affect population access and does it affect which benefits they ultimately use? And what factors lead to reliance on either institutional or HCBS services and vice-versa, and what can be done to

ensure appropriate utilization of both? One major overarching question is, is this level of variation in these different domains appropriate?

So, going forward, we would like your guidance to prioritize from the long list of policy questions we've outlined for you. We would like you to give some thought to what you think we can take on this year and where you think MACPAC can make a contribution. What work do you think that MACPAC can do that will be most relevant and most timely? And what can we save for future work?

CHAIR ROWLAND: Thank you.

COMMISSIONER MOORE: This is an amazing piece of work. Thank you for putting a lot of things together in one place. I think we've covered a few of these things -- well, more than a few -- in the past, but our focus was on people with special needs, high needs, people with disabilities, and I don't think we want to lose sight of that. But I think to go on and look beyond that is important as well.

You've asked a lot of policy questions, and rather than address them specifically, I guess I would look at them through a filter, which asks primarily about timeliness and the impact that we can have on moving the field forward and standardization and such. And actually I should also mention that the Long-Term Care Commission has done some work here that hopefully would be relevant and helpful to us.

So in terms of that lens, my own personal priorities would lie in a couple of areas. One of them has to do with screening and eligibility, who gets into long-term services and supports in the Medicaid program, particularly looking at the ADRC model, the consumer outreach and access questions that are answered through that kind of model or not, and then also the functional status questions.

It seems to me that level of care determinations and determination of functional status is all over the

boards, and it seems like there ought to be more standardization, more of a national look at that than we have had in the past. And it seems like that would be a good place for us.

Similarly, in quality of care, we've been talking about quality of care in home and community-based services for decades, and little studies here and little studies there, but surely -- and I think the Long-Term Care Commission has addressed this, and several other things are in your paper about this, and I certainly think we could do some work on that subject.

CHAIR ROWLAND: I think also on workforce issues that the Department of Labor has just issued new regulations about minimum wage for home health workers, which, to go with quality, would be an important thing to look at.

COMMISSIONER MOORE: Right. And then the final thing, in terms of timeliness especially, is the question of managed long-term supports and services. You said, I think, that 23 states were either running managed long-term programs or planning them. I'd like to know what the breakout is there, because my sense was that there's a lot more people planning it than are actually doing it, because it's certainly not an easy thing to do.

On the other hand, there are parts of states, there are plans that have been doing this, like the one that Richard came from, for a number of years. So I think there's some interesting information out there, and I think that because this is new, because this is of great interest, because we are dealing with frail folks, regardless of their eligibility categories, it would be valuable for us to do work in that area.

So, that said, in the whole area of screening, functional status, quality, and managed long-term supports and services would be my personal priorities. But I think we also have to keep at least a little focus

on the duals, which we're working on in different ways, and people with disabilities as a general sense. So that tiny little workload will, you know, give you lots of time for other things.

COMMISSIONER GABOW: I think that somewhere in here it would be good to think about what are the goals of these interventions and what metric do we have to measure those goals. And I think that while it may be mixed in in the quality, it actually needs to be pulled out separately.

I think these are important questions, and we've talked about them before, but it's not clear that we actually have articulated what -- I mean, not we but the programs. And so I think that's important.

Then I always want to come back to the cost. Under the innovation, what do we know about what really -- it sounds like we really don't know if home and community-based services are more cost efficient than other things, and if so, which ones and how do we measure that. So I think part of the innovation has to be, given how much money is spent on this for the percent of population, what are the pathways for more cost-efficient quality services? And I think those are really important issues to put on the table.

VICE CHAIR SUNDWALL: Are you aware -- and thank you very much. This is a huge issue for all of us who are getting older.

[Laughter.]

VICE CHAIR SUNDWALL: But I would like to know if you are aware from the report of the Long-Term Care Commission, are there complementary issues that they addressed or things that you're aware of? I know that they seem to have put on the back burner financing issues, so that kind of leaves us on our own. They didn't give us much help or guidance.

MS. MCGINN-SHAPIRO: Yeah, they kind of had a couple broad areas that they made some

recommendations on service delivery and then workforce, which Diane -- and then also there was a recent regulation from the Department of Labor, and then finance, they were not able to come to any recommendations on.

So some of the issues, you know, with service delivery can -- they're a little vaguer in the Long-Term Care Commission, but they do overlap, you know, since Medicaid financing --

VICE CHAIR SUNDWALL: Well, I know it was a very contentious group. It was not an easy process for them. I have a friend who was serving as staff on that.

The last comment I have is have you -- or maybe in the workforce issues they dealt with or -- I don't know how we deal with it, but I teach part of this issue in a health policy class, and the preponderance of care is given by family. There's home caregivers. And I guess there's periodically a movement to have them compensated for this, which if you extrapolate a minimum wage would be billions of dollars in care given by family and loved ones. Does that factor into anything we're doing? Or we're just dealing with institutional care? I am just wondering. We don't want to displace care given now that isn't costing money, at least to the federal public dollar. But we do want to make sure they get appropriate services.

MS. McGINN-SHAPIRO: Right.

MS. LELLO: So in some of the Medicaid innovations, particularly in the arena of HCBS, states have tried different approaches to use Medicaid to support family caregivers. There's a set of family support HCBS waivers that a variety of states operate for certain populations. Cash and counseling and consumer-directed services are other Medicaid innovations states have used with the primary purposes of supporting people in their own homes and supporting caregivers.

COMMISSIONER ROSENBAUM: This is such a monumental job that I hate to sort of try and put another issue on the table, but I will anyway. And it's one that I've been concerned about in various contexts, and I think it really fits. And that is that there's a subset of people receiving long-term services and supports who have a primary source of insurance. I'm not talking about the duals now. I'm talking about people who have employer-sponsored coverage where Medicaid then picks up, and it's, of course, very common for parents with very disabled children, but it also involves people who are adults with serious disabilities and who are working. And, of course, I think we need to understand this group of people more because it is the arrangement that is not possible under the Affordable Care Act, at least not as policy now stands. And I think understanding more about services and supports that complement private insurance will become very important as we think about what happens to adults and children with disabilities who are in exchange plans and who may need services above and beyond what a standard plan is going to provide. And we have some experience with it from the employer market, and I know it's a small group of people, but I think it would be valuable to focus a little bit on it.

COMMISSIONER RILEY: I think this is terrific stuff. Appendix 8403 was especially interesting.

[Laughter.]

COMMISSIONER RILEY: But I think I would like to make a suggestion that we drill up, not down. I think what we have is -- unlike the rest of the Medicaid services on the acute side where we purchase care for people who look a lot like other people and for whom there are multiple payers and providers, particularly around disability and aging, this is a cottage industry that is Medicaid, and it's very fundamentally different. And I think it's a black box about which we know very little. We have all these

wonderful data points, but in terms of how it actually works, it's so driven by the profound needs of these populations, by the caregivers who care so much and put up -- are so stressed, by providers, by advocacy groups, it's hard to step back and say, What is in this black box? And I think Judy was exactly right about what the issues are, particularly around people with disabilities. And what are the goals for their services? And we've never articulated that. And how are they determined? Who does the assessment? Is it independent? Is it a provider? Who does the screening?

I almost would like to see case studies about how these dollars get spent, because I think as we move to managed care, which I think for these populations makes tons of sense, if done well, it's built on a base, on a black box that will get us in trouble. It'll be like the early days of managed care when we didn't know what the underpinnings of our costs were when we moved to capitation.

So I think it's such a tough area to understand. I think we almost need to step back a bit and take a harder look at what are the needs of these populations, how are the services defined. Are they consumer driven really or are they -- it seems to me we don't know enough about the fundamentals of how care is delivered, particularly for people with disabilities, to make any kind of meaningful recommendations on the drill-down level that have been pointed out here. We make assumptions, but I don't think we really know.

COMMISSIONER CARTE: This is such a complex area, and you've really done a good job of separating out some significant categories here or variables around what affects the cost of these services. And I just wonder if there wouldn't be a way -- you know, Trish, you were talking about case studies, but for CMS to be gathering data as we go year by year. At first I thought, Wow, I would love to see a longitudinal study of senior adults, particularly because their functionality is changing over time, and at one point they

might be entirely reliant on family caregiving and another time that's not possible. So, you know, could you have a reporting mechanism that kind of captures that as they move along and gives you a lot more analysis kind of based on this template that you put together so nicely?

And, David, I just have to say the flip side of what you're saying, I've thought about that, too, you know, that family caregivers do bear a lot of the cost burden, but also we have to look at those individuals for whom there is no family caregiver and the alternative is a more costly institutionalization, so when can we, you know, reimburse an individual in the community to provide care?

COMMISSIONER CHECKETT: In something as complicated and dense as this -- and, again, really extensive research and good job in starting to help us think through the many, many issues before us. But I like to think about, well, what is the trend? And, of course, the trend that caught my eye is that 23 states are looking at doing some kind of managed long-term supports and services. And so, you know, Judy mentioned it, but I'd like to call that out and say -- and I want to find out what does that mean.

The idea that -- is it that you're putting at risk really the management of home and community-based waiver services, which just seems kind of hard to believe, although I actually know that it is what some states are looking at. Are we pulling in nursing home days, which you can understand a little more, although actually you don't really go at risk for nursing home days. Generally, when somebody is there, they're there.

So I'd really like to learn more about that. What are the models? What is the rationale? Why are they doing that? What's in that package? Because I was really struck by 23 states. That's a lot. And, you know, is that over the past five years, the past two years? But I'm reading a lot about it, too, so -- and I do want to just caution, too, that, for instance, I know New York is doing managed long-term care, which I

would see as being different than managed LTSS. So just make sure we're splitting that.

So, anyway, thank you. Great work so far.

COMMISSIONER MOORE: I wanted to follow on what Sara said and also what Trish said in terms of moving up or thinking up, or whatever you said, the bigger-picture kind of stuff, which is Sara's idea, which she's expressed before, of Medicaid over time, over the next five, ten years, whatever, becoming a wrap-around to private coverage in whatever form to cover the special needs of special populations who will never be covered by private insurance because private insurance has just never been established to take care of those kinds of needs. It's insurance. It's not care -- I mean in the broader sense.

So I don't know whether that has a place in this consideration, but I think a lot of us are comfortable with that notion, and maybe it's another place to explore, that keying off the LTSS discussion is another place to explore that.

And I guess then I have just two other real quick points. One is: Do we really not know if cash and counseling is okay after all those years? And you don't have to answer that. I just actually thought cash and counseling had been studied to death, but I will end that comment there.

And I guess the other thing, on a slightly flip basis, I would say, and non-research, random basis, there's a level at which home and community-based services versus institutional services, which is more cost-effective, is a question that's no longer relevant because people just want to stay in their own homes, and that's where society is and where the world is. So I don't mean that we shouldn't pay attention to important research and data and so forth. I just throw that out there as another consideration.

COMMISSIONER COHEN: Building on the great comments of other people who have spoken

before me, I just want to amplify something that Trish said that I think is really important for us to acknowledge, which is there are places where, when we talk about Medicaid in context, there's places where Medicaid is just another payer, and there are places where Medicaid really is the payer or the leading payer. We've talked about birth -- maternity care is one of them, but long-term care, as Trish said, really is even much more dominant. Like Medicaid is it. And I do think that maybe there's a different kind of both obligation and ambition that the program should have in terms of its impact on health care delivery in areas where it is the main or only or virtually only payer.

So sort of building off of that, and then going back to an earlier theme from this morning and many other meetings that we've had about how one of the challenges that we've had as MACPAC is we sort of have to dive into an incredibly diverse program with just so many variations across states and programs within the states, and waivers and this and that and the other thing. And since we seem to be at the beginning of a real trend on long-term services and supports and Medicaid is the dominant payer, it does seem -- I just want to sort of, again, support Trish's point. It does seem that this is a good point for us to really dig into and maybe make some strong recommendations around standardization up front, like at the beginning of the development of these programs, although I know we're not at the very beginning so it's not going to be easy, some standardization of terms, of determinations, level of care, and other things, and also to really get into the black box that Trish described so well about like what are these services.

But, you know, we can really -- we're not following on somebody else's fee schedule here really. I mean, they exist. I'm not trying to say that we're working on a blank slate, but Medicaid is the driving program. It's at the beginning of some really substantial change, and I think we can be ambitious about how

we want to design this going forward and not just sort of let it happen.

VICE CHAIR SUNDWALL: I'm going to make a couple of comments based on my experience as a primary care physician. One is I take issue when you say there aren't standards for determining eligibility. There really are. I mean, the John Ware stuff -- is it SF-36, the activities of daily living -- is commonly used, and there are measures where we use in Medicaid certainly and other providers, to determine coverage. So I don't know that we're -- I don't know that -- maybe we need to be aware of what they are, but I don't think that they don't exist.

Secondly, we need to also acknowledge that home care is really a great opportunity for fraud and abuse, and that has been documented. And I can tell you as a clinician, I have been appalled at how pushy some of these providers are, sending me faxes to sign authorizing services I wasn't aware was needed. Somebody in their organization determined my patient needs this and this and that and that based on their proprietary interests, and this has been documented, and I think it has been studied. So we need to be aware that this is something that we can't just promote. We need to be aware that it's appropriate.

And the last thing, following up on your comment, Judy, people prefer to be home, that's true. But when I was responsible for the Medicaid program in Utah, we had what the chairman of pediatrics called these million dollar babies, million dollars a year babies, because their families insisted on having -- and, Herman, you know this as well as I do -- these essentially nursing homes without walls at home because they wanted every possible support, technology, and service and 24-hour -- keeping these very, very disabled youngsters alive, and that's not good medicine -- I mean, it's not appropriate. It's preferable but not affordable.

COMMISSIONER MARTINEZ ROGERS: Well, going along a little bit in terms of home care and caretakers at home is that, yes, it does save the government money. However, we also keep in mind that that caregiver that is taking care of that individual at home is also -- there is literature to state that they sometimes get sick quite often because of their stress level. And so at some point we have to look at what is the balance there when we look at what are the best programs. Is it just going to be cost-effective, or is it also going to be that it's quality of care?

I do agree with you, David, and what you were saying about these children that are so sick, that require a lot of care, but I guess in my mind I would not want to be the person to determine whether or not they have the right and deserve that or not. That would not be something that I would want to have to face.

COMMISSIONER CHAMBERS: Okay. I'll join the others in saying amazing work. You know, any report that has 14 pages of footnotes and seven appendixes, I mean, I tell you that is quite a -- yeah, I hope we're not paying by the page because we're in trouble, I think, on the salaries. But, you know, the policy issues that you've grouped in the variation, payment, access, and innovation, you hit all the stuff that, you know, we just have to continue. There's an incredible amount of work. What Trish said, the whole like what we don't know, to understand, and Donna about state innovations, states are moving so quickly on the managed long-term services and supports. And I think just the way we do our work is we're going to -- we almost have to cede the fact that there will be states starting these programs in very close conjunction, and amazing work by Melanie and her office on, you know, not only the dual integration but the LTSS that many states are doing in conjunction. And so, you know, we will not be probably out front, but I think it's to look at very closely.

We had our readiness review the last two days of July for our program in California, and we sat through two days of a very grueling readiness review. And I sat through both days just to listen, and it was -- it's pretty amazing when you think of what the revolution in integration of care for duals but also with the LTSS, if what emerges out the other end in actual delivery of care, it's going to be revolutionary, you know, what the model is for taking care of very, very chronic and very complex persons.

So there's a lot of stuff happening. There's a lot of thought, there's a lot of oversight, reporting, all kinds of stuff that is going to be pretty amazing. So I think we as a Commission can certainly help foster that along in the right way and watch very closely.

So good work. I look forward to working on this over the next six to eight months and coming out with recommendations in the spring and summer.

COMMISSIONER HOYT: I'd second the comments on the quality of the effort and the report. Also, on the definition of services, I think that's worthy of additional thought or discussion as to whether we want to make a recommendation there, not just the definition of services but sometimes the units, too, where that's appropriate. There's so much variation from state to state. Yes, as an actuary, if you're trying to do rates, it would be incredibly helpful to have more of this standardized. And since "payment" and "access" is kind of in our middle name, I was toying with the second bullet in the slide there and just thinking of kind of pairing some other thoughts together. You do have managed care over in the innovation section, but maybe something more along the lines of what are the state fee-for-service and managed care payment policies for LTSS? How does those affect utilization and cost, not just the utilization of the services but the cost as well?

The last point that I'd make about eligibility, I think your point's valid, but to me there's just too much variation. The other way in which there's variation is when are people assessed. It could be just when they go through eligibility. Is there another interval? Is it at six months? Nine months? Twelve months? There's a lot of managed care kind of pilots or things going on right now. I don't know that we're quite ready for risk-adjusted rates there, but even just regular rate setting, or if it does get to risk adjustment, we have no way to do that until we get some of those things standardized. It would be extremely helpful if we could land on one way to do the assessment, if it is ADLs, and then who does it. The chicken and the hen house thing is completely valid here, and sometimes there's different levels of care or, you know, there used to be SNF 1, SNF 2, and so on inside a nursing facility, and you'd have the nursing home decide what level of care somebody needed, you know, and how does that correlate to which beds are available type of thing. You know, then you're flying pretty far away from any kind of science that you want to base rates on.

COMMISSIONER SMITH: I have to say a few things about what David said because I agree with you a lot. Money is not infinite, and we have a finite budget to work with. So we have to be very mindful of how that money is being used.

But I do think it's sad that people who have abused the system are making it difficult for other families who might be quitting their jobs to stay home and take care of their mother or their brother who has a mental illness, or whoever. Families do often sacrifice financially to do this.

We brought Sam home with a trache, an IV for nutrition, a G-tube, five different machines, and we had no nursing, no -- we had nothing. It was just us.

But now I have this great kid who's almost 12 years old, and he's a joy, and he's tubeless. He eats.

And every day somebody different tells me; he just makes my day. He just makes my day.

Parents will come up to me from school and all.

So I think that has value.

And I think that when people remain at home, if that's what the family chooses, that is a quality of life that we can't duplicate because I've had to put parents in a nursing home. And it's very difficult, and they tend not to do as well, often.

So I think we need to look at -- Patty was talking about outcomes. What is it the services are meant to do? What is the outcome we want?

And often, when you're talking about long-term services, unless you're seeing a person that's going to have some type of recovery or substantial improvement, you're talking about maintaining a quality of life for somebody who no longer has the ability to care for themselves, often.

So -- at least that's what my experience has been.

So I think quality of life is one of the things we need to look at.

But what I found when -- I know you all are probably tired of me talking about the medically fragile program.

When the quality of life was improved for the kids that were in that program, it saved money. It just saved socially across the board. It saved DSS money. It saved.

And I told you we didn't go to the emergency room anymore. It was just everything improved once that happened. Sam's quality of life went up tenfold. Our quality of life went up tenfold. And now we have a child who doesn't cost nearly as much.

Of course, that was a child that nobody thought would improve. They thought he was going to die, but luckily, we do have an improved outcome.

But I just want to make sure that when we talk about quality we're not just talking about quality of health care; we're talking about quality of life as well.

COMMISSIONER CARTE: Does CMS still require the minimum data set that has to be completed on admission to a nursing home?

MS. MCGINN-SHAPIRO: Yes. Yeah, for institutions. Yeah, for nursing facilities.

COMMISSIONER CARTE: Well, just to give a little bit more concrete detail to my earlier rambling, that's the kind of thing that we could reimburse a physician to have completed, say, every 5 years for somebody upon age 65, and then you have a data set that would show you the person's change in activity, daily activities, and functionality such that we'd have a much better idea of when it would pay to intervene with supports.

CHAIR ROWLAND: There's one thing I think we ought to also try and put in context here. We just had the tenth anniversary of a Supreme Court decision, the Olmstead decision, that really did try to reshape how Medicaid went from being so institutionally-based to being more community-based. And many people were asking after 10 years, where were the states, what had happened, from Olmstead. And so that might be one other kind of look that we could see what are the forces reshaping the institutional bias and the community bias.

And I think the other issue that I'd like to see teased out a little more in our look at long-term services and supports is how much of that relates to physical disabilities as opposed to the increasing

emphasis that I know we're having as a society on the behavioral and the mental, and to what extent do we need different strategies, depending on what population we're talking about, which kind of gets back to the beginning of let's first talk not about the eligibility rules that get people there but the conditions that get people there and how those conditions are best met.

Trish.

COMMISSIONER RILEY: But, when I think Olmstead, I think lawyers and settlements.

UNIDENTIFIED SPEAKER: You say it like that's a bad thing.

COMMISSIONER RILEY: Well, it can be, but it does raise the issue of what the benefits -- you know, who -- what's the eligibility function? Who does the screening? What are the care plans?

And I think care plans you have to manage more than long-term services and supports if you're managing people.

But it begs the question of, what is the benefit structure?

And I think the issue of housing is one that we have not adequately addressed here because Olmstead reminds us more than anything that these were profoundly -- profoundly -- impaired people who were in institutions because it provided a level of care that's very hard to provide outside in the community, in independent apartments. We've got to rethink the sort of structure of housing for these folks and what Medicaid pays for -- the assisted living issues, personal care homes, the Washington example. I think it's an area we ought to focus some attention on.

CHAIR ROWLAND: And, really, the division we've also talked about between people who are on the rolls because of disabilities and under age 65, or in the young elderly versus the old, old elderly, which I

think have a different set of criteria.

So I think to have a little more of a population focus to be the filter of how you're looking at this issue instead of all based on services.

Other comments?

[No response.]

CHAIR ROWLAND: Well, it's a massive undertaking on a huge topic and one that I know people struggle with how to organize it, and so we always have to give you some comments about how to reorganize really good work that you put before us. But I think the people focus will help also filter it through.

And so thank you, Angela. Thank you, Molly.

And now we'll see if anyone in our public audience has comments or wants to offer any suggestions to the Commission. If so, please come to the mic and identify yourself, of course.

PUBLIC COMMENT

* MS. HUANG: Sure. Good afternoon. My name is Xiaoyi Huang. I'm the Assistant Vice President for America's Essential Hospitals, formerly the National Association of Public Hospitals and Health Systems.

Thank you so much for the opportunity to speak today, and I want to thank the commissioners for your thoughtful consideration of these very challenging topics facing the Medicaid program.

I do want to urge you to take on that early warning alarm role and ensure that plan networks -- so plans that are going to participate in the exchanges -- are adequate enough to ensure the type of access that

the Affordable Care Act envisions for the beneficiaries that are meant to go into the exchanges and to recommend changes to CMS and to Congress if inadequacies are detected early.

In addition, I would ask the commissioners to pay attention to some of the downstream effects of the exchange implementation, in particular, uncompensated care costs associated with unpaid cost-sharing or uncovered costs of services for the exchange population. Uncompensated care costs associated with privately insured individuals, including those that are low income that are in the exchanges, are not DSH-eligible. And for the hospitals that will continue to treat them, their ability to offset that cost will continue to erode as the Medicaid DSH cuts continue in the later years.

And the last point, as the Commission continues its work on Medicaid waivers, I would urge you to pay special attention to some of the delivery system transformation type of 1115 waivers that are going on now in Texas and Massachusetts and California and Kansas and that are in discussion in Florida and New York.

In particular, I note these are monumental waivers that try to actually change the underlying delivery system so that they can improve the quality of care for the entire community. But as CMS is learning, as providers are learning, there are lots of barriers to overcome, in particular, just the sheer number of improvement projects that the hospitals have to do, and to have the bar for each of these projects raised throughout the waiver period is especially difficult from an operations standpoint.

Thank you.

CHAIR ROWLAND: Thank you.

Any other comments?

[No response.]

CHAIR ROWLAND: Okay. Well, we have had a very full day and a lot of very fruitful discussion, and the staff has a lot of additional work to do to continue with the issues we have today.

We'll reconvene tomorrow morning at 9:00 and 10:00 for the public meeting, where we will be discussing children's health policy for the most part.

So, thank you.

[Whereupon, at 4:07 p.m., the meeting was recessed, to reconvene at 10:00 a.m. on Friday, September 20, 2013.]

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

Ronald Reagan Building and International Trade Center
The Horizon Ballroom
1300 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

Friday, September 20, 2013
10:23 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
DONNA CHECKETT, MPA, MSW
ANDREA COHEN, JD
HERMAN GRAY, MD, MBA
DENISE HENNING, CNM, MSN
MARK HOYT, FSA, MAAA
NORMA MARTINEZ ROGERS, PhD, RN, FAAN
JUDITH MOORE
TRISH RILEY, MS
SARA ROSENBAUM, JD
ROBIN SMITH
STEVEN WALDREN, MD, MS

ANNE L. SCHWARTZ, PhD, EXECUTIVE DIRECTOR

AGENDA PAGE

P R O C E E D I N G S [10:23 a.m.]

CHAIR ROWLAND: If we could please convene, that would be great. Today we're going to focus on the Children's Health Insurance Program, CHIP, and look at some issues related to both the future of CHIP and the current status as well as the availability of care for children under various health insurance forms. But I'd like to start the meeting by recapping from yesterday the discussions that we had to really go forward, also looking around the supplemental payment issues, looking at some of the waiver issues, and those will be a continued part of our work as we go forward with the Commission.

But we also have been reminded of the focus of this Commission and of the issues that we really need to keep front and center for our work, and I'd like to turn to one of our Commissioners who has reminded us all of some of the underlying issues about why Medicaid is an important program. Robin?

COMMISSIONER SMITH: Well, just for some background, I have a history of children in foster care and children that we adopted who have special needs, or even some that didn't have special needs, but we have that experience with Medicaid, and so that's where my experience comes from. But I did have support, and we weren't thrust into a situation where I suddenly needed to quit my job to stay home and take care of a child that needed full-time care.

So I just wanted to clarify that I advocate for the families that are in that situation because I understand what it takes for the experience of suddenly having to care for someone that requires 24/7 care at home.

So when we were leaving our discussion yesterday on long-term care services, I was feeling a little bit uneasy, and I just wanted everybody to think, you know, one word: Why does our country even have

Medicaid? I now realize how much the stability of our hospital systems can depend on various Medicaid funding and how much the business of health care revolves around Medicaid. But in my simplified, naive mind of just being a Mom, Medicaid means that those who otherwise would have to go without can obtain health care services to ease suffering from illness or injury or to prevent suffering from illness. But it sounds almost politically incorrect to say this.

It boils down to the quality of life, yet I feel like we're expected to justify spending Medicaid dollars on something more tangible, something bigger or more important than the lives of individuals. And to me it doesn't mean that we have to spend more money or provide everything for everyone. It just means that we need to give everybody a decent shot at a better quality of life. And I'm hoping that as we think and process the payer systems and the possible health care systems and what outcomes we're looking for, we're also considering the individuals and the quality of life and why we actually have Medicaid.

CHAIR ROWLAND: And it's why we appreciate having Robin on this Commission to remind us of this all the time. Thank you, Robin.

And now we are going to turn to an issue that affects millions of America's children, the Child Health Insurance Program and its interactions with the Medicaid program as well as its future. So, Chris Peterson, take us to the slides. Thank you.

Session 8: CHIP ISSUES AND REAUTHORIZATION

* MR. PETERSON: Thank you, Diane.

This presentation will look a lot like the ACA presentation I did yesterday in terms of I'm going to begin with some background information so we're all on the same page of kind of what the facts are as we

know it at this point. And then we will talk about the future of CHIP, what analyses we have planned, what we think some of the issues are, and that's where we would really appreciate your feedback, Commissioners, on which you think are the highest priorities or ones that are not so important for us to spend our time on.

CHIP is an issue that we have written about in several of our reports, beginning with our inaugural one, and we've also done some interim products, a MACBasics on CHIP financing. So we've covered CHIP in a descriptive sense, and we've raised some issues, but the sense we've gotten from the Commissioners is now it's time to assess these a little more deeply and see what options you might want to consider moving forward, and so we're trying to build the evidence and gather the evidence for those conversations.

So in this presentation, I'm going to give you a brief overview of CHIP's history, a current snapshot of where CHIP is now, to remind you of what CHIPRA and the ACA changed, and then we can delve into the future of CHIP and the analyses that we have planned.

CHIP was enacted in 1997. It extended eligibility to children above Medicaid levels up to 200 percent of poverty, or if the state already had Medicaid at a higher level, it could expand up to 50 points of poverty higher. So, for example, Minnesota had already expanded Medicaid up to 275 percent of poverty when CHIP came along. So for the first few years, they opted only -- their CHIP program only consisted of, I think, zero- to two-year-olds from 275 to 280 percent of poverty. So like Medicaid, CHIP has a lot of variation.

CHIP is different in Medicaid in a lot of ways, of course, that it was designed to look a little bit more like employer-sponsored coverage, so it has greater cost sharing and fewer benefits than Medicaid, and it provided capped appropriated federal funds through FY2007, and those funds were provided at a matching

rate that was higher than Medicaid, so that was the stick -- I mean, the carrot, rather, to encourage states to participate in CHIP.

Funding was extended in CHIPRA through 2013, and then it was extended again through 2015, and CHIPRA and the ACA also made some other changes that we will talk about a little bit.

This is CHIP's federal financing kind of in one slide. So you see that the first ten years were funded by the BBA, Balanced Budget Act, and those are shown in the blue bars. And then the dashed line shows spending nationally.

So you might think in 2002 states started to run out of money, and that's actually not the case. The way the CHIP financing structure works is that states have multiple years to spend their allotments, and if states don't spend their allotments after those multiple years, they get redistributed to other states. So there was actually enough money in the system, but there ended up not being enough money in the system around the 2006 period. Some states started to face shortfalls, and Congress appropriated funds to cover those federal CHIP shortfalls.

When it came time to extend the program, Congress said, "We don't want to have to appropriate like that again," so they changed the formula and appropriated levels such that there have not been any shortfalls since then.

The current snapshot of CHIP, every state now has -- and every territory and D.C. has a CHIP program. Eight states use just a straight expansion of Medicaid, so those kids are enrolled, as far as they know and are concerned, in Medicaid. They get EPSDT, but they are financed by the CHIP funds. Fifteen states have a program that is totally separate from Medicaid, and so they can use some of the additional

flexibilities that CHIP provides. And then a majority of states actually use a combination of both approaches, with eight million children enrolled, and some parents and pregnant women, and the CHIP matching rate ranges from 65 percent to 81 percent.

So some of the financing changes that CHIPRA made was, as I mentioned, to extend that financing for five years, substantially more funding, and an allotment formula that provided allotments to states based on their actual historical spending. In addition, although states have the flexibility to extend as high up to income scale as they want, Congress made a change and said, well, if you go above 300 percent of poverty, then you won't get the CHIP matching rate; you'll only get the regular Medicaid matching rate, with the exception of two states that had already passed legislation to go above 300 percent of poverty.

CHIPRA made other changes. The only one that I want to point out that is of particular interest is the dental-only coverage. A key tenet of CHIP was that it did not want to displace other coverage, and so there are screen and enroll requirements where you can't have Medicaid, regular Medicaid, and CHIP; you can't have employer-sponsored coverage and CHIP. That was core to its structure. But in CHIPRA, dental-only coverage was added so that if an individual had employer-sponsored coverage but didn't have dental coverage, the state could opt to wrap around their employer coverage with dental services. If my recollection is correct, I think only Iowa currently does that, but it was kind of a sea change for the program and thinking about wrap issues that we've talked about before.

The ACA extended CHIP financing for another 2 years through 2015, so that is to say October 1st of this year, the 2014 CHIP allotments are given to states. Next year is 2015. The allotments will be provided then as well. It is the following year, on October 1, 2015, where an allotment is not slated to

occur.

The program does not just end there. It's not as if the keys are shut off and thrown away. But states will only have whatever leftover funding they have at that point. So to stick with the car analogy, they may have half a tank; they may have a quarter of a tank; they may be running on fumes at that point. And so they will be running out during FY2016. At the same time, one of the other changes in the ACA was to increase the CHIP matching rate, so they will be burning through whatever they have left pretty quickly -- more quickly than they otherwise would.

Other CHIP provisions in the ACA, we talked about the stair-step children which could affect approximately 500,000, 600,000 children. That takes place in 2014. States are converting to MAGI for CHIP as well as Medicaid. Children cannot be enrolled in CHIP and exchange coverage, and children's eligibility levels must not drop -- they are not permitted to drop until September 30, 2019. So where we had talked about Massachusetts, for example, with their parents and childless adults rolling back -- dropping their eligibility level to 133 percent of poverty, they cannot do that for children.

So for the CHIP experts who were looking at this slide as I went through it yesterday, probably cringing a little bit because I skipped over some detail with just an asterisk, so I'm going to walk through this in a little more detail. So here's North Dakota again, and showing their separate CHIP coverage in the red, and I should note -- I meant to change this, and I changed it in the wording but not on this graphic. Often individuals referred to the CHIP program as "CHIP" or "S-CHIP." It would go back and forth. Now most folks are referring to it as just "CHIP," and we use "S-CHIP" to refer specifically to separate CHIP programs, and "—CHIP" will be Medicaid expansion programs. So just be conscious that when you hear

folks say "S-CHIP," they may mean different things. So it's important to clarify that. In this context, I'm talking about separate CHIP programs.

So 2014 comes along, and what I have now added is the striped area where in this case North Dakota must expand Medicaid up to 133 percent of poverty for those 6- to 18-year-olds, and that will still continue at the enhanced match, and so those will be Medicaid expansion CHIP kids.

So what is our role? Our role is to examine the impact of CHIP on children's coverage, and I just wanted to remind you, I think one of the most compelling numbers that is out there on this is one that we've put in almost every report we've talked about CHIP. And the latest one we did was in January where we talked about CHIP.

If you look at children between 100 and 200 percent of poverty, in 1997, 22.8 percent of children in that income range were uninsured--22.8 percent. In 2012, that number dropped to 9.7. So that is a huge impact relative to what happened to non-elderly adults over that same time where their uninsurance rate rose from 34.9 percent to 39.4 percent.

In addition, we want to assess how CHIP's role changes with the presence of exchange coverage in 2014 and assess how children's coverage would change if federal CHIP funding ends after 2015. Where would they go? What are the benefits they would receive? And what are the financial implications? So once more, I've numbered these, but not necessarily in order of priority.

GAO provided a report last year that looked at the nearly six million children who are uninsured and found that most of them are -- two-thirds of them are eligible for Medicaid or CHIP, and another 8 percent would be eligible for the premium tax credits for exchange coverage.

The key point of this slide is not the number of uninsured children, because you will get different numbers whether you are looking at different years, different data sources, et cetera. The key point is that three-quarters of children will be eligible for subsidized coverage in 2014, according to these estimates. Those who are ineligible are the non-citizens, ineligible non-citizens, and those who are ineligible for exchange coverage due to that affordability test we talked about yesterday, and some whose income is just too high. Other ACA policies we expect will increase CHIP enrollment.

So what are our next steps? We're going to track CHIP enrollment and take-up rates in 2014. I think a lot of -- we're not going to know this information soon. We will have to see the impact as the data come in. At the same time, though, we do want to monitor state enrollment efforts and their effects.

Churning. Once more I do want to note that churning is not only within a year but historically, as we have talked about in our prior reports, churning has historically been talked about in terms of when people go to renew, what are the issues that prevent them from renewing? And our focus has been on what happens within a 12-month period, because the ACA is supposed to address many of those administrative issues that come up at the regular redetermination, and hopefully we'll be looking at that in the future. But in terms of CHIP in particular, an issue has to do with CHIP waiting periods. Thirty-eight states have CHIP waiting periods.

So, before they can be eligible for CHIP, they have to be uninsured or at least not have employer-sponsored coverage for some time. In that case, they can get subsidized exchange coverage.

So we're talking about children who it looks like you're eligible for CHIP, but you're going to have to wait; so now you will have to go to the exchange coverage, and then after the 30 days, 90 days, then you

can go back into CHIP.

So we want to look at estimates of the number of children affected by the CHIP waiting periods and assess how the extent and nature of churning differs between Medicaid expansion versus separate CHIP programs.

Premium stacking and cost-sharing stacking is another issue. Thirty-three states currently charge CHIP premiums. So it's the case that parents may face CHIP premiums and premiums for exchange coverage.

And we already know that three-quarters of exchange-eligible parents will have children who are eligible for Medicaid or CHIP. So this could be an issue.

So we want to obtain estimates of the number of children potentially affected by this policy.

We talked yesterday about the affordability test for self-only ESI coverage. It could be -- GAO has estimated that 500,000 children are projected to receive an offer of affordable ESI but will not be eligible for Medicaid or CHIP because their income is too high, but yet, they're below 400 percent of poverty and, therefore, will be uninsured.

So we want to look at the number and characteristics of children who are ineligible because of this affordability test, and we want to obtain estimates of the extent to which they are ineligible and what they ultimately enroll in. But on that latter piece, again, we won't know that information until we've had some time to see how decisions have played out in terms of what people have actually enrolled in.

Differences in covered benefits -- so, as I mentioned, separate CHIP benefits generally are not as generous as Medicaid. So what are those differences?

And we want to look at those differences. There are publications that are going to be coming out soon, by GAO and the Georgetown Center for Children and Families, and we will want to take a look at those and see how those compare Medicaid and CHIP and exchange coverage.

In 2014, CBO has projected that CHIP spending will be 50 percent higher than in 2013. If that really happens, many states could tap the contingency fund.

You may remember we had talked about the contingency fund a year or two ago, where it was only one state thus far has used the contingency fund.

So what happens there is a state looks like they're going to run out of CHIP money. Then there's a formula that says, okay, we will -- the Federal Government will -- give you certain Federal dollars to cover that based on this formula.

The only state that has used contingency funds was Iowa. They had a shortfall of $3 million. And the way that the formula worked was that they got approximately $30 million in Federal funds.

So we raised the issue of whether or not this was important. And given the fact that only one state had done it at the time, it didn't seem to be an issue, but it could be an issue going into 2014 if what CBO projects actually occurs.

So we want to look at what states are projecting and assess the potential need for contingency funds and other funds available to plug CHIP shortfalls.

COMMISSIONER ROSENBAUM: And why does CBO project such a gigantic leap on the CHIP side of things?

MR. PETERSON: It has to do with the parents.

So these are parents who are currently not eligible for anything. They go to the exchange. They say: What am I eligible for? I don't want to have to pay this individual mandate penalty. I hear that I might have subsidized coverage.

And they find, lo and behold, your children are eligible for CHIP.

After 2015, there are no new Federal CHIP allotments. As I mentioned, some states -- most states, we project, would have some remaining balances, but they would be used up pretty quickly in many cases.

So we want to assess the impact of what happens with no new CHIP funding and where those children would end up.

A related issue has to do with the Children's Maintenance of Effort. As I mentioned, for children's coverage, it continues until 2019.

What happens when the CHIP money runs out?

It appears that the Medicaid expansion kids would go -- would stay in regular Medicaid, and they would be paid for at the regular Medicaid matching rate.

It appears that the separate CHIP children would go into exchanges, but there are some questions about how that would work and what those plans would have to do.

So we want to assess what the impact would be on those children.

Sorry I've flown -- I feel like I've flown through that, but hopefully, that gives you some thoughts, and we'd appreciate any insights you have.

COMMISSIONER ROSENBAUM: Thank you, Chris. That was great. I think the issues that you've raised are all the key issues.

And I'm wondering whether we ought to try to think about -- as we take the factual development, try and take a step back in our work to think about the roles that CHIP might play in an insurance system that looks very different from what it looked like in '97.

In some cases, particularly around family affordability, it plays a clear role. It is compensating for the absence of any other coverage pathway for certain families and children. It provides sort of a template for pediatric insurance although it differs in important ways form the pediatric component of coverage in the exchange. Its scope of benefits is different, but its cost-sharing is, I think, probably more generous than the exchange coverage.

But I think the hardest question we may have to answer -- I think it's completely answerable, but I think we're going to have to answer it -- is given the changes in insurance affordability program pathways is there still a reason to have an independent basis of financing pediatric care apart from Medicaid, apart from the premium subsidies, particularly given the fact that the premium subsidy system, in theory, is going to offer the purchase of a child-only plan?

And so it's that question about why to keep this independent basis of pediatric financing and what added value it brings to the overall financing picture. And some of that, I think, will come out in the answers to the questions that you've raised, and I think some of it we're probably going to have to have some further thinking development.

I don't know if it's factual development as much as it is sort of thinking through how the other dots are playing are out and what may be needed to connect them.

I mean, one issue is, for example, that exchanges work, but they're working more slowly; CHIP is

sort of a known quantity, and you can get your children onto it quickly.

There may be other reasons why -- whether they're mechanical or some other reasons why -- we really still need this independent financing source for children.

CHAIR ROWLAND: Sharon -- oh, let me just also as we proceed on this discussion, remind the commissioners that we are hoping to follow up in October with a panel of CHIP directors as well as others to come in and discuss CHIP. So, as you think through this, if there are questions you'd like to make sure Anne can alert them that they should be coming in to speak on, let's include those in our comments.

But, Sharon.

COMMISSIONER CARTE: Thanks.

Sara has called the important question about whether or not we need to have an independent pediatric financing going forward for CHIP, but I'd like to ask the Commission to focus on some of the domains that raise issues for CHIP going forward.

And, Chris, you did a nice job as usual, running the gamut, and I think it was helpful that you followed that same ACA format that we had yesterday although North Dakota on that chart -- I guess because so many CHIPs are at 200 percent, or even a dozen or so at 300 percent, I'd like to see something a little more representative there.

But I think the important domains are, of course, the enrollment issues, CHIP -- we've always had a certain amount of churning that we've had to deal with between CHIP and Medicaid. At times, that can be administratively burdensome. Now we're going to go to three buckets of churning. That's a major concern.

I would like to see as we go forward discussing this issue -- and I know that CMS is just now

releasing some performance indicators that they will follow and ask the states to follow, but they're currently assessing which performance indicators can be reported.

I know in my state of West Virginia, for example, that the average CHIP -- and Medicaid enrollment -- is about nine months, a year, versus eight months for Medicaid.

So, with that in mind, if we have another bucket -- we also know that lower-income families tend to experience more income volatility or may have a seasonality influence in their earnings, which can put them in one bucket or another.

This Commission -- it was really important to take a stance on the issue of continuous 12-month enrollment, and even though our Commission endorsed that, that will still be there at a state option.

I feel fortunate that our CHIP program was in a state where we had continuous 12-month enrollment ability for both Medicaid and CHIP. I don't think we could have achieved the high levels of coverage without that.

As I think most of you are aware, we recently dropped the waiting period. Actually, we had two different waiting periods a couple of years ago. We had one, a longer waiting period, of 12 months for those families who pay a premium in our separate CHIP, and those were the families from 200 to 300 percent that had a 12-month waiting period. And it was six months. We have dropped that beginning October 1.

As we've seen CHIP programs grow past the focus on enrollment and then looking at access, I think you all now see states going further to look at quality improvement initiatives without really a worry about the gaps and the churning and the relation to what it does to quality improvement, or those states where

managed care is prevalent or the major payment modality.

And then the other domain, of course, is the affordability. What will the take-up be like in the exchanges?

In our state, we have done a survey of CHIP parents, and by and large, they indicate that they would like to pay a very modest premium of around $50 a month. And I don't think that they're going to see that kind of coverage available to them, at least for a very comprehensive benefit. So lower-income families will be driven towards lower premiums.

You heard Chris mention -- I think one of the great achievements of the CHIP program -- while it doesn't offer the full EPSDT benefit, it does have strong dental and mental health; that has meant a lot to children and to the pediatric focus.

So those are my concerns, by and large, and the questions.

And, in closing -- and you'll probably hear me say this over and over again in other meetings -- all of these things together add up to the fact that states will need time to decide on a transition to fix things, such as removing their waiting period. There will be improvement. It will occur slowly, I think, over the course of 2014.

Some of you asked me, well, how do the CHIP programs see this, or where are they headed? But they are so different, as Chris's slides show, from state to state; it will take time.

And my greatest concern is that -- you know, CHIP has done a great job, I think, of covering children. And though we know that in the end we still expect to be as many as six million outside of coverage, we know that those will be focused in probably about eight states or so because there is still a very

small number of states that have large numbers of uninsured children.

Thank you.

CHAIR ROWLAND: Herman and then Norma.

COMMISSIONER GRAY: I agree with much of what's been said thus far.

I think the best question that we will have to wrestle with is do we need a CHIP in the future, as Sara raised.

There's a similar discussion that has been held in years past by child health advocates who would suggest that there should be even a separate program for child health separate from Medicaid because of the political vulnerability and the target that Medicaid has often had on its back.

I don't know what the correct answer is or if there is a correct answer, but I suppose it's just likely to be a political answer as it is a recommendation from MACPAC, necessarily.

Going to the specific domains, I think Chris did a great job as well. I like the format, similar to yesterday's ACA presentation.

My priorities would be the take-up, the enrollment issues that Sharon pointed out, that we have the opportunity to see three-quarters of kids who are currently uninsured pick up coverage if things go in the right direction from a child health coverage perspective.

Churning, I think, is a huge issue as well, as it was in yesterday's discussion.

This issue with waiting periods that I hadn't really thought about is the most convoluted, confusing thing I've -- you know, there are lots of convoluted, confusing things I've heard at least in the last 15 minutes.

To wait for CHIP, so you enroll in the exchange, and then a few months later you disenroll from the exchange and enroll in CHIP -- just, it's insane. So thoughtful consideration of what kind of practical recommendations we might be able to make to address that I think would be really very helpful.

Understanding what the churn -- the impact of churning -- is on kids, as you suggest, I think is important, particularly given what we know about churn, or at least what we think we know about churn and continuity of care for children with chronic illnesses and special needs. That can really -- I think when we look at how it impacts children, it's not such a high-level view of kids that you forget that really small population of kids that are highly complex and challenging who might be the most impacted.

I think we need to better understand from the cost-sharing perspective -- and Sharon alluded to this as well -- whether we will just cost a lot of families -- price a lot of families just right out of the market if they have to pay for an exchange and for CHIP. You could end up with a combination that's just very challenging for the average family.

I'm not sure that issue 5 -- I think it's important. I'm not sure that it has the same degree of prioritization for MACPAC because I think it's going to take us some time to see what the impact of having different benefit packages is for children. I don't know that that's necessarily something that will be the highest priority immediately for us since that's going to take a little bit of time to figure out or to see what those differences might be.

But, overall, I think excellent presentation and analysis. Thank you.

CHAIR ROWLAND: Norma.

COMMISSIONER MARTINEZ ROGERS: You did a great job, Chris.

Just some concerns that I have is that -- of course, coming from the State of Texas -- that 17 percent of our children are uninsured. We have one of the highest rates, next to, I guess, Utah. One in five live in poverty. Concerns of premiums -- even $50 would be too much for these families. The affordability of what's going to happen if they can't afford something.

If we don't have CHIP, what will we have that families will be able to afford, especially when Sharon talked about seasonal-type jobs, which is what we see a lot in Texas, in particular with the migrants that are here legally, that we see, even though we have migrant health care, they don't get into CHIP programs.

The other is the waiting period. That waiting periods, long, extended waiting periods, tend to turn families away. So I think that that is something that we need to look at.

And we have to figure out how it is that we are going to provide care for the children because that is the future, and if we don't have health care for them and preventive care, then we have real problems.

CHAIR ROWLAND: Okay. Denise.

COMMISSIONER HENNING: I have a question, probably for Sharon, for the CHIP waiting periods. Are those waiting periods more a function of the finances of the State government, that they install those waiting periods to kind of control their costs, or is there some benefit to having a waiting period that I can't quite figure out?

COMMISSIONER CARTE: Denise, that's a good question for folks who are outside of a payer entity. The whole purpose of having a waiting period, and the CHIP programs are required to have mechanisms that avoid crowd-out, and crowd-out refers to, more technically, the whole idea of when CHIP was passed is that CHIP not substitute for other coverage. And, primarily, you could see that from the

standpoint of the Congress not wanting a State to shift what they were contributing for their employees and have them shift that burden onto a public program or other commercial plans, to have families dropped.

So, it was to have families not be able to just automatically come into a public program, and States were required to show data. It was always difficult in our State to show that data, but we did have the waiting period protection.

But, for many States where you have lower-income families -- it really wasn't a major question in my State, but I saw a paper recently where markets are so variable from State to State. For example, there could be real inducement for a family in New York to drop their insurance and have their children on CHIP, whereas in West Virginia, the insurance wasn't affordable to begin with. So it was there for State insurance primarily, and also our other way to avoid that shifting, that substitution of coverage, was when we went to the higher-income families, we did charge a premium, and I think that pretty much assures we really get the families who need that coverage.

CHAIR ROWLAND: And the waiting period was how long you had to be uninsured before you could come onto the program.

COMMISSIONER CARTE: Correct. Sometimes, it's called a "going bare" period or being naked. I remember in the early days of CHIP, we had a survey and one family had a young infant and they talked about having to wait six months before they could get CHIP and how terrible that was for them to not have coverage during that time.

CHAIR ROWLAND: Okay. Then I have Trish, and then David, and then Donna.

COMMISSIONER RILEY: One of the -- this is a struggle for us, I think, as a Commission,

because one of the themes that comes up at every meeting, at every issue, is simplicity. So the notion of a CHIP program that operates as another silo in an effort to have a more integrated and comprehensive health program is a dichotomy that I think we need to struggle with. And I think, over time -- you know, here we have waiting periods versus open enrollment periods. We have crowd-out versus now the new environment is crowd-in, everybody in.

So I think it's implicit, then, that we have to think about what's the glide path to get us to an integrated system of delivery. What are the lessons learned from CHIP, especially around premiums, cost sharing, benefit design, because those things look exchange-like. But what's the glide path to get us to an integrated system, because I think it's not in anybody's interest to continue the complexity of this program. And I think the glide path has to be sort of an operational glide path. What are the details that a State has to accommodate to get to an integrated exchange base, Medicaid base?

And to Robin's point, what does it mean for families? So you've got a bunch of kids on CHIP. What does it mean to transition them in an open enrollment period into an exchange-based product for those kids who are not Medicaid eligible? And I think if we could look at that glide path, we could come up with recommendations about a reasonable way to accommodate the integration of CHIP into the exchange, recognizing that it's eight million kids, which is a small number given what's about to befall us, and they could be lost in a system. So we need to do it in a thoughtful, "planful" way, and I think MACPAC has a unique role to sort of show us the glide path, both from the consumer's perspective and from the program perspective.

CHAIR ROWLAND: Is there anything to be learned by looking at the California experience, where

they just transitioned their separate program into Medicaid and what some of the pitfalls were, some of the consequences? But that's kind of a real life example.

COMMISSIONER CARTE: I think I'd rather look at New York as a model. I think that they did that in a much more planned way, whereas California was driven by some pretty terrible budgetary pressures, and I think --

CHAIR ROWLAND: Maybe we should look at both.

[Off record discussion.]

CHAIR ROWLAND: David.

VICE CHAIR SUNDWALL: Yeah. Thanks, Chris. This is an interesting issue. It's certainly top priority from our retreat and we're all interested in this.

Just for my clarification, the ACA and the CHIPRA, those things didn't really -- there's nothing changed in the authority for CHIP, it's just the appropriations run out in 2015, is that correct?

MR. PETERSON: I think it's fair to characterize it that way. I came up with a laundry list of things that --

VICE CHAIR SUNDWALL: Well, there might --

MR. PETERSON: -- changed, you know. It was mental health parity --

VICE CHAIR SUNDWALL: Right.

MR. PETERSON: -- is required in CHIP, things like that. But, by and large, it wasn't a substantial change. I don't know.

VICE CHAIR SUNDWALL: I'm just curious if, and I don't know the political landscape here, if

there are those -- if conservatives look forward to this as a way to streamline the program and that we would merge them, or if there's a partisan thing to this.

But the other -- I have just two specific questions. The remarkable increase in Federal spending for CHIP, I'm assuming that correlates pretty much with the downturn in the economy? I mean, of course, everything else went up with Medicaid, as well, but that's really quite a dramatic chart when you show that from 2008 up to now. Is that, in your opinion, does that reflect the downturn of the economy with the increased spending?

MR. PETERSON: Well, I mentioned that part of it is CBO's projections.

VICE CHAIR SUNDWALL: CHIP Federal funding.

MR. PETERSON: So the jump -- if you see the jump from 2013 to 2014, that may be what's jumping out.

Two things. First of all, spending is in the dotted line.

VICE CHAIR SUNDWALL: Yeah, I understand.

MR. PETERSON: Okay. I just wanted to make sure, because the bars are showing what Congress has appropriated. So the big jump is in 2013, from 2013 to 2014. Those are based on CBO projections. How that will really play out remains to be seen. I mean, I think some States would say, uh, we're not going to see that big of an increase. We've done a good job of enrolling our eligible kids, so that's not going to happen. That means there's going to be a lot of State variation. Surprise. But that'll be something for us to look at.

CHAIR ROWLAND: So, on this slide, there's actual numbers and there's projections?

MR. PETERSON: Correct.

CHAIR ROWLAND: In the future, maybe it would be helpful to distinguish between the actuals and the projections just so that that's clearer.

MR. PETERSON: Mm-hmm.

VICE CHAIR SUNDWALL: And the last thing I just want to say, Norma, I don't think we have the highest rate of uninsured children. I don't know the percentage. What we documented in an article this morning I read was that our rate of outreach or increased enrollment is among the lowest in the country. It's been stable.

But one thing that's interesting about our State is that CHIP is open enrollment. We have no season. If you're qualified, you can be signed up, which is a good thing and kind of surprising.

COMMISSIONER CARTE: Dave, I just wanted to point out to you, too, in terms of that jump that you are seeing on that bar graph, part of that is, as Chris and I often discussed in the old days, the peculiarities of the funding formula. The allotment formula for CHIP early on was resulting -- as we approached CHIPRA, many States were approaching shortfall and it was because the funding really didn't have a base on actual enrollment in the States.

You know, I remember being in front of a hearing with your Senator and he said, well, why did States go beyond that? Well, there was this bifurcation between the formula and what the actual enrollment that States had with a stated intent under Title 21 that States could enroll up to 200 percent. But as States went towards 200 percent, they had inadequate funding stream. So, really, it was a correction that was made under CHIPRA. It wasn't just a sudden surge or anything.

COMMISSIONER CHECKETT: Well, Chris, thanks. You always do a great job in the arcane world of eligibility.

I just want to make sure that I have got this right, and I am looking at the churning slide. So, during the CHIP waiting periods, those 38 States with CHIP waiting periods, a child may enroll in subsidized exchange coverage. Now, just help me understand this. So, individually, a child, or does the parent have to enroll? First question.

And then, secondly, is there just going to be, like, some kind of -- remember that big thing, and then there's magic, and then the magic happens --

[Laughter.]

COMMISSIONER CHECKETT: -- and the child is somehow notified that they're now moving off their exchange coverage and back to CHIP. Do you know how that's going to work, because I don't.

MR. PETERSON: So, first of all, on the parents, the parents aren't going to be eligible for CHIP coverage. They will be eligible for exchange coverage.

COMMISSIONER CHECKETT: Right. I understand that.

MR. PETERSON: So, then what happens with the children -- so, let's walk through an example. So, the parent comes in. Your child is eligible for CHIP but your child recently had employer-sponsored coverage, so now you're in the waiting period.

COMMISSIONER CHECKETT: And I want to stop you. So, the parent is eligible for the exchange --

MR. PETERSON: Correct.

COMMISSIONER CHECKETT: -- or a subsidized exchange coverage, but when they look at the child, the child is actually eligible for CHIP and CHIP would take priority over the exchange subsidy, the subsidized exchange.

MR. PETERSON: Because you can only have one. You're only eligible for one or the other and CHIP trumps.

COMMISSIONER CHECKETT: And CHIP trumps. That's the key there.

MR. PETERSON: CHIP trumps.

COMMISSIONER CHECKETT: Okay. All right.

MR. PETERSON: Okay. So, now the parent has gone in. The child is in the CHIP eligibility range. Let's say that it's in the Federally-facilitated exchange. My understanding in talking to folks is that the exchange would then say, oh, this child is in the CHIP eligibility range. CHIP program, you figure it out.

Then what happens in this case is the CHIP program says, well, wait a minute. We have a waiting period. And they have to test whether or not the exemptions to waiting periods apply, and there are many, and it could be that -- and this is what we need to do more analysis on -- many children may qualify for those exemptions.

But if they don't qualify for those exemptions, then the CHIP program says, well, you're not eligible for CHIP right now. You have to go back to the exchange coverage, and hopefully this happens electronically, quickly, instantly. That remains to be seen. Then they would be eligible for exchange coverage for the duration of that waiting period. Let's say it's three months. The CHIP program is

supposed to give the parents a tickler, that is to say, remember, you're supposed to now go into -- the child is now supposed to go into CHIP. That is the way that's supposed to work.

CHAIR ROWLAND: Okay. So, for our next meeting, you're going to write this up --

[Laughter.]

CHAIR ROWLAND: -- so that we have a flow chart that shows how this would work so that we can discuss whether or not there are some suggestions about how that pathway could potentially be smoother. I think it's a great point to look at.

COMMISSIONER CHECKETT: Other than magic happening.

CHAIR ROWLAND: Right. Sara.

COMMISSIONER ROSENBAUM: I do have one additional question, I mean, related to this, which is -- and this just shows sort of my lack of clarity on how broadly our recommendations can sweep.

So, the specific thing that's going to happen in 2015, that the money is going to run out. The program, of course, is authorized through 2019.

So, the question I have is whether we might think about making recommendations as well as an early revisiting of what is really a ten-year authority, that it would be wise if we're going to end up recommending a continuation of the program to then make recommendations to bring the program into alignment with what has happened in the intervening years. And I just thought it was worth sort of flagging for people that we will need to think about how to do that since the question on the table is not the authorization of CHIP, it's continued funding for it.

CHAIR ROWLAND: Right. Okay. Donna. I mean, Denise.

COMMISSIONER HENNING: Okay. So, it's the purpose of a waiting period for CHIP is to make sure that they're not eligible for other insurances, and if the exchange has said, you're eligible for CHIP, so, therefore -- it's, like, so, why do they have to do the waiting period?

CHAIR ROWLAND: That's why I think we need to look at the waiting period as one of the major --

COMMISSIONER HENNING: All right. I just want to make sure I wasn't missing something here.

CHAIR ROWLAND: Donna.

COMMISSIONER CHECKETT: And, you know, the other thing -- we discussed this yesterday, but I just -- I really want to emphasize it -- is that I feel people do not understand that the exchanges are not 12-month open enrollment, and that's going to figure in here, too --

COMMISSIONER ROSENBAUM: Absolutely.

COMMISSIONER CHECKETT: -- because you just can't get on any time you're ready. You have to enroll and get in that program between January and the end of March, and that really confounds a lot of this, too.

CHAIR ROWLAND: Okay.

VICE CHAIR SUNDWALL: I've just got one more really quick question. Why would CHIP trump? If a family could get family coverage through the exchange, why would they want their child on another health insurance program? Is it because the benefits are richer?

CHAIR ROWLAND: And the cost is lower.

COMMISSIONER CARTE: It's going to have dental coverage, and most standard plans would not include dental. It would be supplemental.

COMMISSIONER ROSENBAUM: The exchange plans will have a pediatric dental benefit, but because of the way in which the pediatric dental benefit has been interpreted, it's probably going to be a clumsier benefit than the cleaner system that CHIP has set up, better cost sharing and more accessible coverage. I think it's worth noting, though, that the essential health benefit package includes certain service classes that don't show up in CHIP at all, so this is -- and that's the point that Chris was making.

CHAIR ROWLAND: Okay.

COMMISSIONER CARTE: But, still, you could have a family paying for the premium for the parent, a CHIP premium, or an exchange premium, and then a supplemental dental premium, right?

CHAIR ROWLAND: I think that what we're saying is we really need to look at how CHIP fits with Medicaid, on one hand, and then with the exchange coverage or employer-based coverage, because some of these families will not be getting coverage through the exchange. They'll actually be getting coverage through the employers.

So, we have our work cut out, and I think now we could turn to Amy to tell us what we know about how children access care today under different insurance forms and provide us with a statistical overview of a lot of individual cases.

Thank you, Chris.

Session 9: HOW ARE CHILDREN FARING UNDER MEDICAID AND CHIP?: FINDINGS FROM THE NATIONAL SURVEY OF CHILDREN'S HEALTH

* MS. BERNSTEIN: Thank you. So today we're going to continue our investigation of how children are faring under CHIP and Medicaid to the extent that we can distinguish CHIP from Medicaid, which I will talk about in a second.

As you know, as Chris has just talked to you about, and as we've heard over the course of many meetings, things are going to change, and as we think about how things are going to change, it's helpful to have some information about what the current experience of children in different groups now is so that you can think about the implications when you're thinking about changes.

So my presentation today will take one large data set. We will look at the experience of children with respect to their health utilization and access, and think about three different policy issues, perhaps to start with:

One is the stair-step children that we've heard about, so if, in fact, these children are going to transition from CHIP to Medicaid, it would be nice to know about their experiences in these things; CHIP reauthorization, that you have just heard about this morning; and also to just sort of look at Medicaid children with respect to their coverage in the EPSDT, early and periodic screening and diagnosis and treatment program, which basically is a very comprehensive set of benefits and are children actually receiving these benefits as reported by their parents.

Under the ACA, again, I'm not going to talk about stair-step children again because I think you've heard enough about them, but some of the questions that, you know, would be relevant to what I am going to talk about is what is the impact of this movement, and, again, changes in eligibility determination methods will result in these transitions, and so how do these groups compare.

CHIP reauthorization we have already talked about.

EPSDT, just as a little review, does mandate that all children enrolled in Medicaid receive all medically necessary Medicaid covered services, and this is even if they are not provided to adults in the state. So, for example, some LTSS that you heard about yesterday, if they are considered medically necessary for a child with special health care needs, would be covered under the EPSDT program if they were Medicaid-covered services, either optional or mandatory, and if they were considered medically necessary. And in addition, children are required to receive a comprehensive set of screening services that they must report on the Form 416. It's a minimal set of measures that are actually reported on the 416, but they are required to receive comprehensive, preventive examinations, and they are required to report dental use. So states are required to report these measures. As it describes in your paper, there's some -- not controversy. There are some concerns that perhaps these data are not being reported as completely or as accurately as they could be. And in managed care in particular, it is not clear exactly how useful these are in evaluating what services children receive.

You may also recall that in our March 2012 report to the Congress, you saw an analysis that was based on a different survey than the one I'm going to talk about today. The previous analysis was based on the National Health Interview Survey, which is a large population survey of children and adults. But in the analysis of children, it focused on the question of how Medicaid children were faring relative to children with employer-sponsored coverage. And in that analysis, you may recall the term -- I believe it was -- it wasn't "similar children," but "equivalent children," and I don't know if you recall the conversation about that, but their sociodemographic and health status characteristics were controlled for. And that was because

you were sort of -- we were evaluating sort of what was due to the Medicaid program and what was due to other factors that might influence access. So if the children that were served by Medicaid were similar to the children that were served by employer-sponsored insurance, you know, sort of how would their utilization and access differ? And the results of that analysis, when these things were controlled, were that the Medicaid and CHIP children were actually comparable or in some cases better in their access and utilization than children on employer-sponsored coverage.

This analysis is a little different, and here are the reasons why it's a little different. This analysis is focusing more on what children actually receive or are reported to receive, because this is a survey. And given that under EPSDT they're supposed to be receiving these preventive services, are they reported to be receiving them? So it's not are we comparing it to private because we want to know sort of the effect of the program in general. The assumption is that all of the children should be receiving all of these services. So you don't control in that instance.

We're using a survey called the National Survey of Children's Health, which is 100,000 children, which I'll talk about in a second. It has a larger sample size, and it's focused specifically on children. And, again, I'll describe it in a second.

This analysis, again, does not control, but there are certain groups of children that we're particularly interested in. So we did do a subanalysis of low-income, privately insured children just to look at whether some of the differences, if there are any, are related to the income of the children. It could be that higher-income children have better access in general, so if you sort of lump them in with the lower-income, privately insured children, it's not as fair a comparison.

We also look at children with special health care needs because they're a population of specific interest. And we look at children who are likely to be enrolled in a separate CHIP program versus the Medicaid program.

One of the problems with survey data in general is that when you call parents in particular and say, "Is your child enrolled in CHIP?" they're not very good at answering that question. And there has been a lot of validation studies of these questions, and they have concluded that really parents are not very good at separating out their knowledge of whether they're in a CHIP program or whether they're in a Medicaid program. So when you see analyses from the National Health Interview Survey or this survey, they generally either say it's Medicaid and CHIP or public coverage, because the parents know they have coverage, but they can't say, you know, specifically what that coverage is.

So what we did in this analysis is we looked at sort of higher-income Medicaid/CHIP program, and we used the separate CHIP cutoff for each state. So we said, okay, here are children in the state that has a cutoff of 200 percent, so we'll take all the children who are between 200 and 400 percent -- all the children who are between that level and the Medicaid level, and we'll put them into one group. So if it's -- let's say the cutoff is 133 percent and all the children in the state above 133 percent are in a separate CHIP program, we put them into the separate CHIP category. And then we took all the children in that state below 133 percent and put them into the Medicaid category.

So we don't know if they actually had CHIP, but they're sort of more likely to be in CHIP because they are in the higher-income group that would have put them into the separate CHIP program in that state. There are a couple states where there is no separate CHIP program, so we don't use them in that analysis,

although those states are in all the other analyses.

And then the last thing that is different from the previous analysis is in the Health Interview Survey analysis that you saw before, they had the ability to control whether the child was in for a full or a part year, whether they had Medicaid for the full year or the part year. The National Survey for Children's Health does not allow you to do that, unfortunately, and we can't distinguish whether the child had employer-sponsored coverage, which was used in the National Health Interview Survey analysis, or just private insurance in general. So we can't distinguish the sort of exchange type private coverage from the employer-sponsored coverage.

So a little bit about the National Survey of Children's Health. This is a random-digit-dial telephone survey that is sponsored by the Health Resources and Services Administration in large part to monitor their outreach and Title 5 and other block grant and preventive programs that they use for children. It's done in two-year increments, so the latest one was in 2011-2012. It was also done in 2007-2008 and 2003-2004. And it has almost 100,000 interviews with families with children age zero to 17 years. One sample child per family. And that's in comparison to the National Health Interview Survey analysis, which had about 13,000 children.

It's only non-institutionalized children, so they don't specifically focus on children in institutions. And unlike the National Health Interview Survey, it was designed to produce state-level estimates for all 50 states. The Health Interview Survey can be used for some state estimates but not for all states. And at least 1,800 children per state were included, although I am not providing you with state-level estimates today, I'm sorry to say. And it has more detailed questions on receipt of specific preventive and other services and

access measures that pertain specifically to children than the National Health Interview Survey does.

So moving on to the results, not unexpectedly, children with Medicaid or CHIP live in lower-income, less educated families. That sort of gives us a little reassurance that the survey is doing what it's supposed to do. If you look on Table 2 in your binders, in fact, Medicaid children do have poorer health status on a variety of measures than do privately insured children, but about the same as uninsured children, and are more likely to have special health care needs compared to privately insured and uninsured children.

Also on that table, which I didn't put on the slide, is the prevalence of specific chronic conditions that can be used to define special health care needs. I should also say that the definition of "special health care needs" is based on a series of five questions. That includes questions on whether they take prescription medications on an ongoing basis, whether they need therapies on an ongoing basis, whether they need more health care than other children, and two other questions that are escaping me at this particular moment, but they're in your materials.

So it's not sort of special health care needs in the sense that all of them need huge amounts of care, but it does mean that they need more care on average than other children, and they need ongoing care.

Looking at just preventive visits, which, again, in relation to EPSDT and are reportable, they should be reporting high levels. They are reporting relatively high levels, but certainly not 100 percent, and for some things not very high at all. So these are reported numbers. Again, these haven't been validated. But they are what the parents report.

Compared to privately insured and uninsured children, I'm just going to say up front that all of the levels of utilization and access are worse for uninsured children. Medicaid/CHIP children do better on all

of these measures, and I would have a million slides if I reported all of them. So I'm just going to say up front that Medicaid rates are consistently better for all of these measures.

A smaller percentage of Medicaid/CHIP children had a reported preventive health care visit, and these other things that are on the slide, a specialist doctor visit, and some of these differences are relatively small. So when I say something is different, I do mean it's statistically significantly different. I'm not making judgments about whether it's meaningful or not.

Some of these levels are, you know, quite comparable, although because it's such a large sample, they are statistically different. But some of them are quite large, so, for instance, those receiving coordinated ongoing comprehensive care within a medical care home is a 20 percentage point difference, and that's probably somewhat meaningful.

A similar percentage had a reported developmental screening for children age 10 months to 5 years, and a higher percentage of Medicaid/CHIP children reported receiving needed mental health care than private insured children, almost double.

When we looked at just the low-income, privately insured children who may have similar barriers related to cultural competency or other things that are associated with low income, many of these differences did, in fact, go away. So differences between privately insured low-income children and Medicaid children were the same -- I mean went away for medical care and whether they had a specialist visit and whether they had a vision screen. But some of the differences did remain. So the percentage reporting unmet need for medical care was still significantly different, although, again, the overall rates of unmet need are really very small for these children. For uninsured children, they were much, much higher.

For both Medicaid and privately insured children, rates of unmet need tended to be below 10 percent.

When we look at the special needs status children compared to the privately insured children, Medicaid again had somewhat more access problems and lower rates of utilization than the privately insured special health care needs children, although they were equally likely to report unmet need, and they had a higher percentage reporting mental health care.

And when we get to the probable CHIP status -- again, I'm calling it "probable CHIP status" because we don't actually know -- really the rates were fairly comparable. The probable CHIP children were slightly less likely to report unmet need for health care and to say that their doctor -- well, actually these were about as likely, so I'm sorry. The doctor asked about parental concerns. All these things were the same for children. And these were a little bit higher. But, again, most of the differences were very, very small.

So, really, the differences were something for you to consider when you are thinking about comparing these groups, that it's not, I think, as different as many people would hypothesize, but, again, it depends on which program you're looking at, and we sort of would like this to help inform your decisions about various things and to actually target areas where you think we need more research, because these really are just survey data and these are very sort of crude tools to compare these groups. So possibly this might help you tell us where you would like to focus in the future.

Thank you.

CHAIR ROWLAND: Thank you, Amy. I think that's very helpful to have data to finally look at and answer the question of are you worse off if you're on Medicaid. We know that you're clearly worse off

if you're uninsured, so I think this is very helpful in setting the tone for what difference having insurance can make and how well the programs are performing. And also the comparison that adjusts for low income really begins to tell you the difference between private insurance and Medicaid is not as dramatic as some people think in terms of changing your access patterns.

Other comments?

COMMISSIONER HOYT: On the 416 forms or just EPSDT in general, what are the consequences to a state that is not meeting the 80 percent bar?

MS. BERNSTEIN: None.

COMMISSIONER HOYT: It just seems inconsistent to me to say that Medicaid children are mandated to receive all medically necessary care and comprehensive screens, vaccinations, et cetera, are part and parcel of the program, but if there's no teeth to this, I don't see what the incentive is to the state. It feels like something's broken here. Either the 80 percent is unrealistic or the data is bad or something should change.

MS. BERNSTEIN: There is a task force now -- there is a working group at CMS that's investigating EPSDT issues. But the report hasn't come out yet, so we don't know what recommendations they're making.

CHAIR ROWLAND: Sharon.

COMMISSIONER CARTE: Mark raises a really important issue, even though earlier we were talking about CHIP will likely transform. We don't need things in silos. But one of the things that really should not be lost and should be augmented is that CHIP has provided this great focus on pediatric quality

issues, and if anything, that needs to have greater emphasis and focus as we go forward, because right now, so much of the quality initiative, performance-driven health care is focusing, understandably, on those with chronic care issues or where savings can be realized.

But although we might not see savings for the reasons Mark just draws your attention to, there should be an increasing emphasis on making sure where we spend dollars on pediatric services, we do get something in return, and it has to reflect those changing developmental needs that children have that adults don't.

CHAIR ROWLAND: Judy.

COMMISSIONER MOORE: I actually agree with Sharon and I would hate to see us lose that quality focus, too, so we can keep that in mind as we go through our deliberations on CHIP and that sort of thing. I think it's a good idea.

But what I -- this is a nice basis for us to think through our other children's issues, but I wondered, and this is just based on my ignorance, are there other parts of the Department that are zeroing in in surveys that look more deeply into behavioral health issues for children and/or dental health issues for children? Because, I mean, there are other parts of the Department that focus on those kinds of issues and I just wondered if there was any other survey work that we should know about at some point.

MS. BERNSTEIN: Yes. The answer is yes. There's the National Survey of Children with Special Health Care Needs, where we're actually in the process of running data from them now, which, again, is -- you can produce State estimates, and they look at dental health and behavioral health specifically. Hopefully, at some point, you'll see some data from them.

There's also the National Survey of Drug Use on Health, which has really, really detailed behavioral health data which can be used at the State level, as well.

And then you have the Behavioral Risk Factor Surveillance System, which asks sort of general questions, but not focus -- actually, that's only 18, so scratch that. That's only adults.

And then there are several surveys. There's the Monitoring the Future survey and the Youth Risk Surveillance System survey which have mental health use and mental health symptoms, as well, for adolescents. So any of them are fair game.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: The other thing that reminded me of is that I know there's a lot of interest in adolescents as a group right now, so I'm wondering whether we might think about sort of a special focus that compares adolescents who get Medicaid and CHIP versus other adolescents.

CHAIR ROWLAND: Donna.

COMMISSIONER CHECKETT: Amy, on the survey that was used to gather a lot of this information, do you know how many questions there are and how long it takes to administer? I'm always fascinated that you can even get anyone to participate, and the old CAHPS survey used to be, like, 300 questions, which was incredibly unbelievable. I'm just curious about that.

MS. BERNSTEIN: It takes about, I believe, 50 minutes.

COMMISSIONER CHECKETT: Five-zero?

MS. BERNSTEIN: Yeah.

COMMISSIONER CHECKETT: Wow.

MS. BERNSTEIN: But -- well, okay. So this is a random digit dial survey, so, you know, think about Caller ID and answering the phone when you don't know who the person is. So they screen a lot of people before they get people who are willing to participate. So it's even really hard to computer response rate. But once they get people -- they do offer an incentive, so -- I think last I heard, it was $20 or $25 to participate. So, people -- you know, if you can get somebody on the phone, they're willing to stay, especially if it's about their children.

COMMISSIONER CHECKETT: Thank you.

CHAIR ROWLAND: Herman.

COMMISSIONER GRAY: I had the same question in terms of, similar to Judy's, as far as the survey is good information for us to better understand the population, but it's really looking at process measures. It doesn't really tell you much about outcome, you know, quality of life, preparation for the future, that sort of thing. So I'm encouraged that there are other surveys to look at.

I'm interested in behavioral health, certainly, but also physical health to the extent that it's possible. Not knowing, understanding those surveys and what their limitations are or what they're looking at, I'm not sure that that's doable, but are there -- is there a connection between number of ED visits, inpatient visits? Are there clues that we might get that there are ways to reduce costs in the pediatric population if they, indeed, get access to preventive care, access to health maintenance activities? I don't know that we know the answers to those questions. Intuitively, you sort of think you know the answer to it, but I'm not sure that we really know the answers to it, and so it would be interesting if we could look more at some sort of outcome kind of measures.

CHAIR ROWLAND: And, Amy, I think the piece that -- you've presented the charts, but I think writing up the survey and having it as part of our chapter would be very helpful, as well, and that in that write-up, I would probably move the material on how this differs from previous MACPAC analyses to an appendix and really focus on really writing up this survey as the highlight that it is, because I think that it provides a very useful data profile.

Okay. Well done. Thank you.

Are there any comments as we come to a close of our meeting that anyone in our public audience would like to offer? If so, please come to the microphone.

PUBLIC COMMENT

* [No response.]

CHAIR ROWLAND: Well, we hope you have enjoyed your time here with us.

Then we will stand adjourned until our October meeting, and thank you, Commission members and staff, for a really engaging time and lots of work to come. Thank you.

[Whereupon, at 11:44 a.m., the meeting was adjourned.]